

Saskatchewan Seniors' Oral Health and Long Term Care Strategy

**Better Oral Health in Long Term Care:
Best Practice Standards for Saskatchewan**

2016

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SASKATCHEWAN
ORAL HEALTH
PROFESSIONS



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Main Messages

A healthy mouth will improve overall health and wellbeing. Six of the best ways to maintain a healthy mouth for residents:

1. Brush morning and night
2. Fluoride toothpaste on teeth
3. Soft toothbrush on gums, tongue and teeth
4. Antibacterial product daily as required
5. Keep the mouth moist
6. Reduce frequency and amount of sugar

It takes a team approach to maintain a healthy mouth, with care aides, nurses, physicians, and other health professionals and oral health professionals taking responsibility for all of the four key processes:

1. Oral health assessment
2. Oral health care planning
3. Daily oral hygiene
4. Oral health treatment

Executive Summary

Canadian population, like many industrialized countries, is aging. Seniors (individuals 65 years old or over) constitute the fastest-growing age group. This trend is expected to continue for the next several decades due mainly to the aging of the baby boom generation, low fertility rate, an increase in life expectancy. In 2015, the seniors outnumbered the children younger than 15 years old and this trend would steadily continue in the coming years. Currently, seniors make up 16.10% of population of Canada. Nearly one in three senior citizens are people aged 80 years or over. The proportion of people aged 80 years or over among the senior population would reach about one person out of three by 2036. Saskatchewan's population is aging as well and is expected to increase. Currently, 14.6% of the residents of Saskatchewan are seniors. By 2026, 20.7% (almost one in five people), and by 2036, 23.3% of residents of Saskatchewan are expected to be 65 or over.

According to the 2006 Canadian census, the vast majority (93%) of seniors live at home. However, as their needs increase for assistance with daily activities and personal care, some will eventually require institutionalization namely long-term care (LTC) homes. The latest *Long-term Care Facilities Survey, 2013*, reported in 2013-2014 there were 1,519 long-term care facilities in Canada serving 149,488 residents. According to *Continuing Care Reporting System*, in 2014-2015, there were 111 residential care in Saskatchewan with 9,024 residents, with the average age of 79 years; of the residents, 55.7% were 85 and above. Given the size of the elderly in these facilities and the extent of systemic disease among this group, it is reasonable to conclude many of them need some level of support with their daily care including oral care.

As noted in the *Canadian Health Measures Survey (CHMS) 2007-2009*, the first national survey on the oral health status of Canadians 6-79 years of age, the number of decayed and missing teeth increases with age along with periodontal disease. This emphasizes the need for regular professional dental care and for appropriate strategies to address the future needs of this growing population. Additionally, today Canadians tend to keep their teeth much longer than in the past. Today, the majority of Canadians retain their natural teeth for a lifetime. In 1972, approximately 50% of Canadians above 60 were edentulous (i.e. without natural teeth), whereas in 2009, almost 22% had no natural teeth. The fact that the seniors tend to have their natural teeth, means most of them might need a professional oral care for problems including tooth decay and periodontal diseases. Today, root caries has become an important dental problem. As people grow older, their gums recede and root surfaces are exposed, making them more susceptible to root caries which is more difficult to detect and treat.

Furthermore, the number of new cases of oral cancers rises with age. Adults over 60 years of age are at the greatest risk for oral cancer. According to Canadian Cancer statistics 2015, oral cancers are the 9th most common cancers among men and 13th among women. Currently in Canada, more deaths occur from oral cancer than from melanoma or cervical cancer. The five-year survival rate for oral cancer is much lower than the most common cancers that is breast cancer and prostate cancer.

According to *CHMS 2007-2009*, the oral health of Canadians has improved significantly over the years; yet, not everyone has enjoyed the same degree of improvement. Significant inequalities in oral health and access to dental care were found to be related to age, dental insurance, and income. The *CHMS* provides an incomplete picture of oral health in very old Canadians. It exclude

people 80 years of age or older, although this age group now constitute about 4% of the Canadian population. It also did not include institutional residents, who are generally frailer, have poor oral health, receive less dental care, and greater treatment needs.

Poor oral health among residents in LTC homes is a rising concern in Saskatchewan and Canada in general. This poor oral health is caused due to inadequate or lack of daily oral care, limited or lack of access to oral health professionals, pre-existing medical conditions of residents and lack of financial support for dental treatment. The proportion of the LTC residents with coronal or root caries is very high. According to the Canadian studies, the average DMFT (an index of dental caries prevalence) in LTC residents falls in the range 23.6-26.6, whereas based on the CHMS 2007-2009 the average DMFT for 60-79 year old adults is 15.7. Among the Canadian LTC home residents 44%-68.8% have root caries as opposed to 11% of 60-79 year old adults in the CHMS. In addition, according to one Canadian study, 41% of LTC residents are edentulous, while 22% of 60-79 years in the CHMS have no natural teeth. Moreover, the denture related problems (including mucosal abnormality, not retentive dentures) are very common in these facilities.

According to the World Health Organization, oral health is an important part of overall health, and a determinant of quality of life. A healthy body cannot be achieved without a healthy mouth. Poor oral health can eventually impact the overall health and well-being. There is a strong association between oral disease and conditions such as aspiration pneumonia which occurs frequently occur in LTC residents. Pneumonia generally develop following aspiration of microorganisms from the oral cavity or throat. Improving oral hygiene can significantly prevent pneumonia as well as decreasing death from pneumonia. There are not only major health, social and psychological consequences, but

also significant economic costs related to poor oral health. Given the potential health risks of undiagnosed oral diseases, ranging from tooth decays to oral cancers, the potential cost to the health care system of untreated oral diseases could rise substantially in the next few years.

Remaining free from oral infections and pain, ability to speak, eat and interact socially, and having a good quality of life is important for seniors. Our seniors have contributed greatly to the development of the society and they deserve to be provided with the best oral health care. While many facilities in Canada have arrangements to manage acute dental problems requiring emergency treatment, basic preventive care measures (such as daily mouth care) are often missing.

In some provinces there are standard oral health assessment protocols or guidelines governing the oral care of residents in LTC homes. Besides, several programs are in place to improve the oral health of the residents, such as Halton, Ontario Oral health Outreach Program, and University of British Columbia Geriatric Dentistry Program. In some provinces, the Colleges of Dentistry are playing an important role in improving the oral health of vulnerable groups of the community. In Saskatchewan, there is no oral health programs/services for residents of LTC homes.

In the Saskatoon Health Region (SHR), the University Of Saskatchewan, College Of Dentistry and a private practice dentist, Dr. Raju Bhargava and his team, implemented an oral health pilot at St. Anne's Home and Saskatoon Convalescent Home in 2006. The pilot was to provide clinical oral health services to consenting residents at both facilities. Over the next few years, Dr. Bhargava and his team provided services to residents. LTC home staff also received basic oral health education from SHR Oral Health Program staff.

A 2006 survey of staff, residents, and residents families showed that:

- 35% of residents were experiencing problems with their teeth /gums;
- 69% of residents only accessed dental care when there were problems (mobility was the main reason);
- 88% of LTC staff visited a dentist in the past year while 67% of family members of residents visited a dentist in the past year;
- 64% of residents perform their own daily care; and
- main reasons LTC staff do not provide daily care to resident is uncooperative resident and not enough time.

This pilot was instrumental in demonstrating the need for oral health treatment services in LTC homes, on-site oral health professionals coordinated services/staff/residents, and basic daily oral prevention for residents.

An outcome of this initial pilot was a second pilot in 2011 that focused on the use of an Oral Health Coordinator at two Saskatoon Health Region LTC homes – Parkridge Community Centre and Sherbrooke Community Centre. This was called the *Oral Health LTC Initiative*. It was supported with a \$20,000 Community Wellness Grant from the SHR. A registered dental assistant was hired in partnership with the University of Saskatchewan, College of Dentistry. The Oral Health Coordinator (OHC) assisted LTC staff and residents to access dental care at each site. The College of Dentistry-Dental Residency Program, delegated dentists from the program to provide treatment for residents who consented. All initial assessments were free of charge to encourage residents to participate.

At the same time these LTC pilots were occurring, the Saskatchewan Oral Health Coalition (SOHC) was launched. Through strategic planning, the SOHC members identified that oral health in LTC was a significant issue, and one that they wanted to focus on. One of the outcomes of the SOHC was the

partnership involved in securing the Saskatoon Health Region's Community Wellness Grant for the OHC.

As a result of the SOHC working with the community related to oral health in LTC homes, the Saskatchewan Oral Health Professions (SOHP) began to develop standardized recommendations.

The SOHP is a group that represents legislated oral health professions. They are:

- College of Dental Surgeons of Saskatchewan
- Denturists Society of Saskatchewan
- Saskatchewan Dental Assistants' Association
- Saskatchewan Dental Hygienists' Association
- Saskatchewan Dental Therapists Association

The SOHP determined that oral health in LTC was a critical issue to address. They worked with the SOHC to build capacity related to oral health in LTC, and to engage the community. The group used best practice evidence to select a strategy and resources that provided a solid foundation for the Saskatchewan Seniors Oral Health and LTC Strategy. The goal was to find a model and resources that provided the necessary education and training for staff, family, and residents. It also included community feedback and participation.

The SOHP embarked upon a best practices literature review to find an appropriate model of oral health care for seniors and LTC residents. After research, the *Better Oral Health in Residential Care* model, which was developed in Australia was selected as the gold standard for the Saskatchewan Seniors Oral Health and LTC Strategy. The *Better Oral Health in Residential Care* is Australia's national program. In 2011, the SOHP and SOHC endorsed the use and adaptation of this program. With the endorsement by the SOHP and SOHC, a licensing agreement was signed between the Saskatoon Health Region (SHR)

and Australia. The license allowed for Saskatchewan adaptations. During 2011-2013, SOHP representatives worked to modify the training resource to Canadian/Saskatchewan standards. In 2013, the resource was retitled *Better Oral Health in Long Term Care – Best Practice Standards for Saskatchewan*.

All of the work to date has contributed to the Saskatchewan Seniors Oral Health and LTC Strategy. It has been a community development and capacity building project from the onset. Partners and stakeholders have been supportive of the need to improve oral health in LTC.

The *Better Oral Health in LTC – Best Practice Standards for Saskatchewan* demonstrates a team approach with care aides, nurses, physicians, other health professionals and oral health professionals, having responsibilities for one or more of four key processes:

1. Oral health assessment
2. Oral health care planning
3. Daily oral hygiene
4. Oral health treatment

The work of the project was to translate evidence-based oral health research into daily practice.

The change in practice was to ensure:

- LTC home staff understand and appreciate the relationship between oral health and general health and the impact this has on residents' quality of life and wellbeing;
- a primary oral health approach is used to improve residents' comfort, wellbeing and quality of life; and
- maintaining residents' oral health as a multidisciplinary responsibility.

Simple key messages were formulated to reinforce the change processes:

- A healthy mouth will improve overall health and wellbeing—good oral health is essential for overall health.
- Six of the best ways to maintain a healthy mouth and protect your residents' oral health are:
 1. Brush morning and night
 2. Fluoride toothpaste on teeth
 3. Soft toothbrush on gums, tongue and teeth
 4. Antibacterial product daily as required
 5. Keep the mouth moist
 6. Reduce the frequency and amount of sugar
- It takes a team approach to maintain a healthy mouth—Work together to protect your residents' oral health.

The framework for implementing changes in oral health practice was based on a preventive daily oral hygiene care regimen, taking into account the influence of residents' responsive behaviours and palliative care considerations on the delivery of oral care.

Recommendations

The Saskatchewan Oral Health Professions (SOHP) and the Saskatchewan Oral Health Coalition (SOHC) have developed and endorsed the following recommendations for consideration and action by the Saskatchewan Ministry of Health. The recommendations are that:

- 1. The Saskatchewan Government, Ministry of Health, endorse the Saskatchewan Seniors Oral Health and Long Term Care (LTC) Strategy developed by the Saskatchewan Oral Health Professions collaboratively with the Saskatchewan Oral Health Coalition and Seniors Health and Continuing Care in the Saskatoon Health Region.**
 - 2. An Oral Health Coordinator (OHC), who is a registered and licensed oral health professional, should be employed in each health region to facilitate the delivery of initial oral assessments, dental examinations and treatment, daily oral hygiene for residents and oral health education. The Oral Health Coordinator will work collaboratively with the long term care, multi-disciplinary team to improve the oral and overall health of residents.**
 - 3. Upon entry into a LTC home, an initial oral assessment must be completed by a registered and licensed oral health professional, through the general and medical consent provided by the LTC home.**
 - 3.1 Oral assessments should be routinely performed every 6 months thereafter, by an oral health professional or a health care professional trained in oral health assessments.**
 - 3.2 Non-oral health professionals performing oral health assessments or care will receive appropriate training developed by the Saskatchewan Oral Health Professions.**
 - 3.3 Training will be provided by oral health professionals.**
 - 4. Initial oral assessments will include:**
 - 4.1 Personal client record*, including consent for dental examination**
 - 4.2 Review of medical and dental history**
 - 4.3 Complete examination of the oral cavity, which includes:**
 - 4.3.1 Assessment of hard and soft tissues**
 - 4.3.2 Assessment of oral hygiene care**
 - 4.3.3 Oral cancer screening**
 - 4.3.4 Denture assessment**

***Note: Implementation of a Saskatchewan electronic health record should include an oral health record.**
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5. Oral Health Care Policies and Procedures for LTC and Personal Care Homes* are standardized and implemented based on best practice for optimal oral and overall health for residents in LTC in Saskatchewan. Policies should ensure that every LTC resident has the right and access to the following oral health care services:

- 5.1 An individualized oral health care plan
- 5.2 Basic oral hygiene supplies
- 5.3 Daily oral hygiene
- 5.4 Access to professional oral health services
- 5.5 Oral health record included within the health record
- 5.6 Dental recommendations/orders are followed

*Note: As per Section 23 of the current *Personal Care Home Regulation*, each resident receive a dental examination, as necessary.

6. Treatment needs based on the dental examination, may be provided by dentists, denturists, dental hygienists, dental therapists and/or dental assistants. Residents may access dental services through their personal oral health professional or through dental services as available through the LTC home. Dental examinations require:

- 6.1 Consent for dental examination
- 6.2 Treatment plan and progress notes
- 6.3 Estimate and consent for financial responsibility
- 6.4 Consent for treatment

7. The Saskatchewan Seniors Oral Health and LTC Strategy is incorporated into post-secondary educational health training programs, orientation, and continuing professional development (i.e. for care aides, nurses, physicians, etc.).

8. The standard for new LTC homes includes provision for a treatment room suitable for a variety of health professionals including access to portable dental equipment to facilitate dental treatment.

9. The Saskatchewan government establish a safety net program to increase access to oral health services for low income seniors (similar to Ministry of Health Supplementary Health/Family Health Benefits or Alberta's *Dental Assistance for Seniors Program* through which low income seniors are eligible for up to \$5000 every 5 years for those aged 65 and older).

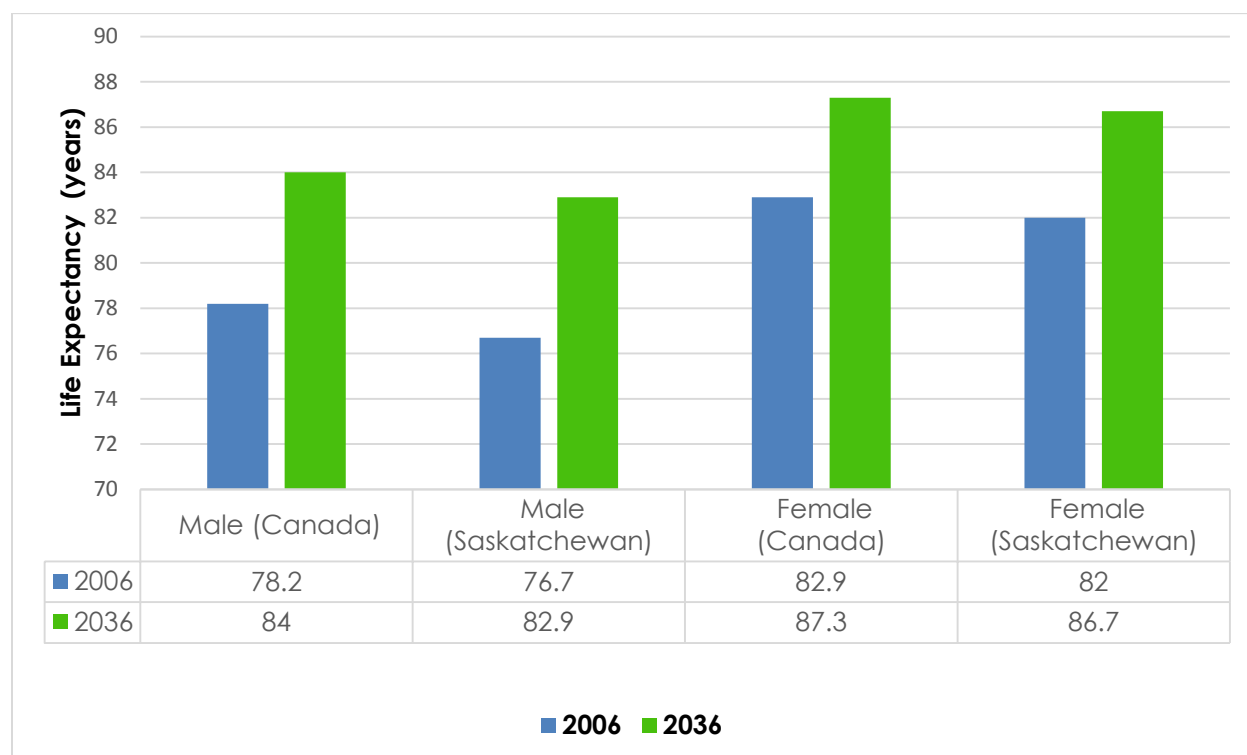
10. Surveillance, evaluation and continuous quality improvement be performed on an ongoing basis to demonstrate improved health and oral health status outcomes.

1. Background

1.1. Aging Population

Canadian population, like many industrialized countries, is aging. There is no universal definition of old age, however in Canada an adult 65 years and over is considered a senior citizen or elderly person (1). Seniors constitute the fastest-growing age group, with the women representing the majority of older people. This trend is expected to continue for the next several decades due mainly to the aging of the baby boom generation, low fertility rate, and increase in life expectancy (2). According to Statistics Canada, the life expectancy for Canadian men and women is 79 years and 84 years, respectively (3). The differences between life expectancy between the two genders would continue to narrow in the coming years. In 2036, Canadian male's life expectancy is expected to be 84 years; for females, life expectancy would rise to 87.3 years. Currently the differences in life expectancy between provinces is fairly small and continue to be as such in the next two decades. In Saskatchewan, in 2036 the life expectancy of men and women would be 82.9 and 86.7 respectively **[Figure-1]** (1).

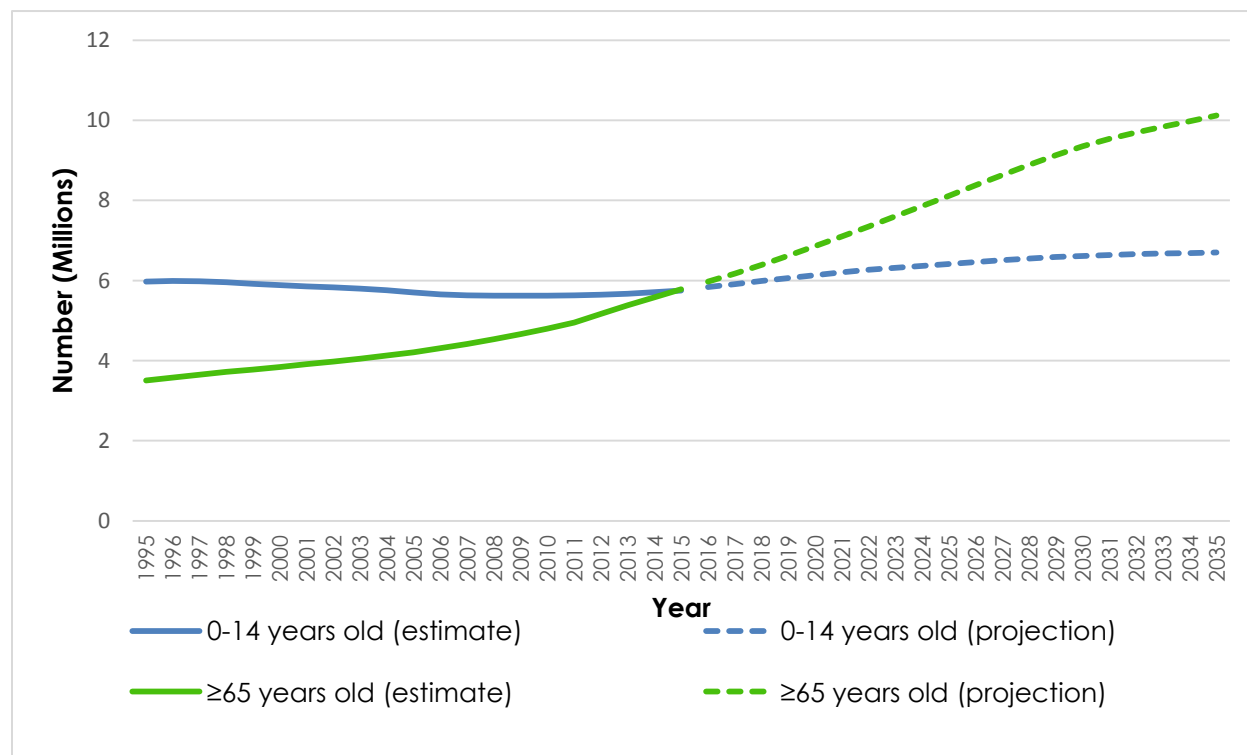
Figure-1: Life expectancy at birth in 2006 and 2036, Canada and Saskatchewan.



Under the medium assumption, Canadian male's life expectancy would increase from 78.2 years in 2006 to 84 years in 2036; and for males in Saskatchewan life expectancy would rise from 76.7 years to 82.9 years, an increase of 6.2 years in 30 years. Canadian female's life expectancy would rise from 82.9 years in 2006 to 87.3 years in 2036; and for females in Saskatchewan life expectancy would go up from 82 to 86.7, a gain of 4.7 years over 30 years. Life expectancy in Canadian women has been and continue to be longer than life expectancy of men. However, the gap in life expectancy between the two genders would narrow in the future (1).

Since 1981 to 2014, the number of Canadian children under 15 years of age has been higher than the number of seniors. However, the trend has reversed in 2015. Indeed, this trend would steadily continue in the coming years; that is, the number of seniors would exceed the number of children **[Figure-2]** (1).

Figure-2: Canadian population aged 0 to 14 years and 65 years and over estimates and projections (1995-2035).

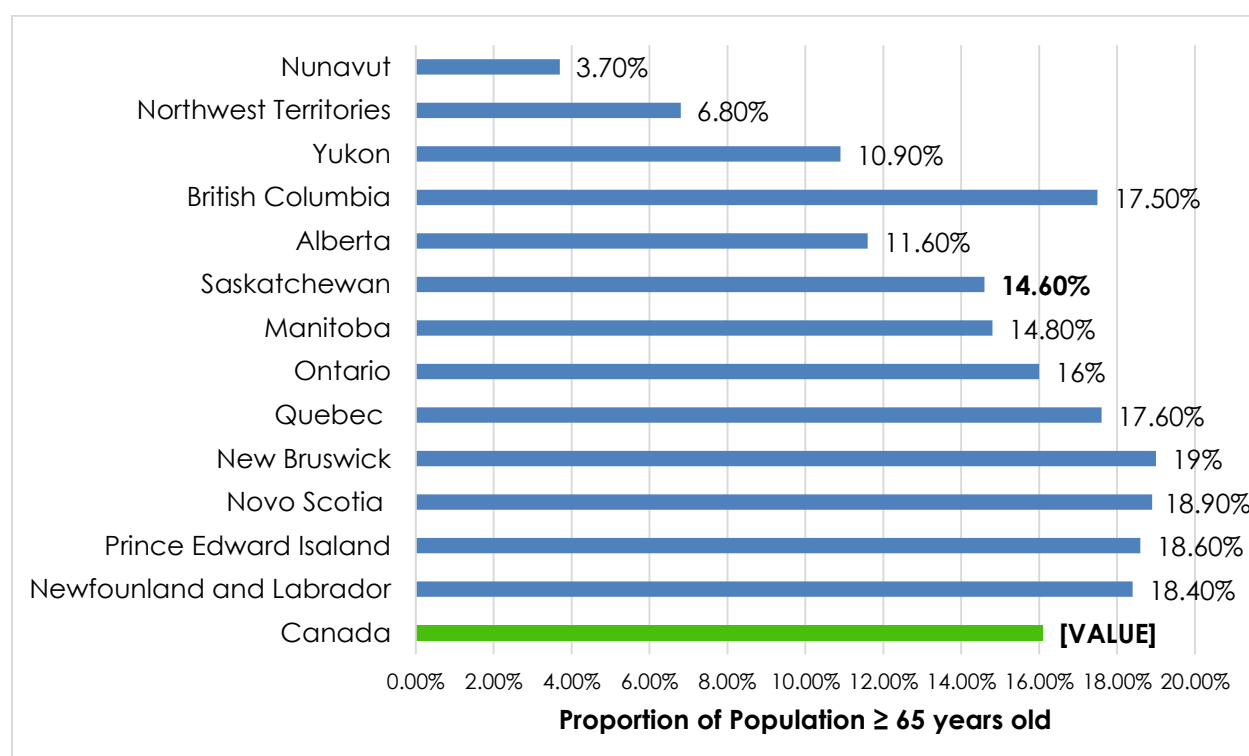


Data for 1995 to 2015, *solid lines*, are population estimates. Data for 2016 to 2035, *dotted line*, are population projections. Since 1995 to 2014, the number of Canadian children (0-14 years old) has been higher than the number of seniors. However, the trend has reversed in 2015; where seniors outnumbered the children. The upward trend would steadily continue in the coming years and the number of seniors would exceed the number of children (4).

In 2015, an estimated 5.781 million Canadians (16.10% of Canadians) were seniors **[Figure-3]**, a number that is expected to reach 10.116 million seniors by 2035. By 2051, about one in four Canadians (25%) is expected to be 65 or over (5). In particular, people aged 85 years and over comprises the fastest growing age group in Canada (6). In 2015, nearly one in three senior citizens were people of 80 years or over (7). According to the medium-growth scenario, the population aged 80 years or over is expected to increase 2.6 times by 2036 and

3.9 times by 2061. Also, the proportion of people aged 80 years or over among the senior population would reach about one person out of three by 2036 and slightly less than two persons out of five by 2061 (1). Saskatchewan's population is aging as well and is expected to increase. In 2015, out of 1,133,600 residents of Saskatchewan, 165,900 (14.6%) were 65 years of age or older **[Figure-3]** (8). By 2026, almost one in five people of Saskatchewan (20.7%), and by 2036, 23.3% of residents of Saskatchewan are expected to be 65 or over (1).

Figure-3: Proportion of the population 65 years and over, 2015, Canada, provinces and territories.



In July 2015, 16.10% of Canadians were seniors. Nova Scotia had the highest percentage of seniors (18.90%). 14.60% of population in Saskatchewan were 65 years and above (9).

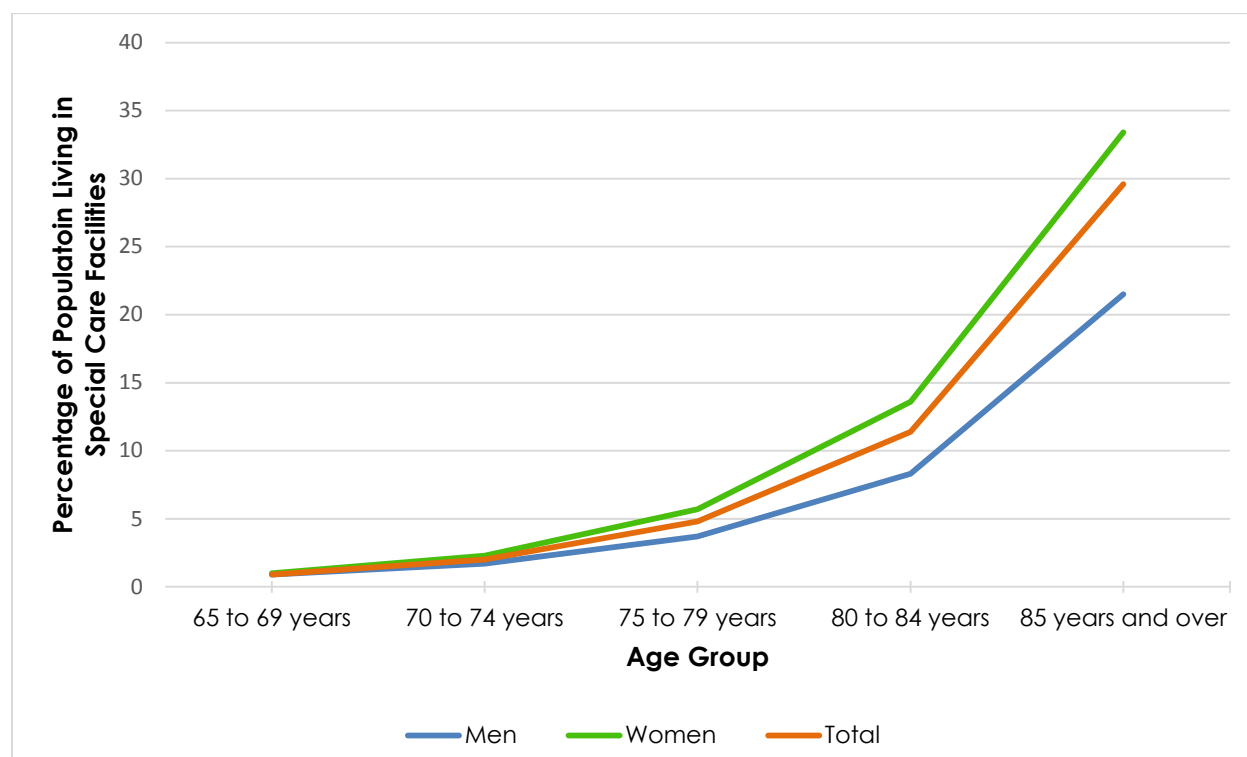
According to the latest Canadian census, i.e. 2006 more than 40% of Canada's seniors were in very good or excellent health, based on their own perceptions. However, at some point, they may require help with personal care or tasks

around the home due to physical or mental decline. In *Canadian Survey of Experiences with Primary Health Care, 2008*, about three out of every four Canadian seniors (76%) reported having at least one chronic conditions, including arthritis, cancer, chronic pain, depression, diabetes and heart disease; 24% of seniors reported being diagnosed with three or more of these conditions (known as multi-morbidity); with increasing age, the likelihood of having at least one chronic condition also increased (10). These conditions typically worsen with increasing age, eventually restricting daily activities, including oral hygiene activities and regular access to dental care (11).

1.1.1. Aging Population and Residential Care Setting

The 2006 Canadian census reports that the vast majority (93%) of seniors age 65 and older live at home. However, as their needs increase for assistance with daily activities and personal care, some will eventually require institutionalization namely residential care settings, known alternatively as nursing homes, long-term care (LTC) homes, and personal care homes (10). Proportion of seniors living in special care facilities increases with age **[Figure-4]** (12). In recent decades, rates of institutionalization among seniors have declined. In 1981, 3% of individuals of 65-74 years of age and 17% of those ≥ 75 lived in special care facility. In 2006, the rates were only 1.4% and 12%, respectively. However, with the substantial rise expected in the number of seniors over the next decade (many of whom will have multiple chronic conditions), the need for long-term care beds in the near future may increase (10).

Figure-4: Proportion of the population aged 65 and over living in special care facilities by age group, Canada, census 2011.



Special care facilities refers to nursing homes, chronic care or long-term care hospitals and residences for senior citizens.

The percentage of seniors living in special care facilities in 2011 increased with age. Among the age group 65 to 69, approximately 1% lived in special care facilities; among seniors aged 85 and over, the proportion was 29.6%. The proportion for seniors living in special care facilities was similar among women and men aged 65 to 74. However, from 75 years of age onwards, the percentage of living in this type of facilities increased significantly for both genders, but at a different pace. Among women aged 85 and over, the share in special care facilities was 33.4%, higher than the share of 21.5% for men (12).

The latest *Long-term Care Facilities Survey 2013*, reported that in 2013-2014 there were 1,519 long-term care facilities in Canada serving 149,488 residents (13). According to *Continuing Care Reporting System 2014-2015*, there were 111 residential care in Saskatchewan with 9,024 residents with the average age of 79 years; of the residents, 55.7% were 85 and above (14). Given the size of the elderly in these facilities and the extent of chronic diseases among this group, it

is reasonable to conclude many of them need some level of support with their daily care including oral care.

The oral health issues in elderly people are not just as a result of age, but rather are the consequences of systemic disease, use of medications cause dry mouth, functional disabilities and cognitive impairment (15, 16). As noted in the *Canadian Health Measures Survey (CHMS) 2007-2009*, which is a first national survey on the oral health status of Canadians, the number of decayed and missing teeth, and the prevalence of periodontal diseases increases with age. This emphasizes the need for regular professional dental care and for appropriate strategies to address the future needs of this growing population of Canadians (17). Moreover, professional care is required for the seniors particularly for those who also have compromised immune systems, to prevent oral infection (18).

Remaining free from oral infections and pain; ability to speak, eat and interact socially is important for seniors. While many facilities have arrangements to manage acute dental problems requiring emergency treatment, basic preventive care measures (such as daily mouth care) are often missing (19). Given the potential health risks of undiagnosed oral diseases, ranging from tooth decays to oral cancers, the potential cost to the health care system of untreated oral diseases could rise substantially in the next few years (18).

Canadian Dental Association (CDA) states that "Staff of long-term care facilities, dentists and other oral health care providers should work cooperatively, individually and collectively to develop constructive relationships and processes to advocate for and to enable the provision of appropriate care for the oral health needs of the residents." (20).

1.2. Oral Health Status in Long Term Care Home Residents

Research shows that oral health in institutionalized elderly worldwide is poor (21-27), mainly due to loss of independence in the elderly, difficulty in accessibility and affordability of oral care (19, 22). Other factors also make seniors more susceptible to oral disease. These include a decline in general health, increased consumption of medications (which can lead to dry mouth), and changes in diet (19). On the other hand some diseases such as dementia poses a significant challenge for health. Residents with behavioral issues associated with dementia frequently have their oral hygiene neglected as they may be resistant and violent towards receiving oral care from LTC staff (28). The number of LTC residents suffering dementia is very high; according to *Continuing Care Reporting System*, in 2014-2015, 49.7% of residents of residential care in Saskatchewan had dementia (6.1% Alzheimer's disease, dementia other than Alzheimer's disease 46%) (14).

The negative impact of poor oral conditions on quality of life has been demonstrated in plenty of studies and is an important issue (29). Chronic diseases such as tooth decay are still highly prevalent in older adults, and the risk of tooth loss in old age is high. Oral health care with an intervention led focus is costly, and demand for this care may increase as the proportion of older dentate adults increases (30).

Note from resident's sister

My brother's teeth are disgusting. It looks like they are never brushed. I took him to a university dental clinic. And they found a sausage piece in his mouth.

Marion

Common oral health conditions occurring in the seniors including residents in LTC homes are **[Table-1]**:

- Dental caries
- Edentulism (tooth loss)
- Oral candidiasis
- Oral pre-cancerous/cancerous lesions
- Periodontal disease
- Xerostomia (dry mouth)

1.2.1. Dental Caries

Dental plaque is a biofilm (sticky mass of bacteria) and sugar that continuously grow on the tooth surface. If the plaque is not removed with regular mouth care, it leads to dental caries (tooth decay) and periodontal diseases (31).

Dental caries occurs due to the interaction of bacteria in dental plaque, mainly *Streptococcus Mutans* and *Lactobacillus*, and sugars from the diet. The bacteria metabolize the sugars for energy, which cause an acidic environment on the teeth and lead to the demineralisation (loss of minerals) of enamel. However, once the plaque has been neutralized by saliva, the mineralized area can return to the enamel surface- a process called remineralization. However, the capacity for remineralization is limited, and continuous exposure to sugar can lead to net enamel mineral loss and cavity formation (31).

Dental caries leads to tooth loss, difficulty eating, and reduced quality of life (32). Tooth decay continues to be as the leading cause of tooth loss in all age groups; nonetheless, the impact is not nearly as high as it was 20 years ago (33). The prevalence of caries has decreased markedly among both children and adults, whereas the prevalence of caries among older adults aged 70 years and older remains high. Root caries prevalence and the number of restored teeth is greatest in the elderly population (34). Older adults are at greater risk for dental

caries than younger adults because of age-related salivary changes, side effects of medications, poor diet, exposure of root surfaces through gum recession (35), changes in cognition and dexterity (32), and the presence of partial dentures (34). Dental caries has a high occurrence rate in residents in LTC homes (27, 36-38), mostly because of poor oral hygiene, excessive sugar consumption, medications that cause dry mouth and lack of dental treatment services (36). A British Columbia study showed, 58% of elderly Canadian nursing home residents were in need of dental treatment; and two-thirds (67%) of the need was attributed to caries and periodontal problems (39).

DMFT index is a well-established measure of caries experience. The DMFT is expressed as the total number of permanent teeth that are decayed (D), missing (M), or filled (F) in an individual. The scores per individual can range from 0 to 28 or 32, depending on whether the third molars are included in the scoring (17). Dental caries is divided into coronal caries and root caries. Coronal caries are cavities in the visible part of the tooth (crown). Root caries, as the name implies, is dental caries that locates on the roots of the teeth.

1.2.1.1. Coronal Caries

The CHMS 2007-2009 reports that:

- Almost everyone in the age group 60–79 years had at least DMFT of 1 (excluding wisdom teeth).
- The individuals 60–79 years had the highest average DMFT (15.7, consisting of D = 0.4, M = 5.6, and F = 9.7) (17).

In 39 LTC hospitals in Vancouver area, on average, each resident had 3.8 carious teeth; 78.6% had at least one carious lesion; 50.4% had coronal caries; and the average DMFT was 26.6 (37). In rural and urban LTC homes in Nova Scotia, among LTC dentate residents, 51% had untreated coronal caries. The most significant predictor of coronal caries was a high debris score. The average

DMFT was 23.6; predictors of an increased DMFT score were years of smoking, increased age, and brushing less than once a day (38).

1.2.1.2. Root Caries

Root caries has become an important dental problem because people are living longer and keeping their teeth longer as opposed to earlier times where teeth were extracted due to coronal caries. As people grow older, their gums recede and root surfaces are exposed, making them more susceptible to root caries. The incidence of root caries in the elderly is associated with number of medical conditions and greater age (35). Root caries appears to be more difficult to detect and is much more difficult to treat (17).

The CHMS 2007-2009 reports that:

- 43.3% of Canadians 60-79 years had at least 1 or more root decayed or filled teeth.
- More than a tenth (11%) of 60-79 year old adults had untreated root caries (17).

The prevalence of root caries among LTC residents are even higher. In Nova Scotia, among LTC dentate residents, 44% had untreated root caries. In Vancouver, the proportion of LTC hospital residents with root caries was 68.8% (37).

The number of Canadians with root caries is expected to grow by 50% from 2001 to 2021 and the majority of those affected by this root caries would be expected to have no dental insurance. Dental insurance has become a major factor influencing Canadian dental visits. By 2021, there would be more Canadians experiencing root caries, than there are children in Canada today. Over the next few years, the uninsured retired Canadian would represent almost

one out of four Canadians. More than one third of these retirees would have root caries and would need dental services (40).

1.2.2. Edentulism (Tooth Loss)

Globally edentulism is prevalent among older people and is associated with socio-economic status. Functional dentitions, as measured by presence of at least 20 natural teeth, are found to be most frequent among elderly of high socio-economic status in contrast to individuals of low socio-economic status. Extensive tooth loss reduces chewing ability and impacts food choice; for instance, edentulous people tend to avoid dietary fiber and prefer foods rich in saturated fats and cholesterol (41). A German survey found that having fewer than 9 teeth had more impact on health-related quality of life than having cancer, hypertension, or allergy (42).

However, for some industrialized countries, including Canada, as people age, they tend to keep their teeth much longer than in the past **[Figure-5]** (41). Where previously most elderly people could expect to replace all of their natural teeth with dentures, today most Canadians retain their natural teeth for a lifetime. In 1972, approximately 50% of Canadians above 60 years old were edentulous, whereas in 2009, almost 22% had no natural teeth (17). The 2006 *British Columbia Dental Association Adult Dental Health Survey* shows that since 1986 there has been a substantial decrease (nearly 40%) in the average number of missing teeth within the 66-85 age group (33). Decline in the edentulous population parallels the use of fluoride in Canada and improved access to dental care over the past decades (17).

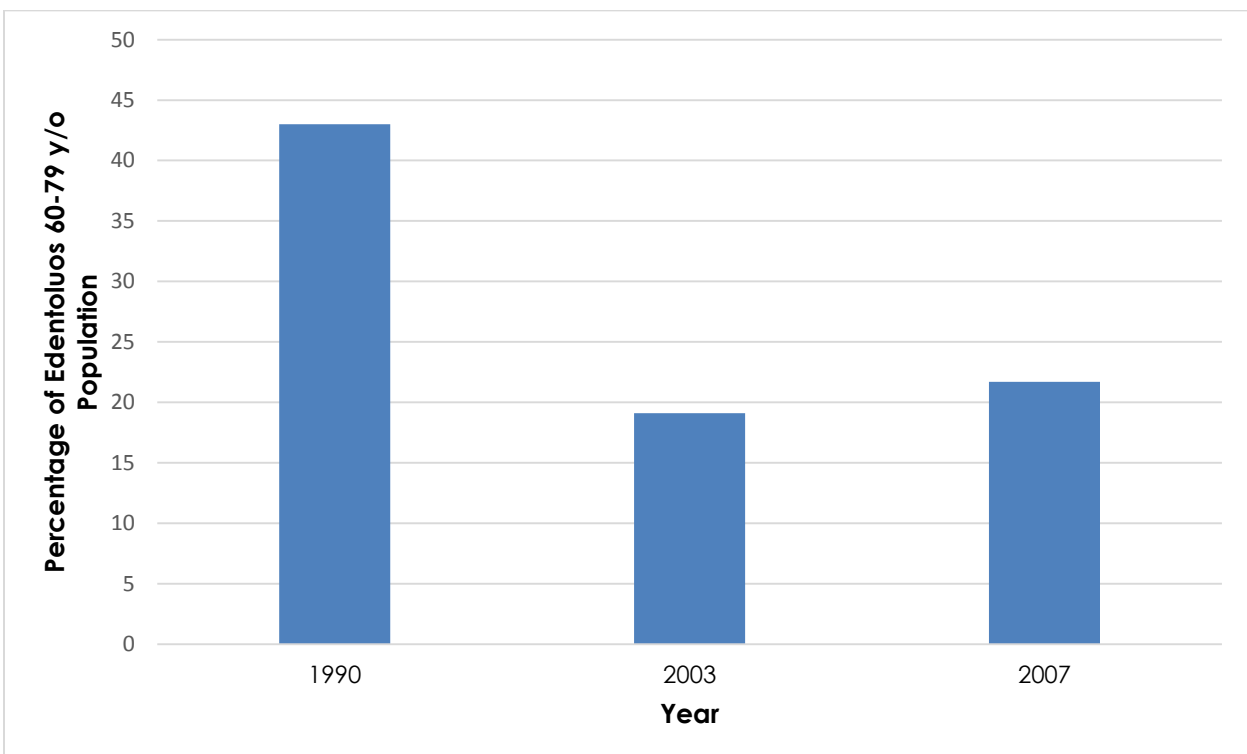
The CHMS 2007-2009 reports that:

- 21.7% of Canadian household population aged 60 to 79 years had no natural teeth.

- 42.2% of Canadian household population aged 60 to 79 years had inadequate dentition, namely fewer than 21 teeth.
- The highest rate of edentulism found in age group 60 to 79 years (22%) (17).

The prevalence of tooth loss among LTC residents are even higher. In Nova Scotia, among LTC residents, 41% were edentulous (38).

Figure-5: Proportion of 60-79 year old Canadian with no natural teeth.



Sources: 1990 Health Promotion Survey (43%); 2003 Canadian Community Health Survey (19.1%); 2009 Canadian Health Measures Survey, 2007 to 2009 (21.7%) (43). Canadians seniors tend to retain their natural teeth throughout their life compared to the past. Today, nearly 22% of Canadian population aged 69-79 years old have no natural teeth.

1.2.2.1. Denture Stomatitis and Other Mucosal Lesions

Denture stomatitis is a common oral mucosal lesion beneath dentures in the elderly. The most common fungal infection linked to denture stomatitis is

Candida Albicans. The prevalence of denture stomatitis is highly associated to denture hygiene or the amount of denture plaque (41).

As with natural dentition, dentures provide surfaces that enable the build-up of plaque biofilms over time. Increased surface roughness of the denture, greatly influences adhesion of microorganism and subsequently enhances retention of microorganism and facilitates plaque regrowth. Therefore, minimization of denture surface roughness by using nonabrasive or low-abrasive cleansing regimens is desirable (44).

Other risk factors include, usage of denture at night, use of defective and unsuitable dentures, lower education, infrequent dental visits, tobacco and alcohol consumption. Other major denture-related lesions include denture hyperplasia and traumatic ulcer (41).

The CHMS 2007-2009 reports that:

- Among edentulous 60-79 year old individuals, 93.5% wore complete dentures (upper and lower arches).
- Among adults 60-79 year old, 20% had one or more oral soft tissue lesions, including 9.1% denture stomatitis, 3.2% traumatic or other ulcers.
- Soft tissue lesions are significantly higher among the edentulous adults (40.9%) compared to the dentate adults (9.6%).
- Soft tissue lesions are significantly more common among 60-79 year olds (20.0%) compared to the youngest adults (5.6%) (17).

In Nova Scotia, among LTC residents, 41% had some mucosal abnormality. Most of the dentures in lower jaw were non-retentive (59%) and almost half were unstable (49%) (38). A study in two LTC homes in Saskatchewan, found 38-54% of the residents had faulty dentures.

1.2.3. Oral Candidiasis

Candidiasis of the mouth, is a fungal infection that occurs when there is overgrowth of a yeast called *Candida*. *Candida* species normally live in the normal oral flora of healthy adults in small amounts. However, certain conditions increase the risk of overgrowth in older persons. These conditions include local factors (e.g., dry mouth, denture irritation, tobacco use, steroid inhaler use); and systemic factors (e.g., diabetes, immunodeficiencies, antibiotic use, chemotherapy, radiation therapy, nutritional deficiencies) (45).

Oral Candidiasis can manifest in different ways: oral thrush, angular cheilitis, and denture stomatitis. Thrush (pseudomembranous candidiasis) is characterized by white patches/plaques on the tongue and other oral mucous membranes that can be wiped off. Angular cheilitis is identified by red scaling fissures at the corners of the mouth. In patients who wear dentures, candidiasis might lead to red lesions beneath a denture called denture stomatitis (see edentulism) (45).

1.2.4. Oral Pre-cancerous /Cancerous Lesions

Precancerous oral lesions consist of a group of diseases which have the potential to develop into oral cavity cancer. Oral leukoplakia, oral submucous fibrosis, and oral erythroplakia are the most common oral lesions with high transformation potential into cancer. With early detection and timely treatment of pre-cancerous lesions, the transformation into cancers could be dramatically reduced (46).

Oral cancer is a malignant tumour that starts in cells of the mouth, including the: lips, tongue, gums, salivary glands, floor/roof of the mouth, tonsils, and side and back of the throat. Oral cancer can metastasize (spread) to other parts of the body. Precancerous lesions and early oral cancer can be present without any symptoms. Some of the manifestations include lump/thickening in the oral soft tissues, feeling that something is caught in the throat, difficulty chewing

/swallowing, numbness of the tongue or other areas of the mouth, or swelling of the jaw that causes dentures to become uncomfortable or fit poorly (47).

Oral cancer is among the top 10 most common cancers worldwide (48). In Canada oral cancers are the 9th most common cancers among males and 13th among females (49). The known risk factors are age, gender, ethnicity (Asian), tobacco, alcohol, diet (less fruit/vegetable), betel/areca nut consumption, and Human Papilloma Virus (HPV) infection (50, 51).

Like most cancers, the incidence (i.e. number of new cases) of oral cancers rises with age. With age the oral mucosa becomes more permeable to noxious materials and more vulnerable to the substances causing cancer (52). The incidence of oral cancer increases sharply over 40 years of age. Patients over 60 years of age are at the greatest risk for oral cancer (51). Canadian males are more likely to develop oral cancer than females in the lifetime, with a 2:1 ratio. According to the *Canadian Cancer Statistics*, in 2015 2,900 men will be diagnosed with oral cavity cancer and 810 will die from it. 1,450 women will be diagnosed with oral cavity cancer and 390 will die from it. Currently in Canada, more deaths occur from oral cancer than from melanoma or cervical cancer. The five-year survival rate for oral cancer is much lower (68% and 61% in female and male respectively) than the most common cancers, that is breast cancer and prostate cancer (49).

Since cancer is an age-dependent disease, the number of elderly people annually diagnosed with cancers is expected to increase within the following decades (49). Oral cancer screening can detect early, localized lesions which are associated with an improved prognosis. Five-year survival rate is 2.5 times greater in patients with localized lesions than those whose oral cancer has spread to other parts of the body (47). As a result, there will be a need for

continued strengthening of cancer prevention and early detection to decrease the future incidence of cancer and improving survival rate (49).

1.2.5. Periodontal Diseases

The structures surrounding the teeth that keep them in place (gingiva, bone, and the attachment mechanism – the periodontal ligament – between the teeth and bone) are referred to as the periodontium. These structures are subject to diseases (53).

Periodontal disease defines as bacteria-induced, chronic inflammatory diseases that destroy the structures supporting the dentition. The two most common forms of periodontal disease are gingivitis and periodontitis (53). Periodontal disease increases the risk of root caries and further tooth loss (48).

1.2.5.1. Gingivitis

Gingivitis refers to inflammation of the gums in the absence of clinical attachment loss, i.e. without any loss of bone and other tissues (53). This is localized to the soft tissues surrounding the teeth and can readily be reversed with treatment. Plaque-induced gingivitis starts as a plaque biofilm accumulates on and around the teeth and gums. The disease may be seen as redness and swelling of the gum tissues and bleeding upon brushing (49). Bad breath due to poor oral hygiene and bleeding gums leads to isolation of an individual from the society. Gingivitis alone could be treated/prevented by an oral hygiene (brushing and flossing) program (17).

According to the CHMS 2007-2009:

- among dentate 60-79 year old adults, prevalence of gingivitis was 22.5% (17).

1.2.5.2. Periodontitis

Periodontitis is an inflammatory disease affecting the periodontium, i.e., surrounding structures around the teeth and is characterized by loss of connective tissue attachment and bone. The primary cause of periodontitis is bacterial plaque (54). Unlike gingivitis, it results in irreversible damage to the attachment apparatus of teeth (53).

In healthy young adults, the attachment is found at the cemento-enamel junction (CEJ) which is junction of the enamel covering the crown and the beginning of the root which is covered with cementum. Conventionally, healthy individuals are defined as those with loss of attachment (LOA) of 3 mm or less (17). The *U.S. National Center for Health Statistics* defines periodontal disease as at least one periodontal pocket with a probing depth of 4 mm or more and a LOA at the same site of 3 mm or more (55). Periodontal pocket results from detachment of gum from tooth and deepening the space between gum line and the root of a tooth. Pockets of ≥ 6 mm are of concern and would need the attention of a dental professional (17).

Some of the signs of periodontitis are tooth mobility, bad breath, bleeding gum and chewing difficulty. Persistent presence of periodontal disease is associated with systematic conditions such as pneumonia (56), diabetes (57), cardiovascular disease (CVD) and stroke (58). Clinically, pocket depths can be reduced by home care and professional treatment, but LOA is largely irreversible (17).

The *CHMS 2007-2009* reports that:

- Among dentate 60-79 year old adults, 23.6% had periodontal pocket depth 4-5mm, 7.1% had pocket depth of > 5 mm, and 7.2% had pocket depth of ≥ 6 mm.
- Among dentate 60-79 year old adults, 14.8% had $LOA \geq 6$ mm.

- Deeper pocketing (≥ 6 mm) was more prevalent in 60-79 year olds (7.2%) than the national average of 4.1%.
- LOA ≥ 6 mm was more prevalent in 60-79 year olds (14.8%) than the national average of 6% (17).

In Nova scotia, among LTC dentate residents, 67% had LOA of ≥ 4 mm at one or more site (38).

1.2.6. Xerostomia (Dry Mouth)

Dry mouth also known as xerostomia, is caused by reduction of saliva production. Saliva flow rate may be reduced in elderly people due to medications and various medical conditions (e.g. Sjögren's syndrome, chemotherapy, radiotherapy). Xerostomia is the most common adverse drug-related effect in the oral cavity and has been associated with over 500 medications. It is a particularly common in elderly patients. People 65 years and older are at greatest risk of developing xerostomia (59). In a survey in LTC residents of Nova scotia, the most common (36%) problem was xerostomia (38).

Saliva plays a crucial role in oral health. It has natural cleansing effects, and aids in tooth remineralization, contains antibodies, helps prevent gingival ulcerations. When salivary function is diminished, there is more risk of individuals experiencing soreness, dryness of the mucosa and lips, dental caries, candidiasis, reduced sensation, difficulty eating, change in taste, impaired ability to speak, choking, difficulty in wearing dentures, and bad breath (41). Loss of the natural cleansing effect of saliva increases the oral bacterial load, which predisposes a frail person to conditions such as aspiration pneumonia (60), coronary artery disease and cerebral infarction (61). Moreover, people with xerostomia and tooth loss may have reduced masticatory ability, food avoidance from fibre, protein, vitamins, and minerals. Malnutrition may reduce immunity against infection (48).

Table-1: Oral health problems in Canadian 60 years and over.

	NCS 1970-1972 (60+ years old)	CHMS 2007-2009 (60-79 years old)
Percentage of edentulous elderly	Male=49.5% Female= 55.7%	21.7%
Percentage of elderly with 28 teeth	-	8.6%
Percentage of elderly with <21 teeth	-	42.2%
Average number of tooth present		19.43
Percentage of edentulous elderly with complete denture	-	93.5%
Percentage of edentulous elderly with at least one implant*	-	4.1%
Percentage of dentate elderly wearing dentures or fixed bridges	-	12.6%
Percentage of elderly with coronal caries (DMFT >0)	Male= 91.3% Female= 92.3%	100%
Average DMFT (coronal caries)	Male= 20.6 Female= 21.5	15.67
Percentage of elderly with ≥1 untreated coronal caries	-	16%
Percentage of elderly with ≥1 root decayed or filled teeth (RDFT ≥1)	-	43.3%
Average RDFT (root caries)	-	1.56
Percentage of RDFT teeth that are decayed among dentate elderly* (RDT/RDFT)	-	18.4%
Percentage of RDFT teeth that are filled among dentate elderly (RFT/RDFT)	-	81.6%
Percentage of elderly with soft tissue lesions	-	20% (9.1% denture stomatitis)
Percentage of elderly needing any kind of oral treatment	-	42.8% (7.8% surgery*, 17.2% restorations, 12.9% prosthodontics)
Percentage of dentate elderly with gingivitis **	-	22.5%
Percentage of dentate elderly with at least one periodontal pocket >5mm**	-	7.1%
Average of periodontal pocket depth among elderly with at least one pocket ≥ 4 mm	-	5.1mm
Average LOA among elderly with LOA of at least ≥ 4 mm	-	5.31mm
Percentage of elderly with persistent pain ***	-	7%

NCS: Nutrition Canada Survey; **CHMS:** Canadian Health Measures Survey.

*Interpret with caution (due to high sampling variability).

** According to the community periodontal index of treatment needs (CPITN) scores.

*** These responses could be an underestimation of the true prevalence, as elderly tend not to report oral pain (17).

1.3. Relationship between Oral Health and Overall Health

According to Audrey Shieham in a World Health Organization (WHO) bulletin “The compartmentalization involved in viewing the mouth separately from the rest of the body must cease because oral health affects general health by causing considerable pain and suffering and by changing what people eat, their speech and their quality of life and well-being.”(62).

Poor oral health has social and psychological implications. Such as:

- Social withdrawal and avoidance of social situations
- Problems with speech
- Avoidance of smiling
- Embarrassment and shame(63).

Also, there is a strong association between oral disease and conditions such as aspiration pneumonia (56, 64), CVD (65, 66) and diabetes (57). These conditions might be aggravated in residents in LTC homes (56, 64).

Poor oral hygiene can lead to systemic conditions. Such as:

- CVD and stroke
- Diabetes
- Malnutrition
- Pneumonia

1.3.1. Oral Health and CVD/Stroke

Studies have shown that periodontal disease is frequently seen in cardiovascular patients, but it not clear whether periodontal infections are a risk factor for or contribute to CVD. *American Heart Association* group, established that there is currently no evidence of a causal relationship between periodontal disease and atherosclerotic vascular disease (66). However, according to two meta-analyses, periodontal disease might be a risk factor or marker for CVD (65, 67).

Studies have also shown an association between oral conditions (such as periodontal diseases) and increased risk of experiencing stroke (58). Bacteria from periodontal pockets can enter the blood during activities such as chewing or tooth brushing. These bacteria induce production of acute-phase proteins like C-reactive protein (CRP). CRP levels in patients with periodontitis are consistently higher compared to healthy individuals. Chronically elevated CRP levels (>2.1 mg/L) in patients with periodontitis exacerbate inflammatory processes in atherosclerotic plaques. These plaques are considered unstable and prone to rupture, with increased risk for CVD and stroke (58).

Conversely, improvements in periodontal disease will lead to better control of CVD. According to a study patients diagnosed with CVD showed a significant reduction of CRP, a marker for systemic inflammation, six months after periodontal therapy (68). Furthermore, a meta-analysis of four most recent clinical intervention trials reports a considerable reduction in CRP levels in patients with periodontitis 2 to 6 months following periodontal therapy (69).

1.3.2. Oral Health and Diabetes

It is well established that there is a link between diabetes mellitus type 2 and periodontitis in adults (57, 70); periodontitis is considered as the sixth complication of diabetes (70). Diabetes mellitus lowers the immunity resistance of the individuals diagnosed with and in turn reduce their healing process. Some of the common oral conditions associated with diabetes are – tooth decay, periodontal disease, fungal infection, taste impairment. Numerous studies have been conducted over the years to report the association between diabetes and periodontal diseases. This association can be termed as a “two-way street”(71) . Diabetes increases the prevalence, severity, and progression of periodontal disease; and periodontal disease may complicate the severity of diabetes (70).

Several recent meta-analysis showed periodontal therapy reduces systemic inflammation and their long term risk of complications in people with diabetes mellitus type 2. Periodontal treatment could improve blood sugar control in type 2 diabetic patients with periodontal diseases (72, 73).

1.3.3. Oral Health and Malnutrition

There is an independent association between oral health status and malnutrition in the elderly residing in a long-term care facility. Malnutrition is a complex and multi-factorial problem in the elderly. Malnutrition can be caused by two main factors: lack of adequate food, and reduced intake of food. Loss of appetite is probably the most common cause of reduced food intake and results from physical problems, mental health issues, intake of certain drugs, or treatments (such as chemotherapy and radiotherapy). On the other hand ageing is associated with problems in oral health like loss of teeth, dry mouth, periodontal diseases, caries, painful mucosal disorders, and decreased masticatory functioning. The oral health status influences the chewing ability, taste perception and the capacity to swallow. These all in turn can lead to malnutrition (30).

The CHMS 2007-2009 reports that:

- The highest levels of food avoidance were found among the edentulous adults (25.5%).
- Among 60-79 year old adults, almost 13% reported avoiding foods because of problems with their mouth.
- Among 60-79 year old adults without natural teeth, nearly a quarter (23%) reported that they avoided certain foods because of oral problems (17).

1.3.4. Oral Health and Pneumonia

Aspiration pneumonia occurs frequently in patients in institutionalized individuals, such as LTC residents. Bacterial species that normally do not colonize the throat

frequently cause aspiration pneumonia (56). The oral cavity serves as an important reservoir for these respiratory pathogens (56, 64). Pneumonia generally occurs following aspiration of microorganisms from the oral cavity or throat. Inadequate oral care which significantly increases the risk for developing pneumonia (74) is considered to be a modifiable risk factor (75).

A systematic review on oral health and aspiration pneumonia suggested that, the best intervention to reduce the incidence of aspiration pneumonia in the elderly is brushing of teeth after each meal, cleaning dentures once a day, and receiving professional oral health care once a week (76). According to another systematic review, there is strong evidence that improving oral hygiene can significantly prevent pneumonia as well as decreasing death from pneumonia; nearly one in 10 cases of death from pneumonia in elderly nursing home residents may be prevented by improving oral hygiene (56). Another study showed professional oral health care by dental hygienists is effective in preventing respiratory infections (including influenza and aspiration pneumonia) in elderly residing in nursing home (77).

Improved oral hygiene and frequent professional oral care decreases the progression or occurrence of respiratory diseases among high-risk elderly individuals living in nursing homes and particularly those in intensive care units (60). According to a 2015 study in Japan, denture wearing during sleep is associated not only with oral inflammatory diseases but also with pneumonia. These results suggest that simple denture care could reduce the risk of pneumonia in the elderly (78).

1.4. Economic Impact of Poor Oral Health

There are not only major health, social and psychological consequences, but also significant economic costs related to poor oral health.

In Saskatchewan, older adults accounted for one third or 37.4% of hospitalizations in 2002-2003 and the top five diseases for hospitalizations included cardiovascular disease, injuries, cancers, pneumonia, and arthritis (79). The cost and burden of oral disease to our health system can be lowered by providing comprehensive oral health programs. These programs which would reduce the prevalence of oral disorders and improve general health and quality of life, and would also decrease the complications resulting in systemic diseases and their associated emergency and hospital costs (80).

Various studies indicate that fewer health care expenditures are required if good oral health care is maintained (81). According to a 2002 analysis done in the United States, it was found that if 19,000 nursing homes employed an "oral care specialist" such as a dental assistant, with an average salary of \$25,000 per years plus benefits, and if a 10% incidence of pneumonia among older adults is reduced due to the improvement in the oral health brought by oral care specialist, there would be a net cost saving of more than \$300 million (82).

In 2007, an economic analysis found the total cost of poor oral health in older Australians to be more than \$750 million per year. Evidence presented to the Inquiry also suggested that thousands of hospital admissions could be avoided each year in Australia if early intervention for oral health problems had been available (63).

Based on the data available from the pilot project in Saskatchewan, it is estimated that non availability of oral care to the residents of LTC homes in Saskatchewan would an expenditure of \$1,436,140 due to medical conditions resulting from oral diseases.

1.5. Challenges with Treatment of Oral Problems in Elderly

There are several challenges in treatment of oral problems in seniors, such as:

- Behavioral barriers
- Financial barriers
- Limited access to dental services
- Systemic diseases

1.5.1. Behavioral Barriers

A lack of interest in oral health professionals is an impediment to dental care (83). Changing and increasing caries patterns in aging dentate patients have created more challenges for clinicians. As people live longer and retain more teeth that are often already heavily restored, they will require significantly more complex treatment (41).

In a study on dentist perceptions of providing care in LTC homes, lack of financial rewards was a main barrier (36). Dentists are discouraged from geriatric services when insurance payments for dental services are less than the usual dental fees (84).

A survey in Vancouver showed that 80% of dentists had never treated a patient in a LTC home; furthermore, about two-thirds of respondents expressed no interest in offering services to elderly patients. Dentists who had attended LTC homes reported they were uncomfortable about the limited options as well as the inadequate space and equipment available (85).

The relationship between the patient and oral health care professional is also influenced by the patients' behaviour. People generally seek dental care for oral problems that cause pain or discomfort (86). There are some individuals who believe that tooth loss is an inevitable consequence of aging and delay treatment until they lose their remaining natural teeth and receive complete

dentures (87). Anxiety about dentistry, which affect 12% of the older population (88), can also seriously impede seek for treatment (89).

1.5.2. Financial Barriers

According to *CHMS 2007-2009*, the oral health of Canadians 6-79 years of age has improved significantly over the years; yet, not everyone has enjoyed the same degree of improvement. Significant inequalities in oral health and access to dental care were found to be related to age, dental insurance, , and income (17). The *CHMS* provides an incomplete picture of oral health in very old Canadians. It exclude people 80 years of age or older, although this age group now constitute about 4% of the Canadian population (7). It also did include institutional residents, who are generally frailer, have poor oral health, receive less dental care, and greater treatment needs (38, 90).

Oral health care in Canada is privately financed and delivered. Canada's public share of expenditure on dental care is approximately 6%, compared to 7.9% in the U.S. (another country with a low public share) and 79% in Finland (a country with among the highest public contributions to the cost of dental care) (91). Although all permanent residents/citizens in Canada have access to a free universal health care plan administered by a provincial/territorial government, the legislation for these plans does not cover dental services (48). Apart from specific oral surgical procedures performed in hospitals, dentistry has been largely excluded from Canada's health care system (Medicare) due to budgetary constraints (89). This system creates substantial barriers to care for Canada's most vulnerable groups, including elderly people living in institutions or with low incomes. Vulnerable and disadvantaged groups in Canada have the greatest burden of oral disease (91).

Income and possession of dental insurance are strong determinants of oral health status, access to care, and dental service utilization. The inequitable

situation is even more noticeable for seniors, especially if they have lost insurance coverage after retirement (48, 92). Uninsured and low- to middle-income people, including the elderly, tend to avoid dental visits because of the financial cost despite many oral problems (17). People with low incomes typically seek only emergency care (93). *Canadian Community Health Survey 2005* showed 40% of the elderly in Ontario made dental visits only in emergencies (94). Utilization of dental services decreases with increasing age (86). The seniors face inequity in oral health care, especially within a fee-for-service system (95) and the aging of the Canadian population will exacerbate the problem of inequity (48). Currently, only Alberta (96) and Yukon (97) provide some financial assistance for dental services to seniors.

The *CHMS 2007-2009* reports that:

- Approximately six million Canadians avoid visiting the dentist every year because of the cost; people without dental insurance of any kind (public or private) do not visit the dentist regularly and avoid oral health care due to the costs; low- to middle-income people, including older adults, tend to avoid dental visits because of the financial cost.
- Among the 60 to 79 years old people, 13% avoided visiting a dental professional within the last year and even more (16%) declined treatment because of the cost.
- Among the 60 to 79 years old people, 40% of high incomes; 73% of middle incomes; and 68% of low incomes have no dental insurance.
- Among 60 to 79 years old people, 7% of high incomes; 24% of middle incomes; and 24% of low incomes avoid dentist because of cost.
- Half (53.2%) of 60 to 79 years old people had no insurance, 38.6% were privately insured.
- 60 to 79 year old people report having no insurance (53%) much more frequently than younger groups.

- Among 60 to 79 years old people, those avoiding the dentist due to cost having an average number of decayed teeth three times that of those elderly people attending a dentist regularly, and over two more missing teeth than that of regular attenders (17).

Financial barrier to dental care in LTC residents has shown in several studies (25, 26). According to a 5-year follow up study in British Columbia, although the expenditure on dental treatment per resident was low, only 60% of residents consented to receive care (25).

Care home managers in some care homes in England, suggested that all residents should receive free *National Health Service (NHS)* care (26). The CDA noted that for residents of LTC homes who require dental examinations and re-evaluation by an oral health professional, the cost of services should be paid by the provincial health care plan or another appropriate plan. The costs of essential dental care should be covered for all residents of LTC homes, regardless of whether the services are delivered in the facility, a hospital or at a community dental office (20). The CDA and the provincial dental associations are working with government and others to develop strategies that support tax-based (income tested) dental benefits for seniors in LTC homes and seniors with low income (18).

1.5.3. Limited Access to Dental Services

Lack of professional dental service for LTC residents is common in Canada and also other countries (38). It is difficult for LTC residents to access dental care because dental services are mostly limited to emergency care within Canadian LTCs (25). In one study, only 25% of LTC residents in Nova Scotia reported having regular dental care; 42% reported their last visit to a dental professional was more than 5 years ago (38).

While many provinces have related legislation in place, many Canadian seniors, especially those in LTC, do not have daily oral care, let alone access to professional dental care (18). Furthermore, many LTC homes lack space for a dental unit, and not all private dental clinics are not wheelchair accessible or do not meet the demands of providing oral care to patients with dementia (89).

The CDA and the provincial dental associations are working with government and others to develop strategies that support LTC facilities to allocate space with the appropriate dental equipment to provide preventive, restorative, and surgical care on site (18).

1.5.4. Systemic Diseases

Management of frail elderly patients with multiple comorbidities usually requires collaboration with other health care professionals (e.g., dietitians, care aides nurses, physicians, social workers and speech language pathologists). However, these interprofessional educational programs are often missing from the curricula of health care professions due to limitation of time /resources, and low perception of the significance of this aspect of career development (98). As a result, other professional groups often overlook the role of dentistry in integrated health care for the elderly (89).

The 10 most common systemic diseases in the aging population that impact oral health care are: arthritis; head and neck cancer; chronic obstructive pulmonary disease; diabetes; ischemic heart disease; hypertension; mental health, cognitive impairment, Alzheimer disease; osteoporosis; Parkinson disease; and stroke. In some of these diseases, the patient dexterity for oral hygiene is reduced. In some, patient cooperation makes it difficult for dental treatment. Many of these disease requires particular managements before, during or after dental treatments. Given the challenges of dental treatments for these patients, the dentist's focus should always be on prevention of dental disease (99).

1.6. Importance of Prevention/Detection of Oral Problems in Elderly

Dental disease in all age groups is readily prevented by daily oral hygiene and adherence to a healthy diet (100). While, oral diseases (including caries, periodontal disease) are highly preventable, considerable emphasis should be placed on prevention strategies. This should include highlighting the importance of an appropriate diet (minimal consumption of dietary carbohydrates, particularly between meals), providing patient-specific oral hygiene techniques (brushing, flossing, fluoride toothpastes), the prescription of additional fluoride to increase tooth resistance to dental caries (e.g. home fluoride rinses, fluoride varnish), and antibacterial agents (chlorhexidine, cetylpyridinium chloride) (41).

Since dental plaque is the main cause for developing dental disease, daily removal of plaque is an important factor for the maintenance of dental, gingival and periodontal health (101). Brushing twice a day is the least expensive and most effective physical method to remove and control dental plaque (102). Despite the fact that tooth brushing is the gold standard of good oral care (82), it was found that the average time spent for brushing teeth for seniors in a LTC was only 16.2 seconds per session (103). Many caregivers use sponge swabs for mouth care, but a swab cannot remove plaque as effectively as a toothbrush (104). Lemon and glycerin swabs as mouth cleanser which has been used in nursing more than 70 years can be ineffective and harmful. Lemon decreases the oral pH to 2-4, which can decalcify teeth, increase the risk of tooth decay, cause pain and irritate the mouth (105). Glycerin can dehydrate oral tissues and contribute to dry mouth (102).

Fluoride plays an important role in prevention of dental caries in all age groups. Fluoride interferes with the process of dental caries in different ways. Fluoride inhibits the function of some enzymes which are essential to the bacteria's ability to produce acid. In addition, the presence of fluoride in the plaque and

saliva encourages tooth remineralization and enhances the strength of the tooth enamel and its ability to resist acid attack (106). A recent two year follow-up study showed, using fluoride toothpaste in elderly people slowed down the rates of progression of both coronal and root caries (35).

Antibacterial agents such cetylpyridinium chloride (Perivex) provides protection against dental plaque and gingivitis. Perivex is non-fluoridated, alcohol free antibacterial mouth cleaning gel and is highly recommended for the residents at risk of choking. As it has thickened form, there is a lower risk for aspiration than foaming toothpastes (107). Chlorhexidine (Peridex™) is another effective antibacterial agent. At low concentration it reduces the growth of bacteria (bacteriostatic). Whereas, at high concentrations it kills bacteria (bactericidal) and is used to treat oral infections. However, chlorhexidine may cause brown discoloration on teeth/dentures. Moreover, chlorhexidine can interact with fluoride, particularly with the toothpaste containing sodium lauryl sulphate; the latter reduces the antibacterial effect of chlorhexidine. Therefore, it is recommended they be used at separate times (108).

Residents who wear denture are at high risk of developing infections such as denture stomatitis. Dentures should be not used overnight to rest gums and are required to be restored in sealed container of water. Brushing with mild soap and water is an effective way to clean dentures. Toothpaste should not be used for dentures as they are abrasive and may scratch the denture over time which can be source of infections. Weekly disinfection of dentures is recommended. Chlorhexidine can be used for both full and partial dentures. Whereas and sodium hypochlorite can only be used for full dentures, because it may cause the metal parts of partial denture to corrode (102).

Daily oral care and basic professional dental services for seniors in LTC homes can:

- enhance the overall health and quality of life (19, 48, 64, 109)
- improve the success of treatment (19);
- reduce dental plaque (101, 109);
- reduce the need for emergency care (19);
- reduce the need for invasive/complex treatment (19);
- reduce the overall cost of care (19, 110); and
- reduce the progression of oral disease (19);

With its latest associations to CVD, and many other systemic conditions (such as diabetes), periodontitis has a large impact on the patient's quality of life and poses a high financial burden not only to the patient but also to the society as well (53). Given the rising health-care costs and the increasing incidence of aspiration pneumonia in the elderly, programs to improve dental hygiene of LTC residents represents an effective cost-saving intervention (64).

Prevention of dental caries among institutionalized elders is far more cost-effective than the provision of dental treatment. Preventive strategies to help reduce the incidence of caries, and possible subsequent tooth loss, should include dietary control of refined carbohydrates, improved oral hygiene practices, and regular applications of remineralizing and antimicrobial agents (110). Ontario Dental Association states given the size of the aging population and the extent of chronic and systemic disease among this group, it seems clear that by mandating preventive daily oral health services (brushing teeth) for elderly persons in LTC homes, the government could avoid considerable health-care costs associated with treating other serious diseases (111).

Also, since the spectrum of oral mucosal lesions changes with age, routine examinations of oral cavities of the aging are critical particularly to detect early precancerous and other mucosal lesions (112). Screening for oral cancer is a simple, non-invasive procedure which can be easily incorporated into the

comprehensive assessment of older patients. Through early detection, the prognosis of oral cancer will be improved.

1.7. Improving Oral Care Practice in Long-Term Care

Access to daily oral care for residents in LTC homes depends strongly on the culture and values of each facility (89). LTC homes often do not enforce oral care policies (38). Nurses, as front-line personnel in LTC homes, are typically given the responsibility for oral care (89). Insufficient education for nurses in LTCs can lead to poor oral care (82). Unfortunately, nurses receive little practical education on oral care. A recent pilot study, demonstrated that senior dental students can play a significant role in residential homes by training caregivers and improving the residents' oral hygiene (113). Furthermore, the oral care service provided by nurses would be impeded by their busy schedules and more pressing priorities. Moreover, care givers often struggle with ethical conflicts in delivering oral care to frail elderly patients, especially with uncooperative/aggressive behaviour ones (89).

Improvement in dental status of LTC residents with treatment has been documented in several follow-up studies (25, 114).

Among the LTC residents in British Columbia who received dental treatment of some form over the 5 years, CODE (an index of Clinical Oral Disorders in Elders) showed a significant improvement (25). According to 6-year prospective cohort study on Japanese LTC residents, the number of teeth needing extraction decreased in the individuals who received dental treatment, and increased in the untreated subjects. Denture status was better in the treated individuals than in the untreated subjects (114).

1.8. Seniors' Oral Health Programs/Services in Canadian Provinces

Given the importance of maintaining good oral health in seniors, the CDA supports a mandatory baseline standard that all LTC facilities provide daily oral care supported by annual access to dentists (18). British Columbia, Ontario and Saskatchewan are the only provinces that have oral health regulations that govern licensed LTC facilities (115). Several provinces have established standard oral health assessment protocols or guidelines governing the oral care of residents in LTC homes; or offers some dental services to the residents through certain programs and initiatives.

1.8.1. Alberta

The Alberta government provides the *Dental Assistance for Seniors* program to low -to moderate- income seniors with financial assistance. The Dental program can provide dental coverage up to a maximum of \$5,000 every five years (96) and include basic dental procedures such as examinations, x-rays, scaling, fillings, trauma/pain control, extractions, root canals, procedures relating to gum disease, partial and full dentures (116).

1.8.2. British Columbia

The British Columbia government in 1997 passed changes to the *Adult Care Regulation* which governs licensed LTC facilities in the province. According to this regulation, licensed LTC facilities are required to provide certain oral health services to the residents. Under the regulation, supervision clause for dental hygienists was removed which led to their enhanced role in providing care to the residents. Full time or retired dentists are encouraged to provide dental treatment in LTC facilities by providing some incentive. Some health regions have oral health programs including oral health assessment, oral health promotion, preventive services and dental treatment (115).

The *Geriatric Dentistry Program* in British Columbia started in 2002 as a joint venture between Providence Health Care and the University of British Columbia (UBC) Faculty of Dentistry. ELDERS (Elders Link with Dental Education, Research and Service) group from UBC have focused their attention on oral health in the elderly. The group was among the first in Canada to document the distribution of oral health problems in LTC facilities, and to explore ways for managing the problems. The program now offers services to the residential care populations of several intermediate and extended care hospitals. Oral examinations and basic dental care are provided at the bedside using mobile dental equipment, while complex treatment is provided at UBC dental clinic, or at clinic within the hospitals. In addition to dental service, the program is also committed to education (hospital nursing staff, LTC residents and their families, dental students, and dentists), and research (117).

1.8.3. Ontario

The Ontario Ministry of Health passed legislation on LTC Reform in 1993. Each LTC home in Ontario should meet Oral and Dental Care Standards to retain or attain a license (115). In Ontario, the Long Term Care Homes Act (2007) requires that every LTC home have a plan of care for each resident, including assessment of oral/dental status and oral hygiene. Each resident must receive oral care to maintain the integrity of oral tissue, including twice daily mouth care and cleaning of dentures, and physical assistance to clean their own teeth if required (118).

Toronto, Ontario Public Health provides free dental services to the eligible individual aged 65 and older at Toronto Public Health dental clinics. There are also Mobile Dental Clinics which provide free dental care for eligible clients with difficulty accessing dental services. In addition, Toronto Public Health provides

services to long-term care facilities, including dental screening, professional denture cleaning, denture labelling, and minor denture adjustments (119).

Halton, Ontario Oral health Outreach Program (HOHO) is a multi-partner project and involves the coordination of dental services for people with special care needs and the elderly population. In 1999-2000 various initiatives were taken which led to the development of partnerships between Health Department and Community Care Access Centres (CCAC) of Halton. CCAC case manager complete oral health assessment for the individuals entering a LTC home or client living in the community who may require oral health services. At the time of the oral health assessment, financial assistance is also offered to the qualifying individuals to pay for the cost of dental treatment. It also provides referral to oral health services and dental resources in the community. Moreover, CCAC maintains a data base of those dental professionals who are willing to provide services to the clients in their offices or other settings(120).

1.8.4. Saskatchewan

There are no oral health programs and services for residents of LTC homes in Saskatchewan; however, the University of Saskatchewan, College Of Dentistry and some LTC facilities in Saskatoon and Regina have established partnerships for the provision of oral care to the residents of LTC homes (121). In the following section the steps that Saskatchewan has taken so far to improve the oral health of LTC residents will be presented.

Note from resident's sister

I think that the dental care at the LTC home is bad. They started an initiative at the care home for residents not to wear bibs: "looked too institutional I guess". So they spend money washing more clothing instead of spending money to pay staff to brush teeth. It is very difficult to brush my brothers' teeth, but a little care would go a long way to keeping the gums in good shape.

Marion

2. Better Oral Health in LTC – Best Practice Standards for Saskatchewan

2.1. Background

In the Saskatoon Health Region (SHR), the University Of Saskatchewan, College Of Dentistry and a private practice dentist, Dr. Raju Bhargava and his team, implemented an oral health pilot at St. Anne's Home and Saskatoon Convalescent Home in 2006. The pilot was to provide clinical oral health services to consenting residents at both homes. Over the next few years, Dr. Bhargava and his team provided services to 8,492 residents. Long Term Care (LTC) home staff also received basic oral health education from SHR Oral Health Program staff.

A 2006 survey of staff, residents, and residents families showed that:

- 35% of residents were experiencing problems with their teeth /gums;
- 69% of residents only accessed dental care when there were problems (mobility was the main reason);
- 88% of LTC staff visited a dentist in the past year while 67% of family members of residents visited a dentist in the past year;
- 64% of residents perform their own daily care; and
- main reasons LTC staff do not provide daily care to resident is uncooperative resident and not enough time.

RECOMMENDATION - 1

That the Saskatchewan Government, Ministry of Health, endorse the Saskatchewan Seniors Oral Health and Long Term Care (LTC) Strategy

developed by the Saskatchewan Oral Health Professions collaboratively with the Saskatchewan Oral Health Coalition and Seniors Health and Continuing Care in the Saskatoon Health Region.

This pilot was instrumental in demonstrating the need for oral health services in LTC homes, on-site oral health professionals to coordinate services/staff/residents, and basic daily oral care for residents.

RECOMMENDATION - 2

That an Oral Health Coordinator (OHC), who is a registered and licensed oral health professional, should be employed in each health region to facilitate the delivery of initial oral assessments, dental examinations and treatment, daily oral hygiene for residents and oral health education. The Oral Health Coordinator will work collaboratively with the long term care, multi-disciplinary team to improve the oral and overall health of residents.

An outcome of this initial pilot was a second pilot in 2011 that focused on an OHC at two SHR LTC homes – Parkridge Community Centre, and Sherbrooke Community Centre. This was called the Oral Health LTC Initiative. It was supported with a \$20,000 Community Wellness Grant from the Region. A registered dental assistant was hired in partnership with the University of Saskatchewan, College of Dentistry. The Oral Health Coordinator assisted LTC staff and residents to access dental care at each site. The College of Dentistry-Dental Residency Program, delegated dentists from the program to provide treatment for residents who consented. All initial assessments were free of charge to encourage residents to participate.

At the same time as these LTC pilots were occurring, the Saskatoon Oral Health Coalition was launched (currently known as Saskatchewan Oral Health Coalition, SOHC). Through strategic planning, the SOHC members identified that oral health in LTC homes was a significant issue, and one that they wanted to focus on. One of the outcomes of the SOHC was the partnership involved in securing the Health Region's Community Wellness Grant for the OHC.

As a result of the SOHC working with the community related to oral health in LTC homes, the SOHP began to develop standardized recommendations.

The SOHP is a group that represents legislated oral health professions. They are:

- College of Dental Surgeons of Saskatchewan
- Denturists Society of Saskatchewan
- Saskatchewan Dental Assistants' Association
- Saskatchewan Dental Hygienists' Association
- Saskatchewan Dental Therapists Association

The SOHP determined that oral health in LTC homes was a critical issue to address. They worked with the SOHC to build capacity related to oral health in LTC. The group used best practice and evidence to select a strategy and resources that provided a solid foundation for the Saskatchewan LTC Strategy. The goal was to find resources that provided the necessary education/training at all levels (staff, family, resident) and that included community feedback and participation.

All of the work to date has contributed to the *Better Oral Health in LTC – Best Practice Standards for Saskatchewan* project. It has been a community development and capacity building project from the onset. Partners and stakeholders have been supportive of the need to improve oral health in LTC homes.

2.2. Resources – Adaptation

A comprehensive literature review of existing, well developed, successful oral health care programs for residents in care homes was conducted. Based on this evaluation, the *Better Oral Health in Residential Care* program (developed in Australia) (102) was adopted.

The resources that are implemented in the *Better Oral Health in LTC– Best Practice Standards for Saskatchewan* program are as follows:

RECOMMENDATION - 4

That initial oral assessments will include:

- 4.1 Personal client record*, including consent for dental examination
- 4.2 Review of medical and dental history
- 4.3 Complete examination of the oral cavity, which includes:
 - 4.3.1 Assessment of hard and soft tissues
 - 4.3.2 Assessment of oral hygiene care
 - 4.3.3 Oral cancer screening
 - 4.3.4 Denture assessment

*Note: Implementation of a Saskatchewan electronic health record should include an oral health record.

RECOMMENDATION - 5

That Oral Health Care Policies and Procedures for LTC and Personal Care Homes* are standardized and implemented based on best practice for optimal oral and overall health for residents in LTC in Saskatchewan. Policies should ensure that every LTC resident has the right and access to the following oral health care services:

- 5.1 An individualized oral health care plan

5.2 Basic oral hygiene supplies

5.3 Daily oral hygiene

5.4 Access to professional oral health services

5.5 Oral health record included within the health record

5.6 Dental recommendations/orders are followed

*Note: As per Section 23 of the current *Personal Care Home Regulation*, each resident receive a dental examination, as necessary.

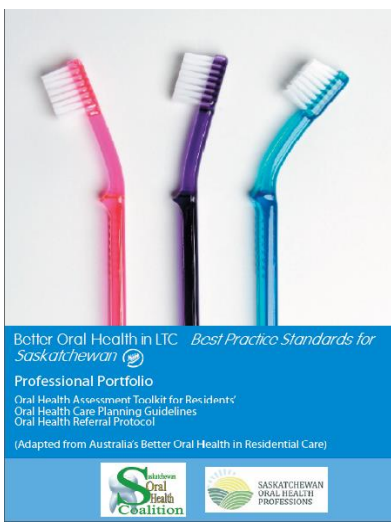
Three Portfolios (Educators', Professional and Staff)

2.2.1. Educators' Portfolio (for delivery of the education and training program)

[Appendix -2]



- This portfolio is utilised as a training guide by the Oral Health Coordinator/oral health professional
- Contains detailed information on oral health, common oral conditions that are prevalent in older adults in residential care, instructions on oral hygiene



2.2.2. Professional Portfolio (for oral health professionals, physicians and other health professionals) [Appendix -3]

- Contains detailed information on oral health problems faced by residents, Oral Health Assessment Tool (OHAT), Oral Health Care Planning guidelines and dental referral protocol.

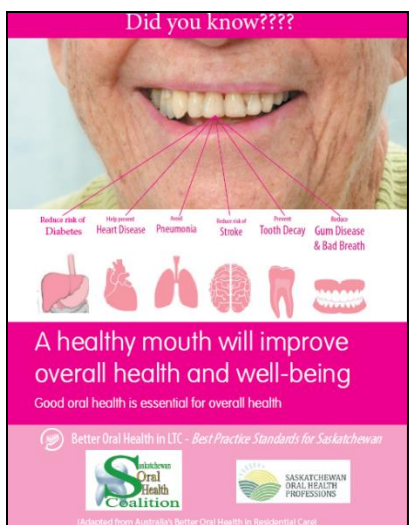
2.2.3. Staff Portfolio (for care aides and nurses) [Appendix-4]



- It is given to every care staff attending the educational session and training. It is developed to be used as a self-learning tool.
- Contains detailed information on oral health, common oral conditions that are prevalent in older adults in residential care, instructions on oral hygiene procedures.

2.2.4. Posters and Pamphlets [Appendix-5]

These posters contain the information on relationship between oral health and general health, daily oral hygiene care and a team approach to resident's daily



2.2.5. Oral Health Assessment Tool (OHAT) [Appendix -6]

The OHAT utilized in this project is modified from the OHAT developed by Chalmers in 2004. In this modified colour-coded OHAT, the following areas of the residents' mouth should be examined. They are divided into 9 categories:

- exterior of face
- lips

- tongue
- gum and tissues
- oral cleanliness
- teeth
- denture(s)
- saliva
- dental pain

Each of these nine categories is graded as Healthy (green), Changes (yellow), or Unhealthy (red). If any one of the categories was assessed as 'unhealthy', the resident is to be referred to an oral health professional for a detailed dental examination. If the resident is assessed as 'healthy' or 'changes', the oral condition should be managed by the caregiver using the Oral Health Care Plan (which is customized for each resident).

Additional referrals to other health professionals may be required.

**Better Oral Health in Long Term Care –
Best Practice Standards for Saskatchewan**

Oral Health Assessment Tool (OHAT)

Resident: <input type="checkbox"/> is independent <input type="checkbox"/> needs reminding <input type="checkbox"/> needs supervision <input type="checkbox"/> needs full assistance			
<input type="checkbox"/> not able to open mouth	<input type="checkbox"/> grinding or chewing	<input type="checkbox"/> head faces down	<input type="checkbox"/> refuses treatment
<input type="checkbox"/> has responsive behaviour	<input type="checkbox"/> bites	<input type="checkbox"/> excessive head movement	
<input type="checkbox"/> not able to rinse and spit	<input type="checkbox"/> cannot swallow well	<input type="checkbox"/> does not take dentures out at night	

Date – dd/mm/yyyy (Re-assessment every 6 months)																	
Exterior of face	Healthy Both sides of face/neck are symmetrical, no lumps or bumps, swallowing normal, lips open and close.																
	Changes Asymmetrical changes to face/neck, presence of lumps or bumps, swallowing challenging, lips do not open or close.																
	Unhealthy * Asymmetrical changes to face/neck, presence of lumps or bumps, painful swallowing, lips do not open and close *																
	Dental referral Y – Yes * N – No																

*Unhealthy signs usually indicate referral to a dentist is necessary

Date	Assessor Comments

2.2.6. Oral Health Care Plan (used as mirror clings) [Appendix -7]

Oral Health Care Plan			
Name: _____			
Oral Health Assessment (OHA) Date: _____			
Challenges: <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> frequent head movement <input type="checkbox"/> difficulty opening mouth <input type="checkbox"/> fear of being touched <input type="checkbox"/> difficulty eating/nutrition			
Interventions: <input type="checkbox"/> bridging <input type="checkbox"/> modelling <input type="checkbox"/> hand over hand <input type="checkbox"/> distractions (activity board/toy) <input type="checkbox"/> alternative provider <input type="checkbox"/> other _____			
Daily Activities of Oral Hygiene			
	Morning	After Lunch	Night
Natural Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist Replace toothbrush (once every 3 months) Date: _____	<input type="checkbox"/> clean teeth, gums, tongue	<input type="checkbox"/> rinse mouth with water <input type="checkbox"/> antibacterial product (teeth & gums)	<input type="checkbox"/> clean teeth, gums, tongue
Denture <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Upper <input type="checkbox"/> Lower Inserted/removed by: <input type="checkbox"/> Self <input type="checkbox"/> Staff Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture	<input type="checkbox"/> rinse mouth with water <input type="checkbox"/> rinse denture <input type="checkbox"/> antibacterial product (gums)	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture with mild soap <input type="checkbox"/> leave dentures out overnight <input type="checkbox"/> soak denture in cold water Disinfect dentures (weekly) Specify day: _____
Oral Hygiene Aids <input type="checkbox"/> soft toothbrush <input type="checkbox"/> modified toothbrush <input type="checkbox"/> toothbrush grip <input type="checkbox"/> denture brush <input type="checkbox"/> spray bottle (labelled)	Oral Health Care Products <input type="checkbox"/> mild soap (denture) <input type="checkbox"/> antibacterial product <input type="checkbox"/> saliva substitute <input type="checkbox"/> lip moisturiser <input type="checkbox"/> fluoride toothpaste	Additional Oral Care Instructions <input type="checkbox"/> antifungal gel <input type="checkbox"/> denture adhesive <input type="checkbox"/> interproximal brush <input type="checkbox"/> tongue scraper <input type="checkbox"/> normal saline solution	
Date of next assessment: _____			
Signed: _____ Date: _____			

The Oral Health Care Plan is completed by the Oral Health Coordinator/oral health professional/health professional. The plan is to be carried out by the care providers on a daily basis. Each care plan is tailored for individual residents, based on their oral care needs.

The Oral Health Care Plan contains information on the residents:

- oral health problems (difficulty in swallowing, etc.)
- special interventions for the resident (bridging, hand over hand, distractions)
- oral hygiene regime, if resident has natural teeth or dentures or both
- oral hygiene aids and oral health care products to be used.

2.3. Primary Oral Health Care Framework for Residents in LTC Home

Based on the principles of the Ottawa Charter (122)*, the following primary oral health care framework for residents in LTC homes is recommended.

❖ Build Healthy Public Policy

- Saskatchewan Ministry of Health enforcement of oral health standards
- Long Term Care (LTC) home oral health policies and procedure
- Regular oral health assessment
- Oral health screening on admission to LTC home
- Resources for oral hygiene and oral health treatment
- Networks between LTC homes and oral health professionals

❖ Create Supportive Environments

- Multidisciplinary involvement
- Incorporation of oral health team into the LTC environment
- Access to oral hygiene care tools
- Addressing issues of nutrition, medication oral adverse effects and swallowing problems

❖ Develop Personal Skills

- Constant theoretical and practical oral health education, training and support for LTC staff
- Addressing issues of a residents' dementia, and responsive behaviours and communication problems

❖ Re-orient Health Services

- Use of oral health team in LTC homes
- Increased access to portable dental equipment
- Provision of a range of oral health treatments
- Availability of room for oral health treatments in the LTC homes
- Focus on primary oral care strategies

❖ Strengthen Community Actions

- Advocacy from community groups
- Distribution of oral health information to community groups

*Ottawa Charter was launched by the WHO in 1968 at the first international conference for health promotion.

Note from Staff

Many of our residents living on Eastridge One have benefitted from the support of the dental service.

The residents who live here with cognitive impairment often express physical aggression that makes dental support outside of PRC not possible. Also they experience less confusion because their familiar environment has been changed less.

Better dental care, we have observed, results in improved well-being for our residents

2.4. Oral Health Care Education and Training

Literature has shown that while a number of oral health programs were developed for residents in care homes, only a handful of programs were successful.

Some of the key reasons that led to the successful programs were:

- A multidisciplinary approach was used. The team included care givers, oral health professionals, general physicians, facility managers and other key organization members.
- An oral health coordinator (registered and licensed oral health professional) should be appointed, who facilitates the program, liaises with LTC staff and management.
- An Oral Health Contact Person (OCLN) can also be appointed. This person can train other new caregivers and also confirm if daily oral care is provided to the residents.
- Educational training should be provided to all caregivers. This training should be both theoretical and hands-on including basic oral health, oral diseases that are commonly seen in residents and how to provide daily oral care.
- Educational materials (information sheets, manuals) should also be provided along with training.
- Caregivers were monitored to ensure guidelines and standard protocols/standard work were followed when providing oral care.

*

Dean's Story

At 3 months of age Dean was diagnosed as having been born with no left side to his brain. He is now 51 years old. He is completely dependent on total care. He is able to walk assisted; however, he cannot speak, does not have hand control, cannot feed himself and is incontinent

He has been dependant all his life and has been in Long Term Care home for almost 10years. It is extremely important for Dean's overall health that he have daily dental hygiene by his care givers and ongoing professional dental cleanings and examinations with any required services to be provided by a dentist or hygienist/assistant.

As a permanent resident in Long Term Care home, it is important that the daily care givers are trained to provide daily proper tooth brushing and any other care that the dental professionals would direct.

At the present time it appears that some care givers do not see that benefit of using a toothbrush with Dean has two, a battery operated one and a manual brush. Many times he is just given a swish with a sponge in his mouth, this does not help his teeth or gums. I do know that direction has been given to brush his teeth with a tooth brush by the management of the LTC home. My husband and I have requested that mouth care sponges remain out of Dean's room and not used, however we still often find them there. Many care givers try their best to address our wishes and Dean's needs, but with new; temporary and part-time staffs and together with staff shortages his dental care is not consistent.

As part of basic care we would like to see a formalized dental training program for care givers and daily adherence as well as professional services on a consistent basis be a part of Dean's care.

Dean's parents

RECOMMENDATION - 7

That the Saskatchewan Seniors Oral Health and Long Term Care Strategy is incorporated into post-secondary educational health training programs, orientation, and continuing professional development (i.e. for physicians, nurses, care aides, etc.).

2.4.1. On-going Oral Health Care Training Program in Saskatoon

Better Oral Health in LTC – Best Practice Standards for Saskatchewan program was first implemented in Parkridge Community Centre in 2013-2014. Parkridge Community Centre is a Long Term Care home for 237 residents, located in Saskatoon, Saskatchewan.

The following steps were undertaken to implement the program:

- Dental Health Educators (DHEs) from Saskatoon Health Region conducted initial oral health assessments using the Oral Health Assessment Tool (OHAT)
- Utilizing the Educators' Portfolio, DHEs provided educational training, as well as hands-on instruction for daily oral care to the Clinical Nurse Educators'
- Clinical Nurse Educators' in turn trained the care aides
- Pre and Post tests were provided during the training, which supported understanding and knowledge transfer between the DHEs and the LTC home staff being trained.
- The Daily Oral Care Plan mirror clings were customised for individual residents and placed in their rooms. The resident's caregivers refer to this care plan to provide daily oral care.

- Oral health kits, containing residents' oral hygiene products: antibacterial product (Perivex), 2 soft handled toothbrushes, and an end-tuft brush were placed in every resident's room.

Note from Staff

You did a marvellous job of my teeth. They were in such bad shape. Now I can chew anything, I wish to eat. They look much better. It is wonderful to be able to eat what they put before me.

Barbara

RECOMMENDATION - 3

That upon entry into a LTC home, an initial oral assessment must be completed by a registered and licensed oral health professional, through the general and medical consent provided by the LTC home.

3.1 Oral assessments should be routinely performed every 6 months thereafter, by an oral health professional or a health care professional trained in oral health assessments.

3.2 Non-oral health professionals performing oral health assessments or care will receive appropriate training developed by the Saskatchewan Oral Health Professions.

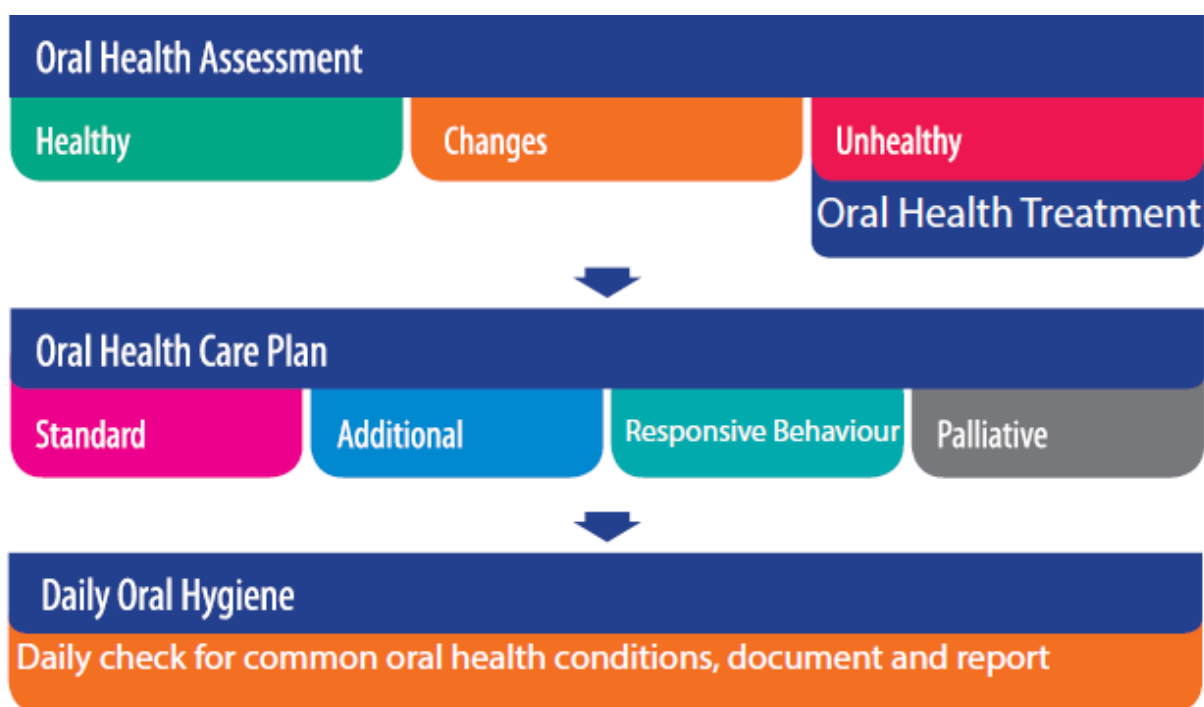
3.3 Training will be provided by oral health professionals.

2.5. Saskatchewan Better Oral Health in Long Term Care Model

The Australian *Better Oral Health in Residential Care* model was modified and adapted to the Canadian/Saskatchewan health care system. The main modification made was the identification and delineation of responsibilities to the four key processes of the *Better Oral Health in LTC – Best Practice Standards for Saskatchewan*. Training and resource materials have been focus tested.

The four keys processes are:

1. Oral Health Assessment
2. Oral Health Care Plan
3. Daily Oral Hygiene
4. Oral Health Treatment



Better Oral Health in LTC – Best Practice Standards in Saskatchewan model requires a team approach to maintain a resident's oral health care.

This Oral Health Care Team (OHCT) may be comprised of an Oral Health Coordinator (OHC), care aides, nurses, physicians, other health professions and oral health professions (dental assistants, dental hygienists, dental therapists, dentists, and denturists).

From this OHCT, appropriate members will be responsible for the four key processes.

- *Oral Health Assessment* – this is performed by a registered and licensed oral health professional on admission of a resident, and subsequently, on a regular basis and as need arises by the Oral Health Coordinator/oral health professional or nurses.
- *Oral Health Care Plan* – The OHCT develops an oral health care plan.
- *Daily Oral Hygiene* – trained care aides are designated to maintain daily oral care based on the oral health care plan
- *Oral Health Treatment* – referrals for a more comprehensive oral health examination and treatment are made on the basis of the oral health assessment. Oral health treatment can be provided in the LTC home or at a private/public dental service outside the care home. It is recognized residents may be best treated at the LTC home.

Note from Staff

We the staff find the Dental Program here fantastic and would like to see this area of expertise expand, and allow possibly more services be provided here in the near future.

Many of our residents have many challenges, and behaviours in which it is difficult in having them be seen out in the community. As well there are residents who may not have family to accompany them to their appointments. It would truly be a great loss to both our residents as well as to the LTC home itself if this program doesn't continue in the future.

Terry

Stakeholders are:

- Residents

The aim of the program is to provide good oral care to residents at the LTC homes. The focus of all the other stakeholders should be the residents and the better oral health outcome to be attained.

- LTC Home Staff

This includes care aides, nurses, physicians and other health care professionals employed at the LTC home.

- Oral Health Professionals

This includes dental assistants, dental hygienists, dental therapists, dentists, and denturists.

2.6. Oral Health Care Policies/Standards for LTC Homes

RECOMMENDATION - 5

That Oral Health Care Policies and Procedures for LTC and Personal Care Homes* are standardized and implemented based on best practice for optimal oral and overall health for residents in LTC in Saskatchewan. Policies should ensure that every LTC resident has the right and access to the following oral health care services:

- 5.1 An individualized oral health care plan
- 5.2 Basic oral hygiene supplies
- 5.3 Daily oral hygiene
- 5.4 Access to professional oral health services
- 5.5 Oral health record included within the health record
- 5.6 Dental recommendations/orders are followed

*Note: As per Section 23 of the current *Personal Care Home Regulation*, each resident receive a dental examination, as necessary.

Standard oral health care policies and procedures should be made available for all the LTC homes in Saskatchewan. This will ensure a uniform practice of daily oral health care throughout the province.

Templates of oral health care policies and procedures that can be implemented are: **[Appendix -8]**

- Foam swab policy
- Lemon glycerine swabs
- Oil based lubricants
- Oral care and tube feeding
- Proper oral care in Long Term Care
- The provision of oral care
- Work standard – Oral care routine assessment
- Work standard – Proper oral care in LTC

Generic forms are: **[Appendix -9]**

- Consent for dental exam
- Oral assessment report
- Annual dental examination consent form
- Record of treatment
- Consent for dental treatment
- Oral services - resident tooth chart
- Consent for financial responsibility for dental treatment
- Assessment of current hygiene care
- Denture assessment care

2.7. Basic Oral Hygiene Supplies

Based on the pilot program at Parkridge Community Centre in Saskatoon the following products should be supplied to each resident within the monthly allowance for personal care items for LTC homes, which is approximately \$20.25 per month.

2.7.1. Residents Needing Assistance or Having Swallowing or Expectorating Difficulties

The oral hygiene products that are supplied are:

- Perivex (antibacterial non-foaming tooth gel) - \$ 1.67 each
- Toothbrushes GUM - \$0.52 each
- End-Tuft toothbrushes GUM - \$0.50 each

Along with these products, the Oral Health Program at SHR provides Collis Curve toothbrushes (at \$4.50 each) to the LTC home for residents in need of this brush.



Supplies for Residents Needing Assistance or Having Swallowing or Expectorating Difficulties

Perivex



Toothbrushes GUM



End-Tuft toothbrushes GUM



Collis Curve toothbrush



Perivex	
Appearance	Clear green liquid gel
Flavor	Spearmint flavor
Ingredients	Cetylpyridinium Chloride 0.05% Propylene Glycol, Sodium Benzoate, Phosphoric Acid, Colorant
<ul style="list-style-type: none"> • Perivex should not be confused with Peridex™ which contains chlorhexidine. • Perivex is an alcohol-free and non-fluoridated antibacterial mouth cleaning gel. • Antibacterial agent, cetylpyridinium chloride, provides protection against dental plaque and gingivitis (107). • Glycerin, helps lubricate the oral cavity, which is particularly valuable for those with dry mouth (107). • As it has thickened form, there is a lower risk for aspiration than foaming toothpastes (107). Therefore it is highly used for residents at risk of choking. 	

2.7.2. Residents that are Edentulous

The oral hygiene products that are supplied are:

- Perivex (anitibacterial non-foaming tooth gel) - \$ 1.67 each
- Toothbrushes GUM - \$0.52 each
- Polident Tablet


Supplies for Residents that are Edentulous	
Perivex	
Toothbrushes GUM	
Polident Tablet	

Polident®	
Appearance	Tablet
Ingredients	Alkaline Peroxide Sodium Bicarbonate Citric Acid Sodium Perborate Potassium Monopersulfate Sodium Lauryl Sulfoacetate
<ul style="list-style-type: none"> • Polident is a denture cleanser. • It reduces plaque and removes stains. • It is gentle on dentures (mild abrasiveness) • Alkaline peroxide is the antibacterial agent. • Sodium bicarbonate and citric acid provide mechanical cleaning through effervescent action. • Sodium perborate and potassium monopersulfate, the oxidants, remove stain and whiten the denture teeth. • Sodium lauryl sulfoacetate acts as the detergent and remove all the particles that were loosened by the active ingredients. 	

2.7.3. Residents with Natural Dentition not Requiring Assistance

The oral that are supplied are:

- Fluoridated toothpaste- \$
- Toothbrushes GUM - \$0.52 each
- End-Tuft toothbrushes GUM - \$0.50 each

Supplies for Residents with Natural Dentition not Requiring Assistance	
Fluoridated toothpaste	
Toothbrushes GUM	
End-Tuft toothbrushes GUM	

2.8. Consortium

2.8.1. Stakeholders

Since 2011, the Saskatchewan Oral Health Coalition (SOHC)* and the Saskatchewan Oral Health Professions (SOHP)* group have worked collaboratively to develop a Saskatchewan strategy for oral health in LTC. This process included a best practice literature review, policy and procedure review, and a collection of various oral health data related to LTC and pilot projects in Saskatchewan.

In 2011, the SOHP and SOHC endorsed the use and adaptation of Australia's national program entitled, Better Oral Health in Residential Care. With the endorsement by the SOHP and SOHC, a licensing agreement was signed between the Saskatoon Health Region (SHR) and Australia. The license allowed for Saskatchewan adaptations. During 2011-2013, SOHP representatives worked to modify the training resource to Canadian/Saskatchewan standards. In 2013, the resource was retitled Better Oral Health in Long Term Care – Best Practice Standards for Saskatchewan.

The benefits of this partnership approach are:

- collaborative development of the Better Oral Health in LTC – Best Practice Standards for Saskatchewan, education, training program and resource portfolios
- sustainability and general adaptability of the project
- integration of oral health care
- policy development initiatives for example, oral health assessment on admission to LTC home
- comprehensive dissemination of standardized information
- consideration of reorienting dental service delivery for residents in LTC home

- * The Saskatchewan Oral Health Coalition (SOHC) - is a group of oral health professionals, community agencies, health region staff, provincial and national government representatives, and interested groups and individuals whose common goal is to improve oral health, particularly among vulnerable populations.
- * The Saskatchewan Oral Health Professions (SOHP) - is a group that represents legislated oral health professions and includes College of Dental Surgeons of Saskatchewan, Saskatchewan Dental Assistants' Association, Saskatchewan Dental Hygienists' Association, Saskatchewan Dental Therapists Association, and the Denturists Society of Saskatchewan).

2.9. Research and Data from Saskatchewan Projects

In 2005, two projects were launched in Santa Maria Senior Citizens Home (Regina), and in St. Ann's Senior Citizens Village and Saskatoon Convalescent (Saskatoon). From these two projects data collection and analysis were made on the oral health status, treatment needs and cost of treatment of the residents.

2.9.1. Oral Health Status

Statistics	Santa Maria	St. Ann's
Average Age (years)	85	87
Male/Female (%)	34/66	24/76
Residents requiring oral health care %	66	68
Dentate (residents with teeth) %	57	43
Edentulous (residents without teeth) %	43	57
Edentulous with dentures (residents without teeth and with dentures) %	85	94

Statistics	Santa Maria	St. Ann's
Faulty dentures (%)	38	54
Dentures without ID (%)	81	62
Residents with decay (%)	43	67

2.9.2. Treatment Needs

Statistics	Santa Maria	St. Ann's
Oral hygiene time (total hours)	30	25
Restorations required (numbers)	40	24
Restoration time (total hours)	40	24
Denture repairs (numbers)	13	5
Dentures repairs (hours)	4	13
Extractions (numbers)	21	18
Extractions (hours)	12	12

2.9.3. Treatment Cost

Statistics	Santa Maria	St. Ann's
Total Treatment (\$)	15255.50	9443.50
Treatment cost per resident (\$)	157.27	255.23

Along with this data and analysis, an oral health survey was gathered at the St. Ann's Senior Citizens Village and Saskatoon Convalescent Home. The purpose of this survey was to gather baseline data on residents, family and staff on their behaviours and beliefs about oral health.

2.9.4. Other Results

Consistent Themes throughout both LTC Homes

- Staff who received an education session and then answered the post-test survey answered significantly more questions correctly than staff who completed the pre-test and had not had an education session in both LTC sites.
- Staff at both LTC sites indicated that the most challenging aspect of providing mouthcare to residents is uncooperative residents.
- The primary reason given by family members who reported that the LTC resident does not go for regular dental treatment is because they wear dentures.
- On average, residents at both sites only answered 7 out of the 13 true and false questions correctly.
- At least 30% of residents at both sites were currently experiencing problems with their teeth or gums.
- Many residents (ranging from 50-80%) at both sites do not believe they need a dental check-up or were unsure because they do not have teeth.

Note from resident's husband

My wife Bonnie has been a resident at the Parkridge Centre in Saskatoon for nearly 23 years. She is in an advanced stage of progressive Multiple Sclerosis and unable to tend her oral health care herself. It is also extremely difficult for her to go to a regular dentist's office for check-ups, cleanings and fillings, if required. So she and I are very pleased, in-fact, quite relieved and grateful to have residents and staff come to Parkridge from College of Dentistry Long Term Care Program. These people are supremely professional and immensely considerate towards Bonnie and myself, and I have no doubt they treat all Parkridge residents as kindly and capably as they do us. We sincerely hope this service will continue. Otherwise, not having the program, would create a severe reduction in Bonnie's dental and oral health.

D'Arcy

2.10. Impact

The province wide implementation of the *Better Oral Health in LTC – Best Standard Practice in Saskatchewan* will result in:

- Consistent integration of oral health into policy and practice of LTC homes in the province
- A provincial framework for oral health assessment, oral health care planning and oral care treatment for residents
- A multidisciplinary team approach, to improve the oral health of the residents
- Improved quality of life for residents who suffer from poor oral health and nutritional deficiencies
- Decreased occurrence of systemic conditions in the residents
- Residents receiving oral health treatment in the LTC homes rather than having to face the challenges involved with travelling offsite for care

- Regular assessments and oral health treatments
- Decreased health care spending

2.11. Conclusion

Since 2011, the Saskatchewan Oral Health Coalition (SOHC) and the Saskatchewan Oral Health Professions (SOHP) group have worked collaboratively to develop a Saskatchewan strategy for oral health in LTC homes. This process included a best practice literature review, policy and procedure review, and a collection of various oral health data related to LTC and pilot projects in Saskatchewan. The review revealed that the *Better Oral Health in Residential Care Model in Australia* has led to significant and measurable gains in oral health status of the residents.

The resources were modified and adapted based on oral health and LTC home practices in Saskatchewan. A new name was given to the project, *Better Oral Health in LTC – Best Practice Standards for Saskatchewan*. SOHC and SOHP will continue collaboratively lobby the policy makers and government to implement the model in LTC homes in Saskatchewan.

Glossary

Cancer: An abnormal growth of cells which tend to proliferate in an uncontrolled way and, in some cases, to metastasize (spread).

Cemento-enamel junction (CEJ): Point on a tooth surface where the tooth crown joins the tooth root.

Complete denture: A removable dental prosthesis that replaces all of the natural dentition in upper/lower jaws or both; full denture (see *partial denture*)

Coronal: Pertaining to the crown of a tooth.

Crown: The portion of tooth covered by white enamel that usually is visible in the mouth.

Dental bridge: Refers to a fixed dental prosthesis used to replace a missing one or more missing teeth; bridges literally bridge the gap created by one or more missing teeth.

Dental caries: Refers to tooth decay. Tooth structure is destroyed by acid produced by bacteria in the mouth.

Dental implant: Refers to a metal post that are surgically placed into jawbones to replace missing tooth.

Dental plaque: A film composed of bacteria and food debris that adheres to the tooth surface and causes dental caries/periodontal disease

Dental restoration: A filling to repair a tooth damaged by decay or injury.

Dentate: Having teeth as opposed to edentulous (see *edentulous*).

Dentin: The main calcified part of a tooth beneath the enamel, surrounding the pulp chamber and root canals.

Denture stomatitis: inflammation and redness of the tissue beneath a denture.

DMFT: An index of dental caries experience measured by counting the number of decayed (D), missing (M), and filled (F) permanent teeth (T) of an individual.

Edentulous: A state of complete loss of all natural teeth (*see dentate*).

Enamel: The hard white substance covering the crown of a tooth.

Fertility rate: average number of children per woman.

Five-year survival rate: surviving at least 5 years after a cancer diagnosis

Fluoride: A naturally occurring trace mineral that helps to prevent tooth decay.

Gingiva: gum

Gingival recession: The shrinkage of gum tissue away from the tooth resulting in exposure of dental roots and creating the appearance of longer teeth and increased exposure for root caries to occur.

Gingivitis Redness, swelling or bleeding of the gums caused by inflammation.

Incidence: Refers to the total number of new cases of disease in a given period of time (*see prevalence*).

Life expectancy at birth: Refers to the average number of years a newborn is expected to live.

Loss of Attachment (LOA) or Attachment loss: The distance (mm) from where the enamel of the tooth meets the root to the bottom of the pocket between the gum tissue and the tooth.

Natural teeth: Refers to a person's own teeth as opposed to artificial teeth.

Partial denture: A removable dental prosthesis that replaces one or several of the natural dentition in upper/lower jaws or both; full denture (see *complete denture*).

Periodontal disease: Disease of the gums and other tissues that attach to and anchor teeth to the jaws.

Periodontal pocket: An abnormal space below the gum line that forms between the root of a tooth and the gum surrounding that tooth.

Periodontium: The bone, tooth cementum, gum and periodontal ligament surrounding and supporting a tooth.

Permanent teeth: Adult teeth.

Pre-cancerous (pre-malignant) condition: The conditions that have the potential to progress to cancer. If left untreated, these conditions may lead to cancer.

Prevalence: Refers to the total number of cases of disease at a given time (see *incidence*).

Prosthodontics (prosthetic dentistry): Refers to the area of dentistry that focuses on dental prostheses.

RDFT: The average number of Root Decayed (RD) or Filled (F) Teeth (T); the average number of decayed or filled root lesions in an individual.

Root: That part of the tooth below the crown which extends into the jawbone.

Root caries: Dental caries that attacks the surface of the root of a tooth which has become exposed due to gingival recession or periodontitis.

Root canal treatment (endodontic treatment): Refers to the process of removing infected/ injured /dead pulp from tooth, cleaning, and then filling and sealing it.

Senior: In Canada refers to individuals aged 65 years or over.

Stomatitis: Inflammation of the mouth; a general term for an inflamed and sore mouth.

Xerostomia: Dry mouth which is resulting from reduced saliva flow.

Appendices

Appendix-1: List of Abbreviations

CDA	Canadian Dental Association
CDSS	College of Dental Surgeons of Saskatchewan
CVD	Cardiovascular disease
DHE	Dental Health Educator
LTC	Long Term Care
OCLN	Oral Health Contact Person
OHAT	Oral Health Assessment Tool
OHC	Oral Health Coordinator
OHCT	Oral Health Care Team
SDAA	Saskatchewan Dental Assistants' Association
SDHA	Saskatchewan Dental Hygienists' Association
SDTA	Saskatchewan Dental Therapists Association
SHR	Saskatoon Health Region
SOHC	Saskatchewan Oral Health Coalition
SOHP	Saskatchewan Oral Health Profession

Appendix-2: Educators' Portfolio

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*

Educators' Portfolio

Education and Training Program

The Educators' Portfolio is designed to assist with delivery of the Education and Training Program for Long Term Care staff. It is part of a suite of three *Better Oral Health in LTC - Best Practice Standards for Saskatchewan* Portfolios:

- The Professional Portfolio for Nurses
- The Educators' Portfolio for delivery of the Education and Training Program
- The Staff Portfolio for care aides.

The Portfolios were developed by the Better Oral Health in Residential Care Project funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) Program. This project was led by SA Dental Service with the support of Consortium members during 2008-09.

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Program Introduction

Better Oral Health in LTC - *Best Practice Standards in Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by a licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/ oral health professional or nurses.

2. Oral Health Care Plan

Oral Health Care Team (OHCT) and residents develop an oral care plan which is based on a simple protective oral health care regimen.

3. Daily Oral Hygiene

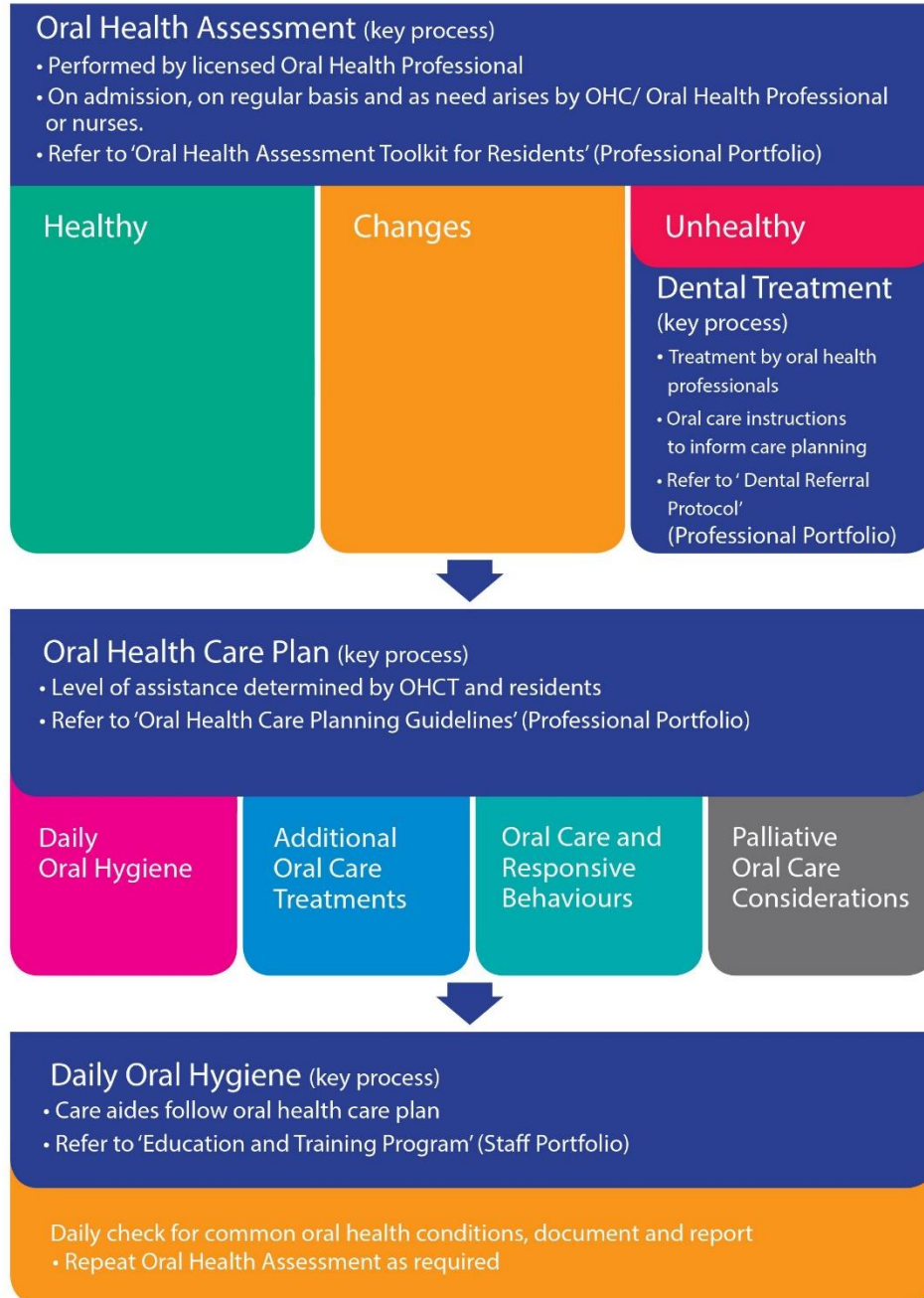
Care aides maintain daily oral hygiene according to the health care plan.

4. Dental Treatment

Referrals for a more comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized that many residents may be best treated at the Long Term Care home.

Program Introduction

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan model*



Program Introduction

Overview

Purpose

The Education and Training Program addresses the key process of daily oral hygiene.

Target group description

LTC home staff, residents and their families.

Facilitator

OHCT trained in facilitating the Better Oral Health in LTC – *Best Practice Standards for Saskatchewan* Education and Training Program.

Duration

3 hours in total.

Learning outcomes

- Knowledge, understanding and appreciation of why good oral health is essential for overall health.
- Knowledge, understanding and appreciation of daily checks for signs of common oral health conditions experienced by residents, documentation and reporting of these to the nurses.
- Knowledge and skills on the six best ways to maintain a resident's oral health.
- Knowledge and skills to intervene residents' with responsive behaviors and improve access.
- Knowledge and skills to use modified oral care application techniques.
- Knowledge, understanding and appreciation of the four key processes (oral health assessment, oral health care plan, daily oral hygiene and dental treatment) required to maintain a resident's oral health.

Recognition given to sessions

Certificate of Attendance issued once the education is completed.

Structure outline and delivery modes

The Program structure is based on three modules:

1. Module one (knowledge): good oral health is essential for overall health.
2. Module two (skills): protect the residents' oral health – activities of daily oral hygiene.
3. Module three (reflective practice): it takes a team approach to maintain a healthy mouth.

The Program has been designed to encompass flexible delivery modes. For example:

- a workshop presentation of all modules (3 hours)
- sequential presentation of one module (one hour each) at a time over a designated timeframe
- sequential presentation of topics (15 minutes each) from each module working through the program over a designated timeframe.

Assessment

Assessment is based on completion of all three training modules and includes the following:

- completion of written self evaluation quiz (pre and post education and training).
- demonstration of oral health care skills
- participation in problem solving scenario group work (reflective practice).

Program Introduction

Overview (Continued)

Resources

- laptop computer and data projector
- Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Education and Training Program resource materials:
 - DVD
 - Facilitator Portfolio
 - resource kit (consumables)
 - Staff Portfolio
 - posters
 - certificates.

Ongoing monitoring and evaluation

- self evaluation quiz (pre and post education and training)
- oral health care skills audit
- oral health outcomes for residents.

References

Primary Source

The Program is based on information from the Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Staff Portfolio.

Accompanying Information

For accompanying information refer to the Long Term Care home policies and procedures:

- clinical practice manual
- infection control protocol
- palliative care protocol.

Program Introduction

Facilitating Adult Learning

The following adult learning principles have been incorporated into the structure of the Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Education and Training Program.

Multi-sensory learning

Most adults learn a new skill or knowledge best by using a combination of visual, auditory and kinaesthetic (by doing) senses.

Oral health information has been supported with a variety of resources such as posters, digital presentations, printed resources, use of practical tasks, reflective practice discussions.

Active Learning

Adults learn by doing.

The Program has been structured in a way which provides opportunities to apply oral health skills and knowledge including reflective practice through a case scenario discussion.

First and Last Impressions

Adults tend to remember what they have seen and heard first and last.

An overview at the beginning of each session followed by summaries of key points throughout is embedded in the Program in order to break information into meaningful 'chunks' which is easier to remember.

Feedback

Many adults often lack self confidence and may have negative memories from previous learning experiences

Facilitators are encouraged to use constructive immediate, ongoing and informal feedback that builds confidence and motivates participants by showing them that they are contributing and progressing.

Reward

Training must include simple and tangible results for adult learners to feel positive and satisfied.

Practical and meaningful resources and activities are used. A highly visual Staff Portfolio is provided and a certificate on completion of the Program.

Program Introduction

Facilitating Adult Learning (Continued)

Meaningful Materials

Adults prefer materials that relate directly to their level of existing knowledge and experience and can be utilised in practical ways.

Resource materials have been designed to match level of knowledge and experience of participating in the Long Term Care home setting. Materials are used to provide opportunities for participants to practise skills and apply knowledge.

Practice and Repetition

Reinforcement helps adult learners to retain and apply the knowledge and skills they are developing.

Oral health skills and knowledge have been pitched at a level relevant for participants. Opportunities to practise new skills are provided. Reflective practice is used to encourage the application of new knowledge and skills.

Respect

A mutual responsibility.

Facilitators and participants are encouraged to demonstrate tolerance, sensitivity and cooperation with regard to others previous experience, culture, learning styles and interests.

Holistic learning

Provide a big picture context and then specific detail provides a logical framework for thinking.

The best ways to maintain a resident's oral health is presented in relation to general health as well as the key processes required to promote Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*.

Program Introduction

Facilitator Presentation Tips

Be well prepared

Lack of organization is a major cause of anxiety.

Make sure you know all the resources very well:

- DVD
- Digital presentations (Module 1)
- Facilitator notes (Module 1, 2, 3)
- Module 1, 2 and 3 sections in Staff Portfolio.

Practice makes perfect

Rather than mentally rehearsing you should practise standing up as if in front of the participants using your visual aids.

At least 2 rehearsals are recommended.

Strive for minimal focus on notes and maximum focus on the participants.

Imagine yourself as confident, successful and doing a great job.

Reduce stage fright

Breathe

- When your muscles tighten and you feel nervous, you may not be breathing deep enough.
- First thing to do is to sit up tall but relaxed and inhale deeply a number of times.

Release tension

- Starting with your toes, then tighten your muscles up through your body finally making a fist.
- Immediately release all tension and take a deep breath.
- Repeat this until the tension starts to drain away.
- This can be done quietly so no one knows you're relaxing.

Move

- Move when you speak to stay relaxed and natural.
- If you find you are locking your arms then release them so they do the same as they would if you were in an animated one on one conversation.
- Moving your feet can also release tension. You should be able to take a few steps either side or toward the audience or to the side of the lectern.

Voice

Be aware of your volume.

Vary your pitch, volume and pacing as you would do in natural conversation or story telling.

Pace

When we become anxious we tend to talk fast and tend to trip over words.

Deliberately slow down your speech.

Pausing

Don't be afraid to pause.

Pausing can be an effective way to allow important points to sink in.

Use a pause to take a breath and relax a moment and to fill in those spaces that you might otherwise fill with sounds of 'umm' or 'you know'.

Posture

Keep your posture erect but relaxed.

You want to stand up straight but not stiff.

Your weight should be evenly distributed.

Don't place your weight on one hip then shift to the other and back again – shifting can be distracting.

Smile

Remember to smile.

Make eye contact

Rule of thumb for eye contact is 3 to 5 seconds per person.

Speak to one person at a time when you speak rather than the back of the wall or at the screen or at notes.

Try not to dart your eyes around the room.

With large groups make eye contact with individuals in different parts of the room.

Program Introduction

Facilitator Presentation Tips (Continued)

Where and how to stand

One major problem when using visual aides is that speakers often give their presentation to the visuals and not the participants.

Keep your body facing the participants as much as possible as this will help you keep your eye contact with them.

Look at the screen momentarily to recall the point you want to make and then turn to the participants and deliver it.

If you need to write something on a white board or butcher paper stop talking while you write.

Gestures

The importance of natural gestures cannot be overstated.

Often anxiety holds back this important means of communication.

Learn to gesture in front of the participants as if you were having an animated conversation with a friend.

Room set up

Computer and projector

- Set the screen at a 45 degrees angle to the participants to give the speaker centre stage.
- Always check you can use them and they are in working order before your presentation.
- Have a back up plan if you should have a technology break down.

Lighting

- If able adjust for visual presentation.

Seating arrangement

- If possible arrange seating so the exit and entrance to the room are at the back.
- Know how many people are expected and make sure there are as many seats as people this will stop them from sitting at the back of the room.
- Keeping the participants closer will focus their attention on you.



Module 1

Good Oral Health is Essential for Overall Health

TABPAGE

PrintfromTabPagefile

Module 1 – Competency Outline

Topic

A healthy mouth will improve overall health and wellbeing.

Purpose

To inform and raise the profile of oral health and its interaction with general health and wellbeing of residents.

Element of Competency	Performance Criteria
1. Identify why residents are at high risk of poor oral health.	1.1 Describe the factors contributing to the poor oral health of residents.
2. Identify the relationship between oral health and general health and wellbeing.	2.1 Describe the impact of poor oral health on quality of life and general health.
3. Identify common oral health conditions experienced by residents.	3.1 Describe daily checking and reporting to Nurses of common oral health conditions.
4. Provide oral care to residents with responsive behaviour.	4.1 Demonstrate ways to manage changed behaviour. 4.2 Demonstrate how to improve access to the resident's mouth. 4.3 Demonstrate modified oral care techniques.

Module 1 – Session Plan

Module 1: Good Oral Health is Essential for Overall Health		
Topic	Resources	Time
Pre education & training quiz • pre-quiz to be completed	Pre education & training quiz	10 min
Introduction Brief overview of Better Oral Health in LTC - <i>Best Practice Standards for Saskatchewan</i> Good oral health is essential for overall health • Facts - why residents are a high risk group • Relationship between oral health and general health and wellbeing. Better Oral Health key processes 1. oral health assessment 2. oral health care plan 3. daily oral hygiene 4. dental treatment Daily oral hygiene • 6 best ways to protect a resident's oral health • Common oral conditions – why daily checks are important • Oral health care and responsive behaviours	Computer Projector Screen (or clear wall) Prepared PowerPoint presentation: Module 1 Module 1 Facilitator Notes Module 1 Staff Portfolio	20 min
????	DVD	25 min
Conclusion – summarize • 4 key processes • 6 best ways to maintain a healthy mouth • Importance of daily checks		5 min
Total		60 min

PowerPoint Presentation – Facilitator Notes

Slide 1



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*

Education and Training Program

Supports Key Process – Daily Oral Hygiene

Room preparation

The participants will need to be sitting as a group for this session.

Ensure there is enough comfortable seating and the participants can easily see the PowerPoint presentation and DVD.

Please give yourself enough time to set up

Make sure you know how to use the computer and projector, particularly note if you need speakers so the participants can hear the DVD.

Test the PowerPoint presentation and the DVD before beginning the session.

Make sure you are very familiar with the content of the PowerPoint presentation, the information in the Staff Portfolio and the DVD.

Start Session

Welcome participants.

Distribute pre-quiz for participants to complete. The pre-quiz can be found on the accompanying CD.

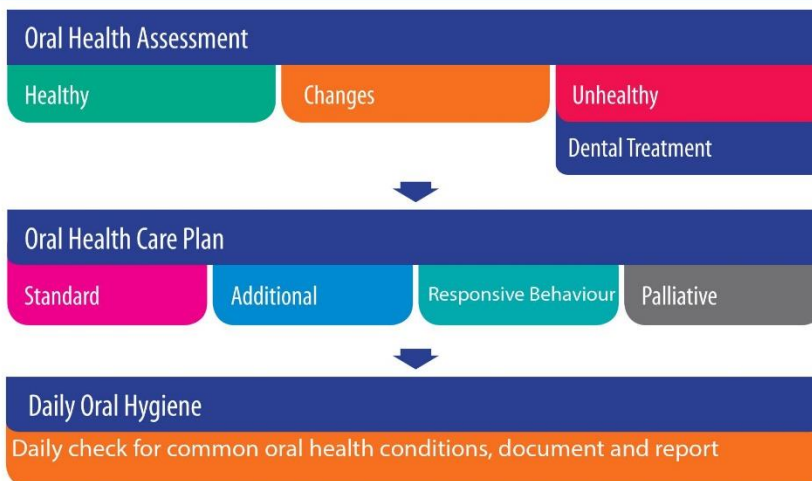
Distribute Staff Portfolio to participants.

Give brief overview of the session – eg. “I will be presenting a PowerPoint presentation introducing Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* followed by a DVD.”

PowerPoint Presentation – Facilitator Notes

Slide 2

Flow Chart Showing Key Processes



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* advocates a team approach to maintain a resident's oral health. The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), nurses, Care aides, physicians and oral health professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.

There are 4 key processes

1. **Oral Health Assessment** - performed by licensed oral health professional on a regular basis and as the need arises by OHC/oral health professional or nurses.
2. **Oral health Care Plan** - OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen.
3. **Daily Oral Hygiene** - Care aides oral hygiene according to the oral health care plan.
4. **Dental Treatment** - Referrals for a comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized that many residents may be best treated at the Long Term Care home.

PowerPoint Presentation – Facilitator Notes

Slide 3

Education and Training Program

- Module 1** Good oral health is essential for overall health
- Module 2** Protect your resident's oral health – daily oral hygiene
- Module 3** It takes a team approach to maintain a healthy mouth

Education and training is important.

It is the **day to day practice of oral hygiene** which is essential in protecting a resident's oral health from deteriorating.

Module 1 Good oral health is essential for overall health - which is today's session – is about setting the scene and describing why it is important to maintain good oral health.

Module 2 Protect your residents' oral health - daily oral hygiene - is about skills development and is a hands-on workshop.

Module 3 It takes a team approach to maintain a healthy mouth – is about reflective practice. This is about working through problems which might occur in day-to-day practice and what you would do about them.

PowerPoint Presentation – Facilitator Notes

Slide 4

Good Oral Health is essential for Health

Quality of Life

Bad breath
Bleeding gums
Tooth decay
Self esteem
Speech
Ability to eat
Dental pain
Responsive Behaviour



Impact on General Health

Aspiration pneumonia
Heart attack
Stroke
Lowered immunity
Poor diabetic control

Quality of Life

Before showing the content of this slide, ask the participants what this might include.

Poor oral health will significantly affect a resident's quality of life in many ways:

- bad breath
- bleeding gums, tooth decay and tooth loss
- appearance, self-esteem and social interactions
- speech and swallowing
- ability to eat, nutritional status and weight loss
- pain and discomfort
- change in behaviour.

Impact on General Health

Before showing the content of this, ask the participants what this might include.

Oral integrity is as important as skin integrity in protecting the body against infection.

When this defence barrier is broken because of poor oral health, the bacteria in dental plaque can enter airways and the bloodstream. This can cause infection of tissues far away from the mouth and may contribute to:

- aspiration pneumonia
- heart attack
- stroke
- lowered immunity
- poor diabetic control.

PowerPoint Presentation – Facilitator Notes

Slide 5

The Facts

More residents in Long Term Care home have their natural teeth.

Many residents take medications that contribute to dry mouth.

The onset of major oral health problems takes place well before an older person moves into Long Term Care home.

Residents are at high risk of their oral health worsening if their daily oral hygiene is not maintained adequately.

A simple daily oral health care regimen will maintain good oral health.

Why are residents at high risk of poor oral health?

Today more residents Long Term Care home have their **natural teeth**.

Many residents take medications that contribute to **dry mouth**.

The onset of **major oral health problems** takes place well before person moves into Long Term Care home.

Residents are at **high risk** of their oral health worsening if their daily oral hygiene is not maintained adequately.

A **simple daily oral health care** regimen will maintain good oral health.

The important message here is that residents are in a high risk group for oral health problems and need to have preventative measures in place to protect their oral health from deteriorating.

PowerPoint Presentation – Facilitator Notes

Slide 6

Oral Health Assessment

[illegible]

This is an example of Oral Health Assessment form. You may see this form in the residents' notes.

An **Oral Health Assessment** should be performed by a licensed oral health professional on admission, and subsequently on a regular basis and as the need arises by OHC/oral health professional or nurses (e.g. following an acute incident).

8 categories of oral health are checked – lips, tongue, gums and soft tissues, saliva, natural teeth, dentures, oral cleanliness and dental pain.

Each category is assessed as being healthy, changes or unhealthy. An unhealthy assessment indicates that the resident must be seen by an oral health professional.

PowerPoint Presentation – Facilitator Notes

Slide 7

Standard Protective Care

Six of the best ways to maintain a healthy mouth

Brush morning
and night



Fluoride
toothpaste
on teeth



Soft toothbrush
on gums, tongue
& teeth



Antibacterial
product after
lunch



Keep the
mouth moist



Cut down
on sugar



Oral Care Plans are developed by the OHCT and should be based on the 6 best ways to protect a resident's oral health:

1. Brushing teeth and or dentures morning and night
2. Fluoride toothpaste on teeth
3. Use a soft toothbrush on gums, tongue and teeth
4. Apply an antibacterial product after lunch
5. Keep the resident's mouth moist
6. Cut down on sugar.

PowerPoint Presentation – Facilitator Notes

Slide 8

Daily check, document and report

There are many common oral health conditions experienced by residents.

Early detection means early treatment and relief for the resident.

As mentioned residents are in a **high risk group** and many are likely to experience oral health conditions.

The earlier these are noticed the better.

It is **very important to check every day** when oral hygiene is complete and report any changes you see.

PowerPoint Presentation – Facilitator Notes

Slide 9

Lips

Sore corners of the mouth

Angular Cheilitis



Angular Cheilitis

Bacterial or fungal infection at the corner of the mouth.

Check for

- soreness and cracks at corners of mouth.

PowerPoint Presentation – Facilitator Notes

Slide 10

Tongue

Sore Tongue

Glossitis



Thrush

Candidiasis



Sore Tongue (Glossitis)

Commonly caused by fungal infection.
May be a sign of a general health problem.

Check for:

- reddened, smooth area of tongue
- tongue generally sore and swollen.

Thrush (Candidiasis)

Fungal infection of oral tissues.

Check for:

- patches of white film that leave a raw area when wiped away
- red inflamed areas on the tongue.

PowerPoint Presentation – Facilitator Notes

Slide 11

Gums and Oral Tissue

Gum Disease

Severe Gum Disease

Oral Cancers

Gingivitis

Periodontitis



Gum Disease (Gingivitis)

Inflammation of the gums caused by bacteria in dental plaque accumulating on the gum line at the base of the tooth. It gets worse and more common with age.

Check for:

- bright red gums that bleed easily when touched or brushed
- bad breath.

Severe gum disease (Periodontitis)

Severe gum disease that causes gum recession and breakdown of the bone that supports the teeth. This can impact seriously on general health and wellbeing.

Check for:

- receding gums, exposed roots
- loose teeth
- tooth sensitivity
- bad breath.

Oral Cancers

Oral cancer is a major cause of death. People who smoke and drink alcohol heavily are at higher risk.

Check for:

- ulcerations that do not heal within 14 days
- white or red patch or change in texture of oral tissues
- swelling
- unexplained speech patterns
- difficulty in swallowing.

PowerPoint Presentation – Facilitator Notes

Slide 12

Gums and Oral Tissue

Ulcers and Sore Spots



Sore Mouth

Stomatitis



Ulcers & Sore Spots

May be caused from chronic inflammation, poorly fitting dentures or trauma. May also be a sign of a general health problem.

Check for:

- sensitive areas of raw tissue, particularly under dentures
- broken dentures
- broken teeth
- difficulty eating meals
- responsive behaviour.

Sore Mouth (Stomatitis)

A fungal inflammatory infection of tissues commonly found where oral tissue is covered by a denture. May also be a sign of a general health problem.

Check for:

- red inflamed gums and palate.

PowerPoint Presentation – Facilitator Notes

Slide 13

Saliva

Dry Mouth

Xerostomia



Dry Mouth (Xerostomia)

Is a very common and uncomfortable condition that may be caused by medications, radiation and chemotherapy or by medical conditions such as Sjogren's syndrome and Alzheimer's disease. It is also commonly experienced by palliative care residents.

Check for:

- difficulty with eating and or speaking
- dry oral tissues
- little saliva present in mouth or thick stringy saliva.

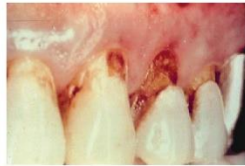
PowerPoint Presentation – Facilitator Notes

Slide 14

Natural Teeth

Tooth Decay

Caries



Root Decay

Root Caries



Retained Roots



Tooth Decay (Caries)

Is a diet and oral hygiene related infectious disease which affects the teeth and causes pain.

Check for:

- holes in teeth
- brown or discoloured teeth
- broken teeth
- bad breath
- oral pain and tooth sensitivity
- difficulty eating meals
- responsive behaviour.

Root Decay (Root Caries)

Gums recede and the surface of the tooth is exposed. Decay can develop quickly because the tooth root is not as hard as tooth enamel.

Check for:

- tooth sensitivity
- brown discolouration near the gum line
- exposed roots
- bad breath
- difficulty eating food
- responsive behaviour

Retained Roots

The crown of the tooth has broken or decayed away leaving the root behind

Check for:

- broken teeth
- pain
- swelling
- bad breath
- trauma to surrounding tissues from sharp tooth edges
- difficulty eating meals
- responsive behaviour

PowerPoint Presentation – Facilitator Notes

Slide 15

Dentures

Requiring Attention



Poorly Fitting



Requiring Attention

Check for:

- resident's name marked on denture
- chipped or missing teeth
- chipped or broken acrylic (pink) areas
- bent or broken metal wires or clips
- damage of soft tissues.

Poorly Fitting

Cause of irritation and trauma to gums and soft tissues.

Check for:

- denture belongs to resident
- denture is a matching set if resident has several sets of dentures
- denture movement when the resident is speaking or eating
- resident refuses to wear denture
- overgrowth of tissue
- ulcers and sore spots.

PowerPoint Presentation – Facilitator Notes

Slide 16

Oral Cleanliness

Poor Oral Hygiene



Poor Oral Hygiene

Poor oral hygiene allows bacteria in dental plaque to produce acids and other substances which are damaging to teeth, gums and surrounding bone.

Dental plaque is an invisible film that sticks to all surfaces of the teeth and mouth including the tongue.

It forms continually and can only be removed by brushing.

Check for:

- build up of plaque on the teeth particularly at the gum line
- unclean dentures
- bleeding gums
- coated tongue
- bad breath
- food left in the mouth.

PowerPoint Presentation – Facilitator Notes

Slide 17

Dental Pain

Responsive behaviour

Refusing to open mouth

Fear of being touched

Confused

Uncooperative

Grabbing or hitting out

Biting

A resident may not be able to say he or she is in pain.

This is particularly so with residents who have dementia.

Often a change in behaviour is a sign. Instead of thinking urinary track infection, perhaps consider whether it is dental pain.

PowerPoint Presentation – Facilitator Notes

Slide 18

Responsive Behaviour

Effective Approaches

- Talk clearly
- Caring attitude
- Right environment
- Body language

We know it's not easy but sometimes a change of approach can make a difference.

Some behaviours, particularly concerning residents with dementia, make it difficult for staff to perform oral hygiene care.

Ask the participants to give some examples of effective approaches using the headings in the slide as prompts.

Caring Attitude

Firstly, focus on building a good relationship with the resident before you start oral care. Use a calm, friendly and non-demanding manner.

Talk Clearly

Always explain what you are doing and give one instruction at a time. Ask questions that require a yes or no response. Use reassuring words and positive feedback.

The Right Environment

Choose the location where the resident is most comfortable. Ensure there is good lighting as residents with dementia need higher levels of lighting. Use a brightly coloured toothbrush so it can be seen easily by the resident.

Body Language

Approach the resident from the diagonal front and at eye level. By standing directly in front you can look big and are more likely to be grabbed or hit. Touch a neutral place such as the hand or lower arm to get the resident's attention. Position yourself at eye level and maintain eye contact if culturally appropriate.

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Slide 19

Improving interaction

Overcoming fear of being touched

Bridging

Distraction

Modelling

Hand over hand

Alternative provider

Modified oral care techniques

Overcoming Fear of Being Touched

The resident may respond fearfully to intimate contact when the relationship with you has not been established.

This process may need to be staged over time until the resident becomes trusting and ready to accept oral care. Start by slowly introducing a small amount of toothpaste on the resident's top lip so that it can be tasted. Then, gently try introducing a toothbrush to the mouth and progress with other types of oral care.

Bridging

Bridging aims to engage the resident's senses, especially sight and touch, and to help the resident understand the task you are trying to do for him or her.

Undertake this method only if the resident is engaged with you.

Describe the toothbrush and show it to the resident.

Mimic brushing your own teeth so the resident sees physical prompts, and smile at the same time.

Place a brightly coloured toothbrush in the resident's preferred hand (usually the right hand).

The resident is likely to mirror your behaviour and begin to brush his or her teeth.

Continued on following page

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Slide 19 (Continued)

Modelling

If the resident does not initiate brushing his or her teeth through bridging, gently bring the resident's hand and toothbrush to his or her mouth, describing the activity and then letting the resident take over and continue.

Hand over Hand

If modelling does not work, then place your hand over the resident's hand and start brushing the resident's teeth so you are doing it together.

Distraction

If the hand over hand method is not successful, place a toothbrush in the resident's hand while you use the other toothbrush to brush the resident's teeth.

Alternatively, place a familiar item such as a towel, cushion or activity board in the resident's hands to distract the resident's attention from the oral care.

Familiar music may also be useful to distract and relax the resident during oral care.

Alternative provider

If your relationship with the resident is not working and attempts at oral care are not going well, then tell the resident that you will leave it for now. Ask for help and have someone else take over the oral care.

Modified oral care techniques

This includes how to use a bent toothbrush to gain better access to the mouth, smearing of toothpaste over the teeth as a short term alternative to brushing and also the use of a spray bottle. Module 2 will show you how to do this.

PowerPoint Presentation – Facilitator Notes

Slide 21

Show DVD

????

Close off out of this presentation

Play DVD - duration 23 mins

After DVD has finished conclude session by asking audience what was new or useful information that they would take away from the session.

Summarize key take home messages: importance of 4 key processes, 6 best ways to maintain oral health and the significance of daily reporting.

Remind participants to bring their Staff Portfolio to each session.

Staff Portfolio Resource

Module 1



Module 1

Good Oral Health is Essential for Overall Health

Staff Portfolio Resource | Module 1 | 26

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*

Oral diseases and conditions can have social impacts on quality of life, including comfort, eating, pain and appearance, and are related to dentate status... People 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.

Chalmers, JM 2003, 'Oral health promotion for our ageing Australian population', Australian Dental Journal; vol. 48, no.1, pp.2-9.

The Facts

More LTC residents have their natural teeth.

Many residents take medications that contribute to dry mouth.

The onset of major oral health problems takes place well before a person moves into Long Term Care home.

As residents become frailer and more dependent, they are at high risk of their oral health worsening in a relatively short time if their daily oral hygiene is not maintained adequately.

A simple protective oral health care regimen will maintain good oral health.

Quality of Life

Poor oral health will significantly affect a resident's quality of life in many ways:

- bad breath
- bleeding gums, tooth decay and tooth loss
- appearance, self-esteem and social interactions
- speech and swallowing
- ability to eat, nutritional status and weight loss
- pain and discomfort
- change in behaviour.

Impact on General Health

Oral integrity is as important as skin integrity in protecting the body against infection.

When this defence barrier is broken because of poor oral health, the bacteria in dental plaque can enter airways and the bloodstream. This can cause infection of tissues far away from the mouth and may contribute to:

- aspiration pneumonia
- heart attack
- stroke
- lowered immunity
- poor diabetic control.

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by the licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses.

2. Oral Health Care Plan

OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen.

3. Daily Oral Hygiene

Care aides maintain daily oral hygiene according to the oral health care plan.

4. Dental Treatment

Referrals for more comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized many residents may be best treated at the Long Term Care home.



Common Oral Health Conditions experienced by Residents

This section examines common oral health conditions experienced by residents. When doing a resident's oral hygiene, care aides should check daily for signs of the following conditions. Changes should be documented and reported.

Daily Check, Document and Report

Lips

- sore corners of mouth (angular cheilitis)

Tongue

- sore tongue (glossitis)
- thrush (candidiasis)

Gums and Tissues

- gum disease (gingivitis)
- severe gum disease (periodontitis)
- oral cancers
- ulcers and sore spots
- sore mouth (stomatitis)

Saliva

- dry mouth (xerostomia)

Natural Teeth

- tooth decay (caries)
- root decay (root caries)
- retained tooth roots

Dentures

- requiring attention
- poorly fitting

Oral Cleanliness

- poor oral hygiene



Lips

Sore Corners of Mouth (Angular Cheilitis)

Bacterial or fungal infection which occurs at the corners of the mouth.

Check for:

- soreness and cracks at corners of the mouth.

Tongue

Sore Tongue (Glossitis)

This is commonly caused by a fungal infection. It may be a sign of a general health problem.

Check for:

- a reddened, smooth area of tongue
- a tongue which is generally sore and swollen.

Thrush (Candidiasis)

This is a fungal infection of oral tissues.

Check for:

- patches of white film that leave a raw area when wiped away
- red inflamed areas on the tongue.



Gums and Tissues

Gum Disease (Gingivitis)

This is caused by the bacteria in dental plaque accumulating on the gum line at the base of the tooth. It gets worse and more common with age.

Check for:

- swollen red gums that bleed easily when touched or brushed
- bad breath.

Severe Gum Disease (Periodontitis)

This causes gums and bone that support the teeth to breakdown. This condition can impact seriously on general health and wellbeing.

Check for:




- receding gums
- exposed roots of teeth
- loose teeth
- tooth sensitivity
- bad breath.

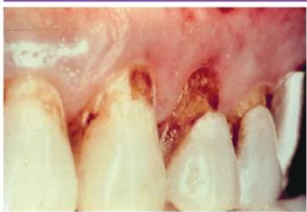


Oral Cancers

Oral cancer is a major cause of death. People who smoke and drink alcohol heavily are at higher risk.

Check for:

- ulcers that do not heal within 14 days
- a white or red patch or change in the texture of oral tissues
- swelling
- unexplained changes in speech
- difficulty in swallowing.

Gums and Tissues (Continued)	Saliva
 	
<p>Ulcers & Sore Spots</p> <p>These are caused by chronic inflammation, a poorly fitting denture or trauma.</p> <p>Ulcers may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • sensitive areas of raw tissue caused by rubbing of the denture (particularly under or at the edges of the denture) • broken denture • broken teeth • difficulty eating meals • changed behaviour. 	<p>Sore Mouth (Stomatitis)</p> <p>Usually, this is caused by a fungal infection.</p> <p>It is commonly found where oral tissue is covered by a denture.</p> <p>It may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • red swollen mouth usually in an area which is covered by a denture. <p>Dry Mouth (Xerostomia)</p> <p>This can be a very uncomfortable condition caused by medications, radiation and chemotherapy or by medical conditions such as Sjögren's syndrome and Alzheimer's disease.</p> <p>Check for:</p> <ul style="list-style-type: none"> • difficulty with eating and/or speaking • dry oral tissues • small amount of saliva in the mouth • saliva which is thick, stringy or rope-like.

Natural Teeth		
		
<p>Tooth Decay (Caries)</p> <p>Tooth decay is a diet and oral hygiene related infectious disease which affects the teeth and causes pain.</p> <p>Check for:</p> <ul style="list-style-type: none"> • holes in teeth • brown or discoloured teeth • broken teeth • bad breath • oral pain and tooth sensitivity • difficulty eating meals • responsive behaviour. 	<p>Root Decay (Root Caries)</p> <p>Gums recede and the surface of the tooth root is exposed.</p> <p>Decay can develop very quickly because the tooth root is not as hard as tooth enamel.</p> <p>Check for:</p> <ul style="list-style-type: none"> • tooth sensitivity • brown discolouration near the gum line • bad breath • difficulty eating meals • responsive behaviour. 	<p>Retained Roots</p> <p>The crown of the tooth has broken or decayed away.</p> <p>Check for:</p> <ul style="list-style-type: none"> • broken teeth • exposed tooth roots • oral pain • swelling • bad breath • trauma to surrounding tissues from sharp tooth edges • difficulty eating meals • responsive behaviour.

Dentures



Requiring Attention

The denture is in need of repair or attention.

Check for:

- resident's name on the denture
- chipped or missing teeth on the denture
- chipped or broken acrylic (pink) areas on the denture
- bent or broken metal wires or clips on a partial denture.



Poorly Fitting

A denture can cause irritation and trauma to gums and oral tissues.



Check for:

- denture belonging to resident
- dentures being a matching set, particularly if the resident has several sets of dentures
- denture movement when the resident is speaking or eating
- resident's refusal to wear the denture
- overgrowth of oral tissue under the denture
- ulcers and sore spots caused by wearing the denture.

Oral Cleanliness



Poor Oral Hygiene

Poor oral hygiene allows the bacteria in dental plaque to produce acids and other substances that damage the teeth, gums and surrounding bone.



Dental plaque begins as an invisible film that sticks to all surfaces of the teeth, including the spaces between the teeth and gums. It forms continuously and must be removed by regular brushing. If dental plaque is not removed, it hardens into calculus (tartar).



Check for:

- build up of dental plaque on teeth, particularly at the gum line
- calculus on teeth, particularly at the gum line
- calculus on denture
- unclean denture
- bleeding gums
- bad breath
- coated tongue
- food left in the mouth.



Oral Health Care and Responsive Behaviour

Responsive Behaviour

Residents, especially residents suffering dementia, can respond in a way that makes it difficult to provide oral health care. They may display responsive behaviour, such as the following:

- fear of being touched
- not opening the mouth
- not understanding or responding to directions
- biting the toothbrush
- grabbing or hitting out.

Oral Health Care

Establish effective verbal and non-verbal communication.
 Develop ways to improve access.
 Develop strategies to manage responsive behaviour.
 Use oral aids such as a modified toothbrush or mouth prop.
 Use modified oral care application techniques as short-term alternatives to brushing.
 Seek dental referral to review oral care.

Oral Hygiene Products & Aids



Use a soft toothbrush suitable for bending.

Use a brightly coloured toothbrush.

Use mouth props (but only if trained in their use).

Use modified oral health care application techniques; for example, spray bottle.

Use a chlorhexidine mouthwash (alcohol free and non-teeth staining) as prescribed by the family physician or dentist.

Effective Communication



Talk Clearly

Speak clearly and at the resident's pace.

Speak at a normal volume.

Always explain what you are doing.

Use words the resident can understand.

Ask questions that require a yes or no response.

Give one instruction or piece of information at a time.

Use reassuring words and positive feedback.

Use words that impart an emotion; for example, 'lovely' smile or 'sore' mouth.

Observe the resident closely when you are talking with him or her. A lack of response, signs of frustration, anger, disinterest or inappropriate responses can all suggest the communication being used is too complex.

Effective Communication Strategies (continued)



Caring attitude

Firstly, focus on building a good relationship with the resident before you start oral care.

Use a calm, friendly and non-demanding manner.

Smile and give a warm greeting using the resident's given name. Using the given name is more likely to engage the resident.

Allow plenty of time for the resident to respond.

If you cannot remain calm, try again at another time or get assistance.



The Right Environment

Choose the location where the resident is most comfortable. This may be the bedroom where there are familiar things or the bathroom because this is the usual place for oral care.

Maintain regular routines.

Ensure there is good lighting as residents with dementia need higher levels of lighting.

Use a brightly coloured toothbrush so it can be seen easily by the resident.

If possible, turn off competing background noise such as the television or radio.



Body Language

Approach the resident from the diagonal front and at eye level. By standing directly in front you can look big and are more likely to be grabbed or hit.

Touch a neutral place such as the hand or lower arm to get the resident's attention.

Position yourself at eye level and maintain eye contact if culturally appropriate.

Be aware that the personal spaces of residents can vary.

Be consistent in your approach and maintain a positive expression and caring language.

Improve Access



Overcoming Fear of Being Touched

The resident may respond fearfully to intimate contact when the relationship with you has not been established.

Firstly, concentrate on building up a relationship with the resident. Once you have engaged the resident, gently and smoothly stroke the resident's face. The aim is to relax the resident and create a sense of comfort and safety.

This process may need to be staged over time until the resident becomes trusting and ready to accept oral care.



Bridging

Bridging aims to engage the resident's senses, especially sight and touch, and to help the resident understand the task you are trying to do for him or her.

Undertake this method only if the resident is engaged with you.

Describe the toothbrush and show it to the resident.

Mimic brushing your own teeth so the resident sees physical prompts, and smile at the same time.

Place a brightly coloured toothbrush in the resident's preferred hand (usually the right hand).

The resident is likely to mirror your behaviour and begin to brush his or her teeth.



Modelling

If the resident does not initiate brushing his or her teeth through bridging, gently bring the resident's hand and toothbrush to his or her mouth, describing the activity and then letting the resident take over and continue.

Improve Access (Continued)



Hand over hand

If modelling does not work, then place your hand over the resident's hand and start brushing the resident's teeth so you are doing it together.



Distraction

If the hand over hand method is not successful, place a toothbrush or a familiar item (such as a towel, cushion or activity board) in the resident's hand while you use the other toothbrush to brush the resident's teeth.

Familiar music may also be useful to distract and relax the resident during oral care.



Alternative provider

If your relationship with the resident is not working and attempts at oral care are not going well, then tell the resident that you will leave it for now. Ask for help and have someone else take over the oral care.

Manage Responsive Behaviour (First Stage Dementia)

Responsive Behaviour

The resident has delusions.

The resident may think:

- you are not who you are
- you are trying to hurt or poison him or her
- he or she has cleaned their teeth already

What To Do

Mime what you want the resident to do.

Allow the resident to inspect the items.

Take the resident to another room; for example, move from the bedroom to the bathroom.

Manage Responsive Behaviour (Second Stage Dementia)

Responsive Behaviour

The resident grabs out at you or grabs your wrist.

What To Do

Pull back and give the resident space.

Ask if the resident is OK.

Offer the resident something to hold and restart oral care.

Responsive Behaviour

The resident hits out.

What To Do

Think about what may have caused the resident's behaviour.

Was the resident startled?

Did something hurt?

Was the resident trying to help but the message was mixed?

Was the resident saying 'stop'?

Did the resident feel insecure or unsafe?

Responsive Behaviour

The resident walks away.

What To Do

Allow the resident to perch rather than sit.

Perching is resting the bottom on a bench or table.

Manage Responsive Behaviour (Third Stage Dementia)

Responsive Behaviour

The resident does not open his or her mouth.

What To Do

Stimulate the resident's root reflex with your finger by stroking the resident's cheek in the direction of the mouth.

Place toothpaste on the top lip to prompt the resident to lick his or her lips.

Responsive Behaviour

The resident keeps turning his or her face away.

What To Do

Reposition yourself.

Sit the resident upright.

Stimulate the resident's root reflex with your finger by stroking the resident's cheek in the direction of the mouth. The resident's head will turn to the side which is being stroked.

Responsive Behaviour

The resident bites the toothbrush.

What To Do

Stop moving the toothbrush.

Ask the resident to release it.

Distract the resident with gentle strokes to the head or shoulder, using soothing words.

Responsive Behaviour

The resident holds onto the toothbrush and does not let go.

What To Do

Stroke the resident's forearm in long, gentle rhythmic movements as a distraction and to help relax the resident.

Responsive Behaviour

The resident spits.

What To Do

Ensure you are standing to the side or diagonal front.

Place a face washer or paper towel on the resident's chest so you can raise it to catch the spit.

Modified Oral Hygiene Methods



Wipe fluoride toothpaste onto teeth

Instead of brushing teeth, try wiping a smear of toothpaste along the teeth with a toothbrush or oral swab.

Alternatively, a chlorhexidine gel can be applied the same way.

This does not replace brushing but is a short-term alternative.



Mouth props

Mouth props can be used for residents who clench or bite or who have difficulty opening their mouth. Use mouth props only if you have been trained to do so.

Caution

Never place your fingers between the teeth of a resident.

Modified Oral Hygiene Methods (Continued)



Modified Soft Toothbrush

A backward bent toothbrush can be used to retract the cheek, while another brush is used to brush the resident's teeth.

Use one hand in a 'pistol grip' to support the chin and roll down the lower lip while you insert a backward toothbrush and retract the cheek. Release your grip to hold the backward bent brush and use another toothbrush in your other hand to brush the resident's teeth.

To bend a soft toothbrush handle:

- place the brush in a cup of hot water to soften the plastic
- apply downward pressure on the brush until it bends to a 45 degree angle
- take care as some brands of toothbrush may snap
- clear plastic toothbrushes are the easiest to bend.



Use of a Spray Bottle

If it is difficult to brush or smear fluoride toothpaste or chlorhexidine gel onto the teeth, a chlorhexidine mouthwash can be sprayed into the mouth.

This does not replace brushing but is a short-term alternative.

The mouthwash should be placed undiluted into a spray bottle. You must follow the Long Term Care home's infection control guidelines for decanting the mouthwash, or have a pharmacist do this for you.

The spray bottle must be labelled with the resident's name and the contents.

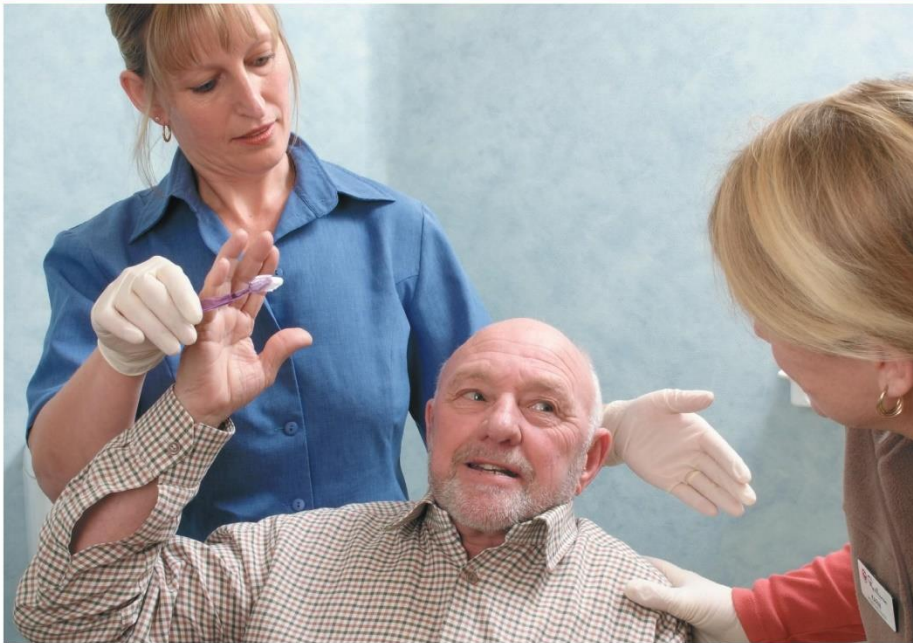
Spray four squirts directly into the mouth. Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Refusal of Oral Care



Review what you are doing

Are you using the right oral hygiene aids?

Are you approaching with a caring attitude?

Is your language and expression effective?

Is the resident not concentrating or participating because of the environment?

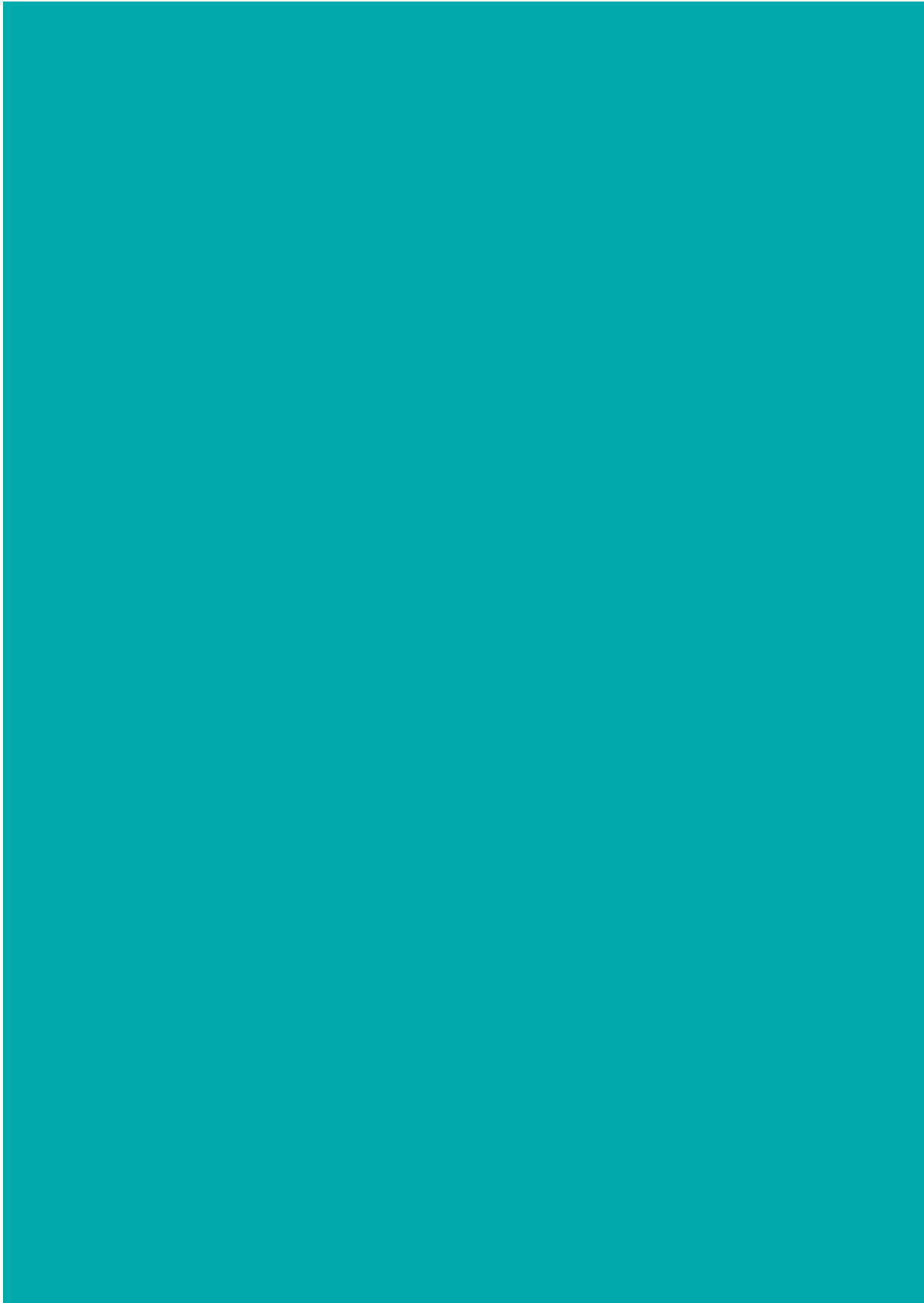
Is it the right room or location for the resident?

Is your approach familiar to the person?

Is the time of the day best for the person, such as morning versus evening?

Ask others, including family, for ideas.

Ask for help.

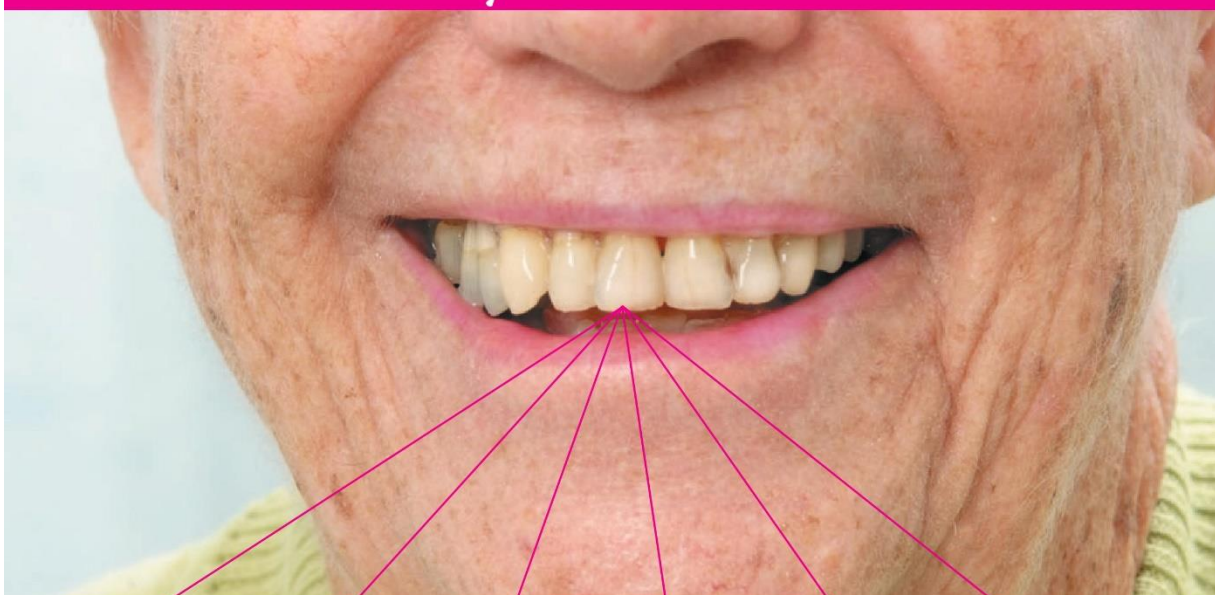


Poster for staff

Time the distribution of the Poster to coincide with the delivery of the Module.

Place it in staff room areas in the Long Term Care home to reinforce participant learning.

Did you know????



Reduce risk of
Diabetes

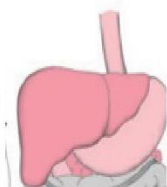
Help prevent
Heart Disease

Avoid
Pneumonia

Reduce risk of
Stroke

Prevent
Tooth Decay

Reduce
Gum Disease
& Bad Breath



A healthy mouth will improve overall health and well-being

Good oral health is essential for overall health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*



Pre-Quiz

The pre-quiz has been designed for participants to use as a self evaluation tool.

The pre-quiz can be downloaded from the accompanying CD. Print off the required number of copies and distribute at the beginning of Module 1.

Encourage the participants to keep their copy so they can compare it with the results of a post-quiz at the completion of the Program.

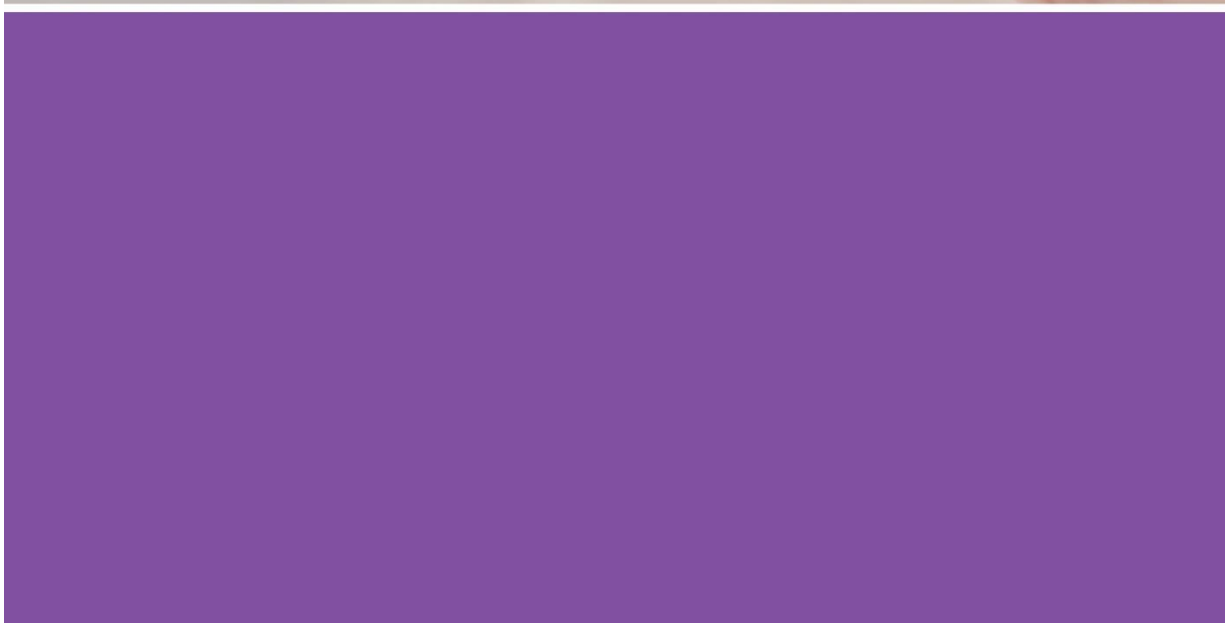


Education and Training Program

Name _____

Date _____

Pre - Quiz	Yes	No	Don't Know
1 When a resident refuses dental care it could mean they are experiencing dental pain			
2 When brushing a resident's teeth it is important to focus on the gum line.			
3 If a resident's gums bleed you should stop brushing.			
4 It is important to rinse a resident's mouth with water after brushing their teeth.			
5 A resident with dementia may start brushing their teeth after holding a toothbrush for a few minutes.			
6 Residents' teeth or dentures, gums and tongues should be brushed morning and night.			
7 It is a good idea to have residents drink water after eating.			
8 When brushing a resident's teeth, apply a strip of toothpaste across the top surface of the brush.			
9 Chest infections may be caused by a build up of plaque in the mouth.			
10 Bad breath should be reported.			
11 Oral integrity is as important as skin integrity in protecting the body against infection.			
12 Dentures should be cleaned with toothpaste.			
13 The choice of denture disinfection product is important for partial dentures.			
14 The presence of stringy saliva in a resident's mouth is normal.			
15 Chlorhexidine products and fluoride toothpaste can be used at the same time.			
16 Drinking a lot of caffeine can affect a resident's oral health.			
17 It is best to try to reduce snacking on sugary foods between meal times.			
18 Toothbrushes should be replaced with the change of season (every three months).			
19 The daily application after lunch of an antibacterial product helps to prevent gum disease.			
20 Dentures should be taken out at night, cleaned and soaked in cold water.			



Module 2

Protect your Residents' Oral Health

Module 2 – Competency Outline

Topic

Six best ways to maintain a healthy mouth.
Protect your residents' oral health.

Purpose

To develop oral hygiene skills required to maintain a healthy mouth and how to use oral hygiene aids and products.

Element of Competency	Performance Criteria
1. Provide standard protective oral care	1.1 Describe the six best ways to maintain a healthy mouth: <ul style="list-style-type: none">• brush morning and night• use fluoride toothpaste• use soft toothbrush• use antibacterial product after lunch• keep the mouth moist• reduce sugar intake.
2. Provide care of natural teeth	2.1 Demonstrate brushing technique for teeth, gums and tongue. 2.2 Demonstrate toothbrush modification. 2.3 Demonstrate toothbrush care. 2.4 Identify common oral conditions to check daily, record and report.
3. Provide care of dentures	3.1 Demonstrate denture removal and reinsertion. 3.2 Demonstrate denture brushing and disinfection. 3.3 Demonstrate brushing of gums and tongue. 3.4 Identify common oral conditions to check daily, record and report.
4. Provide oral care to prevent gum disease	4.1 Demonstrate how to apply antibacterial products.
5. Provide oral care for relief of dry mouth	5.1 Demonstrate how to keep mouth and lips moist. 5.2 Demonstrate how to apply dry mouth products.
6. Provide oral care to reduce tooth decay	6.1 Describe ways in which sugar intake can be reduced.

Module 2 – Session Plan

Module 2 – Protect your Residents' Oral Health - Activities of Daily Oral Hygiene Workshop		
Topic	Resources	Time
Introduction – Brief review Module 1 • quality of life • impact on general health • six best ways to protect a residents' oral health • daily checks – what to look for	Computer Projector Screen (or clear wall) Module 2 Facilitator Notes Module 2 Staff Portfolio Poster 2 (Six best ways to maintain a healthy mouth) Resource Kit (oral hygiene aids and products)	5 min
Workshop		
Care of Natural Teeth • how to modify a toothbrush • how to use backward & forward bent toothbrush • toothpaste application • positioning alternatives • toothbrushing technique • bleeding gums advice • toothbrush care • other aids	Gloves Tissues Soft toothbrushes (enough for participants) Mug and hot water (to modify brushes) Fluoride toothpaste Tongue depressor for purposes of sampling toothpaste Interproximal brush Toothbrush hand grip Tongue scraper Plastic cup – toothbrush storage	15 min
Care of Dentures • denture labelling • daily denture care • how to take full dentures out • how to take partial dentures out • brush gums, tongue and if partial denture remaining teeth • cleaning technique (upper denture, lower denture and partial denture) • putting dentures back in • denture disinfection • removal of calculus and stains • denture adhesives • denture brush and toothbrush care	DVD Gloves Denture models (full and partial) Denture labelling equipment Denture brush Denture container Liquid soap – mild Denture adhesives White vinegar – removal of calculus Chlorhexidine & denture tablets – denture disinfection Plastic cup – denture brush & toothbrush storage	15 min
Accompanying Oral Care Prevention of gum disease • antibacterial product application technique Relief of dry mouth • dry mouth product application technique Reduce tooth decay • sugar substitutes	Tongue depressor for sampling oral care products Oral Chlorhexidine gel-toothpaste and mouth rinse Gloves Glass of water Spray bottle Lip moisturiser – water based Saliva substitutes - gel or liquid Dry mouth gel Mouth spray Xylitol	15 min
Conclusion - summarize • Ask what was new /interesting/different • Reinforce six best ways to protect a residents' oral health		10 min
Total		60 min

Module 2 – Session Plan | 48

Facilitator Notes

Participant Training Numbers

Module 2 is designed to be run as a skills workshop. In other words it is not a lecture but rather an opportunity for participants to interact, practise new skills and ask questions. Small group work at each station is preferred as it promotes greater participation.

You need to know in advance how many participants you will be expecting at the workshop as this will determine how you run the session:

- If numbers are less than 10, you can work through each station sequentially by yourself.
- If numbers are greater than 15, you will need other facilitators to help you (eg. a facilitator for each station). Divide participants into 3 groups and rotate at 15 minute intervals.
- If numbers are more than 20 then the running of a concurrent session is recommended. You will need to adjust for extra facilitators and space or rooms accordingly.

Room Preparation

Room set up needs to be flexible.

Check Resource Kit to ensure you have enough consumable oral hygiene products for participant numbers.

Introduction

The participants will need to be sitting as a group for this.

- explain workshop plan
- provide brief review of module 1. Good oral health is essential for overall healthy:
 - quality of life
 - impact on general health
 - daily checking and reporting of common oral health conditions
 - Six best ways to protect a resident's oral health.

Workshop setup

Organise 3 separate workstations (ie 3 tables set out with oral hygiene resources):

1. Care of natural teeth
2. Care of dentures (including DVD on cleaning dentures)
3. Accompanying oral care.

Noise can be a problem if you have 3 groups interacting at the same time. If possible each station should be set up in different spaces or rooms which are close together.

Conclusion

Bring group together at end of workshop.

Review session:

- ask what was new or interesting or different
- reinforce Six best ways to protect a resident's oral health.

Remind participants to bring their Staff Portfolio to next session. It will be important as participants will need to refer to scenario descriptions in Module 3.

Facilitator Notes

Care of Natural Teeth

Demonstrate

How to modify a soft toothbrush

Provide 2 sample toothbrushes to each participant (one for bending, the other for brushing).

A **forward bent** toothbrush can be used to brush the inner upper and lower teeth.

A **backward bent** toothbrush can be used to retract the cheek, while a second brush is used to brush the resident's teeth.

Show and ask participants to practise bending a soft toothbrush handle:

- **note: some toothbrushes are soft enough to bend using your hands, others need to be placed in hot water**
- clear plastic toothbrushes are the easiest to bend.
- place the brush in a cup of hot water to soften the plastic
- apply downward pressure on the brush until it bends to a 45 degree angle
- take care as some brands of toothbrush may snap

Toothbrushing technique

- Put on gloves
- Pea-size application of fluoride toothpaste
 - offer taste test using tongue depressor as a spatula, or participant can apply own sample on toothbrush
- Show both cuddle and standing in front positioning
- Demonstrate holding of chin and curling down lower lip often referred to as 'pistol grip' ask participants to practise with holding their own chin.
- Demonstrate toothbrush technique incorporating how to use a forward and backward bent toothbrush
- Stress importance of brushing at gum line
- Demonstrate tongue cleaning
- Spit not rinse.

Toothbrush care (talk this through)

- Rinse toothbrush under running water
- Tap toothbrush on sink
- Store uncovered in a dry place
- Replace when bristles become worn or after communicable disease.

Identify common oral conditions to check daily, record and report

- Ask participants what they should check for.

Show and talk through the following:

- Interproximal brush
- Handgrip
- Tongue cleaner.

Facilitator Notes

Care of Dentures

Show DVD

Denture Cleaning section (5min) on DVD.

Note: DVD shows insertion of lower denture first and Module 2 recommends insertion of upper denture first. Both ways are acceptable, however insertion of the upper denture first can be an easier option as it is the larger denture.

Demonstrate

Denture labelling

- All dentures should be labelled with the resident's name.

Daily cleaning of dentures

- Place cloth or bowl in sink
- Correct way to hold dentures and partial dentures
- Denture brush used to brush all surfaces, morning and night
- If the denture has been relined with a soft cushion liner, use a soft toothbrush to clean it gently
- Use soft toothbrush to clean partial dentures
- Use mild liquid soap – toothpaste can be abrasive and damage denture
- Rinse well and soak in cold water overnight
- Removal of dentures at night
- Clean gums and tongue also remaining teeth (if partial denture) with soft toothbrush.

Weekly denture disinfection

- Chlorhexidine is suitable to use for both full and partial dentures (with metal components)
- Note: some cleaning agents will corrode metal parts – product must clearly identify that it is non corrosive if using on partial dentures
- Weekly disinfection of dentures and partial dentures is recommended to reduce risk of fungal infections (eg thrush). Only a short time is needed rather than soaking overnight which may stain the denture. For example, disinfect dentures while resident is showering.

Denture disinfection – treatment of fungal infection

- If a resident is being treated for a fungal infection, dentures should be disinfected more frequently on a daily basis using chlorhexidine until the infection is resolved
- Denture brush and soft toothbrush should be replaced before and after treatment.

Removal of calculus

- Soak acrylic dentures in full strength vinegar for 8 hours (overnight)
- Brush dentures to remove the softened calculus
- You may need to try this more than once if there is heavy staining or calculus deposits
- Not suitable for partial dentures, vinegar will cause corrosion of metal wires – professional cleaning recommended.

Denture brush and soft toothbrush care

- Rinse toothbrush under running water
- Tap toothbrush on sink
- Store uncovered in a dry place
- Replace when bristles become worn, after communicable illness or at least every 3 months.

Denture adhesives

- Used only if required for poorly fitting dentures
- Remind to only apply small amounts of paste or powder
- Adhesive must be cleaned off each time dentures are brushed.

Identify common oral conditions to check daily, record and report.

- Ask participants what they should check for.

Facilitator Notes

Accompanying Oral Care

Give each participant a tongue depressor to be used for the purpose of sampling different oral care products. As each product is discussed, place a small amount of product on the tongue depressor so participants can use their finger to taste.

Commence by providing an overview of accompanying oral care products then describe application techniques.

Demonstrate

Prevention of gum disease (gingivitis)

Antibacterial (alcohol free) products for chemical control of dental plaque

Protective daily use:

- Low strength chlorhexidine gel-toothpaste (alcohol free and non-teeth staining)
- Apply daily after lunch
- Explain rationale for doing this after lunch
 - chlorhexidine and toothpaste cannot be used with in 2 hours of each other

Treatment of gum disease:

- Higher strength chlorhexidine used

Relief of dry mouth

Keep mouth moist

- Emphasise the importance of frequently sipping water
- Lubricate lips with water based moisturiser
- Saliva substitutes – provide taste sample of product
- Saliva stimulants

Reduce tooth decay

- Emphasise the importance of drinking water to cleanse the mouth after eating
- Show Xylitol (sugar free) products

Application techniques

- Apply pea-size amount of product onto resident's finger and ask the resident to rub the product over their teeth and gums. Never place your fingers between the teeth of a resident.
- Apply pea-size amount of product and wipe with soft toothbrush (rather than brush) over teeth and gums concentrating on gum line.
- In severe cases of gum disease (gingivitis) product can be applied to an interproximal brush and used to brush between the teeth.
- Mouth rinse can be decanted into a spray bottle (this may require a pharmacist and must be labelled). Spray 3 to 4 squirts of product into resident's mouth. This is particularly useful for residents with changed behaviours or residents who are unable to rinse mouth.

Resource Kit Components

Care of Natural Teeth

- Gloves
- Fluoride toothpaste (presence of Canadian Dental Association symbol denotes fluoride in toothpaste)



- Soft toothbrushes – sufficient quantity for each participant to practise modifying a toothbrush and to also practise toothbrushing

- Clear plastic toothbrushes are the easiest to bend
- Tongue depressors for purposes of sampling toothpaste etc.
- Cups of hot water – sufficient quantity for staff to practise modifying a toothbrush
- Interproximal brush
- Hand grip
- Tongue cleaner

Care of Dentures

- DVD
 - Laptop computer
 - Data projector
 - Screen or clear wall
- Denture labelling equipment
- Sample dentures
 - Full upper denture
 - Partial denture (mental components)
- Denture container (denture bath)
- Denture brush

- Soft toothbrush
- Liquid soap
- Chlorhexidine and denture tablet (non-corrosive variety)
- White vinegar
- Denture adhesives
 - Paste
 - Powder
 - Strips

Accompanying Oral Care

Tongue depressors for purpose of product sampling

Prevention of gum disease

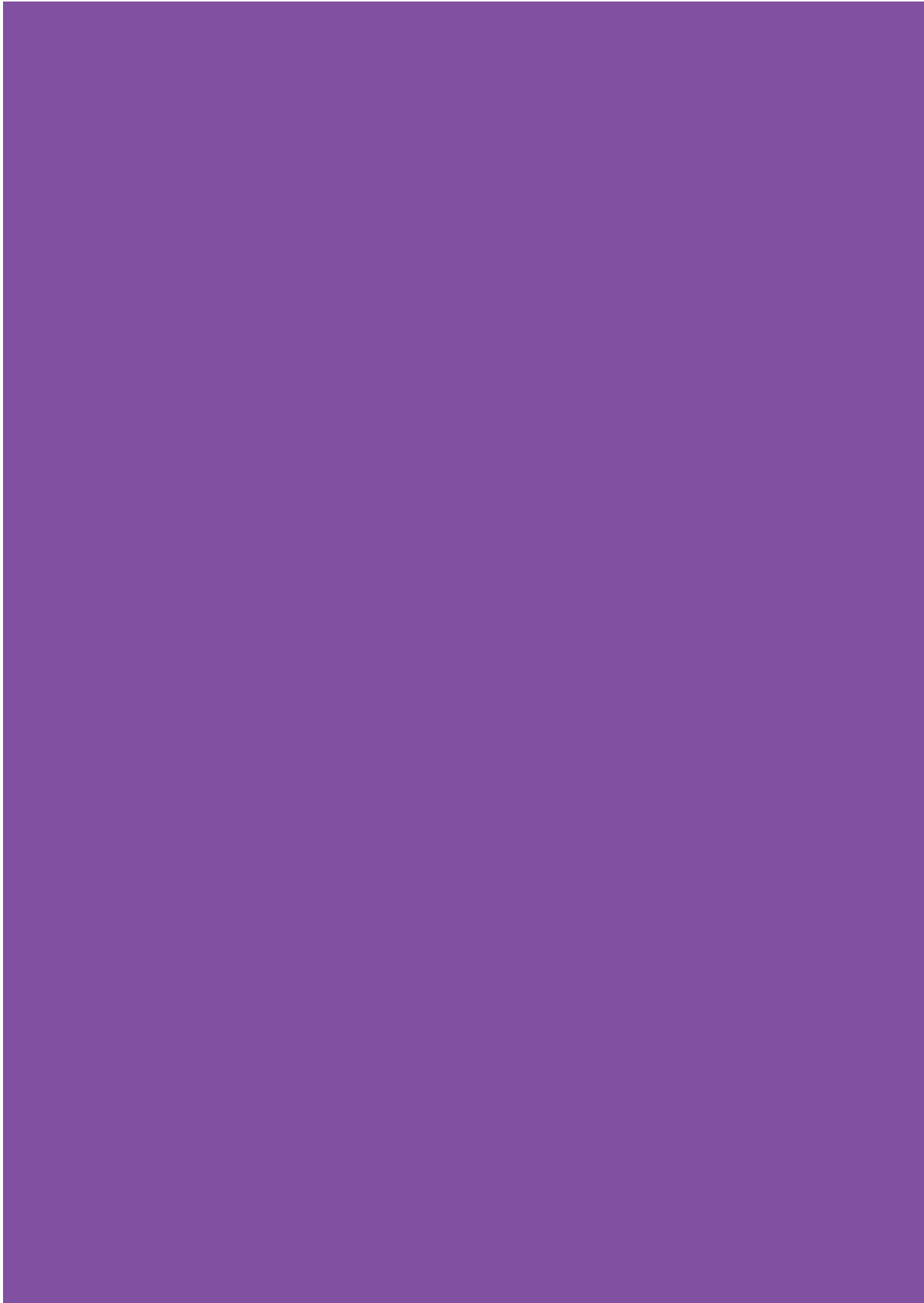
- Gentle daily brushing and flossing
- Antiseptic mouthwash
- Spray Bottle containing chlorhexidine (opaque as non staining element is light sensitive)

Relief of dry mouth

- Glass of water
- Lip moisturisers (water based)
- Dry mouth spray
- Dry mouth moisturiser
- Dry Mouth Gel
- Xylitol products

Reduce tooth decay

- Xylitol
 - Small container of Xylitol



Staff Portfolio Resource

Module 2



Module 2

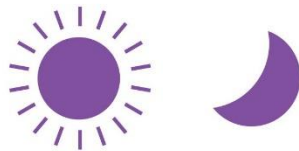
Protect your Residents' Oral Health

56 | Staff Portfolio Resource | Module 2 | 56

Six of the Best Ways to Maintain a Healthy Mouth

Protect your Residents' Oral Health

Brush Morning and Night



Fluoride Toothpaste on Teeth



Soft Toothbrush on Gums, Tongue and Teeth



Antibacterial Product After Lunch



Keep the Mouth Moist



Cut Down on Sugar





Care of Natural Teeth

Teeth are mainly made up of minerals including calcium. Bacteria in dental plaque convert sugars into acid, which can dissolve the minerals out of teeth. If the teeth are not cleaned, this can lead to decay (caries) in the teeth and lead to tooth infections and pain. Good oral hygiene is extremely important to help avoid tooth decay. Fluoride toothpaste helps strengthen teeth as well as reverse the effects of the acid produced by the bacteria in dental plaque.

Rationale	Recommended Oral Health Care
<p>Strengthen Teeth</p> <p>Fluoride toothpaste strengthens teeth.</p> <p>Encourage the resident to spit and not rinse the mouth after brushing so the fluoride can soak into the teeth.</p>	<p>Use fluoride toothpaste morning and night. (presence of Canadian Dental Association symbol denotes fluoride in toothpaste)</p>  <p>Use a soft toothbrush to brush teeth, gums and tongue morning and night.</p> <p>Encourage the resident to spit and not to rinse the mouth after brushing, so the fluoride can soak into the teeth.</p> <p>Encourage the resident to drink water after meals, medications, other drinks and snacks to keep the mouth clean.</p>
<p>Brushing</p> <p>Brushing is the best way to remove dental plaque.</p> <p>A soft toothbrush is gentle on oral tissues and is more comfortable for the resident.</p> <p>Brushing before bed is important as bacteria can grow in number by as much as 30 times overnight.</p>	

Oral Hygiene Aids & Products



Use a fluoride toothpaste (presence of Canadian Dental Association symbol denotes fluoride in toothpaste)



Use a soft toothbrush suitable for bending

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Mask
- Protective eyewear/face shields
- Protective clothing

Toothbrush Alternatives



Modified Soft Toothbrush

A soft toothbrush can be bent to give better access to the mouth.

A forward bent toothbrush can be used to brush the inner upper and lower teeth.

A backward bent toothbrush can be used to retract the cheek, while another brush is used to brush the resident's teeth.



Electric Toothbrush

An electric toothbrush may help residents with limited manual dexterity, due to stroke or arthritis for example, to manage brushing by themselves.

Vibration can be a problem for some residents.

Cost and maintenance can be a barrier.

This type of brush is recommended if the resident is currently using one.



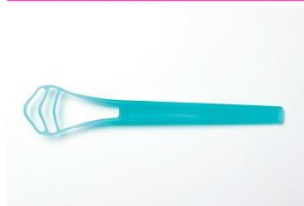
Interproximal Brush

This type of brush is ideal for cleaning the larger spaces between teeth, underneath bridges, around crowns and between tooth roots where gum recession has occurred.

The brush can also be used to apply antibacterial gels between the teeth.

Interproximal brushing does not replace normal toothbrushing. The brushing of teeth, gums and tongue must still take place with a soft toothbrush.

Additional Oral Hygiene Aids



Tongue Scraper

This can be used as an alternative when a toothbrush is not able to clean the surface of the tongue sufficiently; for example, when thrush is present.



Hand Grip

This is useful for residents with reduced grip strength.

Toothpaste Application



Use fluoride toothpaste morning and night.

Only a small pea-sized amount of toothpaste is required.

Positioning



When the resident requires assistance, try different positions to suit the situation.

Standing in front position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrushing Technique Lower Teeth



Toothbrushing Technique Upper Teeth



Toothbrushing

Place the toothbrush at a 45 degree angle to the gum line.

Gently brush front, back and chewing surfaces of the teeth and gums in a circular motion. Give particular attention to the gum line.

If some teeth are missing, make sure all surfaces of single teeth are cleaned.

Encourage the resident to spit and not rinse the mouth after brushing, so the fluoride soaks into the teeth.

Bleeding Gums

Report this as it may be a sign of a general health problem.

Bleeding gums is usually caused by the build up of dental plaque.

Brushing is the best way to remove the dental plaque and heal the gums.

Continue to brush teeth (with particular attention to the gum line) with a soft toothbrush twice a day. The bleeding should resolve in a week.

Tongue Cleaning



Ask the resident to stick out the tongue.
Scrape the tongue (using tongue scraper or toothbrush) carefully from back to front.
Do not go too far back as it will cause the resident to gag.

Alternative Toothbrushing Techniques



Electric Toothbrush

Turn the brush on and off while it is in the mouth, to limit toothpaste splatter.
Use the vibrating brush to reach all surfaces of the teeth and gums.



Interproximal Brush

Brush into the space between the teeth at the level of the gum and gently move back and forth to remove dental plaque and food.
An interproximal brush can also be used to apply antibacterial product between the teeth.

Toothbrush Care



After Brushing

Thoroughly rinse the toothbrush under running water.
Tap the toothbrush on the sink to remove excess water.
Store the toothbrush uncovered in a dry place.
Replace the toothbrush with a new one when:

- bristles become worn
- with the change of seasons (every three months)
- following a resident's illness such as a 'bad cold'.

When a resident is being treated for a fungal infection (such as thrush), replace the toothbrush when the treatment starts and again when the treatment finishes.
If a toothbrush grip is used, remove the grip and wash and dry the toothbrush handle and grip after each use.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document and Report

- Lip blisters/sores/cracks
- Tongue for any coating/change in colour
- Sore mouth/gums/teeth
- Swelling of face or localised swelling
- Mouth ulcer
- Bleeding gums
- Sore teeth
- Broken or loose teeth
- Difficulty eating meals
- Excessive food left in mouth
- Bad breath
- Refusal of oral care



Care of Dentures

Many problems can occur in residents with dentures. If dentures are not removed, allowing for the tissues to rest, infections such as thrush, or denture sore mouth can develop. Poorly fitting dentures can also lead to soreness or cracking at the corners of the mouth. Over time, dentures can wear out and the shape of the gums and jaws can change. Because of this, dentures may need to be relined or re-made to cater for these changes. Reduced saliva flow can also affect the ability to wear dentures comfortably.

Daily Oral Hygiene	Oral Health Care Practice
<p>Residents who wear dentures are at high risk of developing fungal infections (such as thrush).</p> <p>Dentures must be taken out and brushed to remove dental plaque.</p> <p>Gums and tongue should be brushed to remove dental plaque.</p> <p>Gum tissue needs time to rest from wearing dentures.</p>	<p>Label dentures with the resident's name.</p> <p>Brush dentures with a denture brush morning and night, using a mild soap.</p> <p>Rinse dentures well under running water.</p> <p>Brush gums and tongue with a soft toothbrush morning and night.</p> <p>Take dentures out of the mouth overnight, clean and soak in cold water.</p> <p>Disinfect dentures once a week.</p> <p>Encourage the resident to drink water after meals, medications, other drinks and snacks to keep the mouth clean.</p>

Oral Hygiene Aids & Products



Use a soft toothbrush suitable for bending to brush gums, tongue and partial dentures.

Use a denture brush for full dentures.

Use mild soap (liquid or foam) for cleaning dentures – handwashing soap as supplied by the Long Term Care home should be suitable.

Provide a denture storage container (disposable or non-disposable).

Use a denture disinfection product (suitable for full or partial denture or both).

Soak dentures in white vinegar for calculus removal (not suitable for partial dentures).

Use a denture adhesive (if required).

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Protective eyewear/face shields
- Protective clothing
- Mask

Denture Care



Label Dentures

Dentures must be labelled with the resident's name.

Dentures are best named permanently by a dental professional.

To name dentures after manufacture:

- lightly sandpaper the pink acrylic on the outside (cheek side) of the denture
- write the resident's name in permanent marker
- using several coats of sealing liquid or clear nail polish to cover the name.

The denture storage container should also be labelled with the resident's name.

Daily Denture Care

Either remove dentures after each meal and rinse mouth and denture with water or encourage the resident to drink water after meals to help keep the mouth clean.

Brush dentures morning and night.

Encourage the resident to remove dentures overnight to rest the gums.

Soak cleaned dentures in a denture container of cold water.

Do not let dentures dry out completely.

Denture storage containers should be washed and dried daily.

Removing Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own dentures.

If the resident requires assistance, it is easier to take out the lower denture first by holding the lower front teeth with the thumb and index finger and lifting out.

To remove upper denture, break the seal by holding front teeth with the thumb and index finger and rocking the

denture up and down until the back is dislodged.

Remove the denture at a sideways angle.

If you are unable to break the seal, use a backward bent toothbrush to carefully push down on the side of the denture towards the back of the mouth until the denture is loosened and can be easily removed.

Removing Partial Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own partial denture.

If the resident requires assistance, place your finger tips

under the clasps that cling onto the natural teeth and push down carefully.

Gently grasp the plastic part of the denture and lift it out of the resident's mouth, taking care not to bend the wire clasps.

Brush Gums, Tongue and Teeth (Partial Denture)



Use a soft toothbrush to brush the gums morning and night. This will remove dental plaque, any food particles and stimulate the gums.

Ask the resident to stick out the tongue and brush the tongue carefully from the back to the front.

Do not go too far back as it will cause the resident to gag.

For residents who wear a partial denture, give particular attention to the teeth that support the denture clasps. Make sure all surfaces of single teeth are cleaned (back, front and sides) with fluoride toothpaste.

Residents Who Have No Teeth and Do Not Wear Dentures

For residents who have no teeth and do not wear dentures, it is still important to brush the gums and tongue morning and night to maintain good oral health.

Use a soft toothbrush to brush the gums morning and night. This will remove dental plaque, any food particles and stimulate the gums.

Ask the resident to stick out the tongue and brush the tongue carefully from the back to the front.

Do not go too far back as it will cause the resident to gag.

Cleaning Dentures



Cleaning Technique

Clean the denture over a sink with a bowl filled with water or place a wash cloth in the base of the sink to protect the denture from breakage if dropped.

Use a denture brush and a mild soap (liquid or foam) to clean food, dental plaque and any denture adhesive from all surfaces of the denture. The handwashing soap as supplied by the Long Term Care home should be suitable for denture cleaning purposes.

Do not use normal toothpaste as it may be abrasive and over time will abrade and scratch the denture. A scratched denture can be a source of irritation and increase the risk of fungal infections.

Support the denture while cleaning as it can break very easily if dropped.

Holding a lower denture from end to end may apply force and cause the denture to break.

Cleaning Lower Denture



Cradle the lower denture between the thumb and the base of the index finger for a stable hold.

Brush all surfaces to remove dental plaque and any denture adhesive.

If the denture has been relined with a soft cushion liner, use a soft toothbrush to clean it gently.

When the denture is relined, it cannot be soaked or disinfected.

Cleaning Upper Denture



Support the upper denture between the thumb and fingers for a stable hold.

Brush all surfaces to remove dental plaque and any denture adhesive.

If the denture has been relined with a soft cushion liner, use a soft toothbrush to clean it gently.

When the denture is relined, it cannot be soaked or disinfected.

Cleaning Partial Denture



Use a soft toothbrush to clean metal clasps.

Gently brush around the metal clasps, taking care not to bend or move them as this will affect the denture fit.

Denture Adhesives



Residents with poorly fitting dentures, should be referred.
Denture adhesives can be used to hold dentures more firmly in place and prevent dentures from rubbing.
Denture adhesives come as a paste, powder or sticky strips.

Follow the product instructions for directions on how to apply the denture adhesive.
Thoroughly remove all traces of the denture adhesive from both the denture and gums morning and night.

Putting Upper Denture In



Putting Lower Denture In



Dentures must always be rinsed well under running water before being placed in the resident's mouth.
Encourage the resident to insert his or her own dentures.

If the resident requires assistance, insert the upper denture first followed by the lower denture.
Ask the resident to open his or her mouth. Hold the denture at a sideways angle as it enters the mouth and then rotate into position.

Putting Partial Denture In



Partial dentures must always be rinsed well under running water before placing them in the resident's mouth.

Encourage the resident to insert his or her own dentures.

Ask the resident to open the mouth, hold the denture at a sideways angle as it enters the mouth and then rotate and click into position.

Denture Disinfection



Disinfect dentures once a week and as directed if the resident is being treated for a fungal infection (such as thrush).

Always rinse dentures well under running water before placing in the resident's mouth.

Take care with the choice of denture disinfection products as some may cause the metal components of a partial denture to corrode. The following may be used.

Chlorhexidine solution with or without alcohol:

- This is suitable for both full plastic and partial dentures.
- Alcohol content is acceptable for this purpose as it is not in direct contact with the mouth.
- Chlorhexidine has a low allergy risk.
- Disinfect by using enough solution to cover the denture, soak for no more than 30 minutes, then rinse well.
- Follow the Long Term Care home's infection control guidelines for decanting the solution.

Commercial denture cleansing tablet:

- The product used should clearly identify whether it is suitable for either full plastic or metal partial dentures or both.
- Follow the manufacturer's instruction for soaking time.

Caution

Excessive soaking in chlorhexidine may cause discolouration.

Allergy Alert

Persulphate (persulfate), a denture cleanser ingredient, may cause an allergic reaction. This may happen quickly or after many years, even with correct use.

Symptoms include irritation, tissue damage, gum tenderness, breathing problems and low blood pressure. If symptoms occur remove dentures and refer to an oral health professional.

Removing Calculus and Stains



Calculus (tartar) is dental plaque that has been hardened by the minerals in saliva.

Thorough daily brushing should stop calculus from forming on the denture.

To remove calculus from a full acrylic denture, soak denture in full strength white vinegar for 8 hours to soften calculus and then scrub off using a denture brush.

Caution

Vinegar has corrosive properties and is not suitable for partial dentures.

For heavy calculus, staining and for stain removal on partial dentures, cleaning by a oral health professional is recommended.

Denture Brush and Toothbrush Care



After Brushing

Thoroughly rinse the toothbrush and denture brush under running water.

Tap the brushes on the sink to remove excess water.

Store the brushes uncovered in a dry place.

Replace the brushes when:

- bristles become worn
- with the change of seasons (every three months)
- following a resident's illness such as a bad cold.

When a resident is being treated for a fungal infection (such as thrush), replace the toothbrush and denture brush when the treatment starts and again when the treatment finishes.

If a toothbrush grip is used, remove the grip and wash and dry the toothbrush handle and grip after each use.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document & Report

- | | |
|--|---|
| <ul style="list-style-type: none"> • Lip blisters/sores/cracks • Tongue for any coating/change in colour • Sore mouth/gums/teeth • Swelling of face or localised swelling • Mouth ulcer • Bleeding gums • If partial denture, sore or broken teeth • Broken denture or partial denture • Lost denture | <ul style="list-style-type: none"> • Denture not named • Poorly fitting denture • Stained denture • Difficulty eating meals • Excessive food left in mouth • Bad breath • Refusal of oral care |
|--|---|



Prevention of Gum Disease (Gingivitis)

Dental plaque is the major contributor to the two main dental diseases, tooth decay and gum disease. It forms continuously on the teeth and, if left on the teeth over a period of time, it can harden to become calculus (tartar).

Severe gum disease (periodontitis) results in the break down of the gums and bone that support the teeth. This condition affects general health and wellbeing.

Daily Oral Hygiene	Oral Health Care Practice
<p>Antibacterial Control of Dental Plaque</p> <p>Daily application of an antibacterial product can reduce harmful bacteria in the dental plaque and help to prevent gum disease. Chlorhexidine is a safe and effective antibacterial product.</p> <p>Use an alcohol free product because alcohol can dry out the mouth and damage oral tissue.</p>	<p>Use a low-strength (0.12%) chlorhexidine product (alcohol free and non-teeth staining) applied daily after lunch for all residents.</p> <p>Note</p> <p>Higher-strength chlorhexidine products are used as a treatment for severe gum disease and are prescribed by the family physician or dentist.</p>

Oral Hygiene Aids & Products



Use a soft toothbrush suitable for bending.

Use a low-strength (0.12%) chlorhexidine product (alcohol free and non-teeth staining).

Use an interproximal brush (as directed).

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Mask
- Protective eyewear/face shields
- Protective clothing

Application Techniques for Chlorhexidine Product



Resident Self Application

Before you start, ask the resident to have a drink of water or rinse the mouth with water before applying the chlorhexidine gel.

If the resident is able, put a small pea-size amount of gel on the finger and ask him or her to rub it over the teeth and gums.

If the resident has dentures, remove and rinse the dentures, apply a small pea-size amount of gel to the gums, and replace dentures.

Alternatively, the gel can be applied to the fitting side of the denture.

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Application Techniques for Chlorhexidine Product (Continued)



Use a Toothbrush to Wipe over Teeth

If the resident requires full assistance, apply a small pea-size amount of gel to a toothbrush and wipe over the teeth and gums.

In severe cases of gum disease, an interproximal brush can be used to apply the gel into the space between the teeth at the level of the gum.

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Never place your fingers between the teeth of a resident.

Application Techniques for Chlorhexidine Product (Continued)



Use of a Spray Bottle

If it is difficult to apply the chlorhexidine gel, an alternative is to spray a chlorhexidine mouthwash into the mouth.

The mouthwash should be placed undiluted into a spray bottle.

You must follow the Long Term Care home's infection control guidelines for decanting the mouthwash or a pharmacist may do this for you.

The spray bottle must be labelled with the resident's name and the contents.

Spray four squirts directly into the mouth. Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Positioning



When the resident requires assistance, try different approaches or different positions to suit the situation.

Standing in Front Position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrush Care after Application of Chlorhexidine Product



After use, thoroughly rinse the toothbrush under running water.

Tap the toothbrush on the sink to remove excess water.

Store the toothbrush uncovered in a dry place.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document and Report

If a chlorhexidine product has not been applied according to the oral health care plan, document this and report.



Relief of Dry Mouth (Xerostomia)

Reduced saliva flow is known as dry mouth or xerostomia and is common in residents of Long Term Care homes. Relief from dry mouth also reduces tooth decay, gum disease and other oral diseases.

Daily Oral Hygiene

Relief of Dry Mouth

Saliva is the key to maintaining a healthy mouth.

Medications taken by residents contribute to dry mouth.

When the quantity and quality of saliva is reduced, oral diseases can develop very quickly.

Dry mouth increases the incidence of mouth ulcers and oral infection.

Dry mouth can be very uncomfortable for the resident.

Oral Health Care Practice

Keep the mouth moist by frequent rinsing and sipping with water (and increase water intake if appropriate).

Keep the lips moist by frequently applying a water-based lip moisturiser.

Discourage the resident from sipping fruit juices, cordial or sugary drinks.

Reduce the intake of caffeine drinks.

Stimulate saliva production with Xylitol based products as required.

Encourage the resident to drink water after meals, medications, other drinks and snacks, to keep the mouth clean.

Oral Hygiene Aids & Products



A dry mouth product best suited to the resident can be recommended by the dentist.

There are a variety of products available; for example:

- Dry Mouth gel
- mouth spray.

Apply water-based lip moisturiser; for example, water based products or Gel.

A variety of Xylitol based products are available.

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Protective eyewear/face shields
- Protective clothing
- Mask

Keep Mouth Moist



Encourage the resident to frequently sip cold water especially after meals, medications, other drinks and snacks.

Reduce intake of caffeine drinks such as coffee, tea.

Apply saliva substitutes according to the oral health care plan to teeth, gums, inside of cheeks, roof of mouth and the fitting surface of dentures.

Saliva substitutes are especially useful before bed, upon awakening and before eating.

If appropriate, Xylitol based products may be used to stimulate saliva.

Keep Lips Moist



Apply a water-based lip moisturiser before and after mouth care and as required.

If the resident is able, put a small pea-size amount of lip moisturiser on the finger and ask him or her to rub it over the lips.

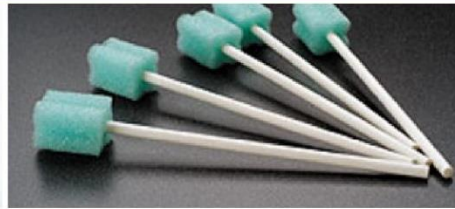
If the resident requires full assistance, apply a small pea-size amount of lip moisturiser to your gloved finger or use a swab and rub it over the lips.

Caution

Petroleum-based lip moisturisers may increase the risk of inflammation and aspiration pneumonia and are contraindicated during oxygen therapy.

Never place your fingers between the teeth of a resident.

Protect Oral Tissue



Take care when choosing oral care products as some ingredients, in particular alcohol, can dry out the mouth and damage oral tissue.

Pineapple, lemon and other citric juices may over-stimulate and exhaust the salivary glands causing the dry mouth condition to worsen.

Dry mouth products are recommended and are particularly soothing for residents receiving palliative care.

Caution

Do not use mouthwashes and swabs containing the following as they may damage oral tissues and may increase the risk of infection:

- alcohol
- hydrogen peroxide
- sodium bicarbonate (high-strength)
- lemon and glycerine.

Application Techniques for Saliva Substitutes



Resident Self Application

Before you start, ask the resident to have a drink of water or rinse the mouth with water before applying the dry mouth gel.

If the resident is able, put a small pea-size amount of gel on the finger and ask him or her to rub it over the teeth and gums.

If the resident has dentures, remove and rinse the dentures, apply a small pea-size amount of gel to the gums, and replace dentures.

Alternatively, the gel can be applied to the fitting side of the denture.

Use a Toothbrush to Wipe over Teeth

If the resident requires full assistance, apply a small pea-size amount of dry mouth gel to a toothbrush and wipe over the teeth and gums.

Use a Spray Bottle

If it is difficult to apply a gel, an alternative is to use a dry mouth spray.

Follow the manufacturer's instructions.

Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Never place your fingers between the teeth of a resident.

Positioning



When the resident requires assistance, try different approaches or different positions to suit the situation.

Standing in Front Position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrush Care after Application of Saliva Substitutes



After use, thoroughly rinse the toothbrush under running water.

Tap the toothbrush on the sink to remove excess water.

Store the toothbrush uncovered in a dry place.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document and Report

If saliva substitutes have not been given as per the oral health care plan, document this and report.



Reduce Tooth Decay

Tooth decay is directly related to the frequency of eating and drinking food and drinks containing sugar.

Many foods contain sugar including bread and cereals. Foods and drinks containing sugar should be limited to meal times.

Consider sugar substitutes between meals.

Daily Oral Hygiene	Oral Health Care Practice
<p>Reduction of Sugar in Diet</p> <p>Sugars that are harmful to teeth include ordinary sugar (sucrose) which is added to many manufactured foods and fruit juice, and honey.</p> <p>Tooth decay is directly related to the frequency of sugar intake rather than the total amount of sugar eaten.</p> <p>Encourage the use of natural chemical free sweeteners such as xylitol, made from fruit and vegetables.</p>	<p>Encourage the resident to drink water to rinse the mouth after meals, medications, other drinks and snacks.</p> <p>Provide xylitol sugar substitute products. Eating too many sugar substitute products may have a laxative effect or cause flatulence.</p> <p>Encourage healthy snacks and beverages between meals.</p>

Rinse Mouth



Water reduces the acid that causes tooth decay.
Encourage the resident to drink water to rinse the mouth after meals, medications, other drinks and snacks.
A small drink of water before bed is also encouraged.

Sugar Substitute



Use xylitol instead of sugar for sweetening tea and coffee between meals.

Normal sugar may be used for drinks and cooking at meal times.

Xylitol does not leave an after-taste like other substitute sweeteners.

Xylitol also acts like other dietary fibre and improves the health of the digestive tract. However, if it is used in excessive amounts it may cause similar discomfort as other high fibre foods, such as diarrhea.

Sugar Substitute (Continued)



Foods labelled 'no added sugar' or 'sugar free' do not necessarily mean they are tooth friendly.



Encourage residents' families to bring tooth friendly treats.
Xylitol products are safe for all consumers including children.

Caution
Foods containing xylitol may be harmful to pets.



Oral Health Care Kit

An Oral Health Care Kit should be placed in every residents washroom.

Some of the oral health care tools may include tooth brush, toothpaste, interdental brush, mouth wash. These tools should be labelled and be placed in a metal or plastic kit.

The content of the kit will vary , depending on the type of dentition.

Natural Teeth	Natural Teeth and Denture	Complete Denture
<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash 	<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash • Non-foaming toothpaste • long handled toothbrush • Denture kits 	<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash • Non-foaming toothpaste • long handled toothbrush • Denture kits

Poster for staff

Time the distribution of the Poster to coincide with the delivery of the Module.

Place it in staff room areas in the Long Term Care home to reinforce participant learning.



Brush morning
and night



Fluoride
toothpaste
on teeth



Soft toothbrush
on gums, tongue
& teeth



Antibacterial
product after
lunch



Keep the
mouth moist



Cut down
on sugar

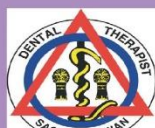
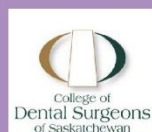


Six of the best ways to maintain a healthy mouth

Protect your residents' oral health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*





Module 3

It Takes a Team Approach to Maintain a Healthy Mouth

Module 3 – Competency Outline

Topic

It takes a team approach to maintain a healthy mouth.
Better oral health reflective practice.

Purpose

Application of reflective practice to situations experienced in everyday practice
and to promote Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*.

Element of Competency	Performance Criteria
1. Apply reflective practice in oral health in Long Term Care home.	1.1 Demonstrate the ability to apply decision making skills in oral health care. 1.2 Demonstrate the ability to apply oral hygiene knowledge and techniques to various situations.
2. Implement team approach to Better Oral Health in LTC - <i>Best Practice Standards for Saskatchewan</i>	2.1 Describe the 4 key processes 2.2 Identify Oral Health Care Teams roles in providing daily oral hygiene.

Module 3 – Session Plan

Module 3		
It Takes a Team Approach to Maintain a Healthy Mouth: Better Oral Health Reflective Practice		
Topic	Resources	Time
Introduction Brings together Module 1 & Module 2 Explain purpose of guided questions and rules for small group work	Module 3 – Facilitator Notes Module 3 Staff Portfolio Poster 3 (It takes a team approach to maintain a healthy mouth) Optional – PowerPoint slides of scenario – Computer and projector	5 min
Oral Health Scenario Part 1 New resident Part 2 Responsive Behaviour Part 3 Daily Checking & Reporting Part 4 Follow up OHA and treatment	Flip chart paper Pens Blu Tack to hang flip chart paper	10 min 10 min 10 min 10 min
Conclusion - summarize It takes a team approach to maintain a healthy mouth. Reinforce Better Oral Health in LTC - <i>Best Practice Standards for Saskatchewan</i> 4 key processes		5 min
Post education & training quiz • Post-quiz to be completed	Post education & training quiz and answer sheet Print from CD	10 min
Total		60 min

Facilitator Notes

Module 3 Overview

Module 3 brings together the content from Module 1 (knowledge) and Module 2 (skills).

It uses clinically based situations and guided questions to encourage reflection and application to everyday practice using guided learning.

Guided learning is an approach to small group work which aims to help participants address situations they meet in their everyday practice and to enhance evidence based practice for better oral health in Long Term Care home.

Participant Training Numbers

You need to know in advance how many participants you will be expecting as this will determine how you run the session:

- If numbers are more than 10 it is recommended they be divided into 2 or 3 smaller groups
- A facilitator will be required to lead each group

Room Preparation

Group work setup

• One Group

- Arrange a circle of chairs facing where butcher paper is displayed

• More than one group

- A facilitator will be required for each group
- For each group arrange a circle of chairs facing where the flip chart paper is to be displayed
- Noise can be a problem with several groups interacting at the same time. If possible each group should be set up in a different room

Note: Individual groups are to come together as one large group:

- Introduction section
- Conclusion section and to complete the post-quiz
- Remember to organise enough seating in one room to accommodate all participants for these sections of the presentation

Optional

A PowerPoint presentation of the scenario photos is available on the accompanying CD. You may like to have this set up just in case participants fail to bring the Staff Portfolio with them to refer to.

Facilitator Notes

Introduction

5 min

Explain the following

- Module 3 “Reflective oral health practice” brings together the content from Module 1 (knowledge) and Module 2 (skills).
- Reflecting on situations that occur everyday in Long Term Care home provides you with the opportunity to identify your knowledge, skills and attitudes and apply them to clinical practice.
- Today’s session will focus on aspects of oral care by presenting a scenario to think about and discuss.
- A series of guided questions will be used to assist you to think about the situation, identify facts presented and to recognise the knowledge and skills you already have.
- You will then be asked to suggest ideas you have about what’s going on and why and identify actions you would choose to respond to the situation.
- This involves working in a small group.
- When working as a group it is important to be respectful to beliefs and opinions of others.
- Following the scenario we summarize what is Better Oral Health in LTC – *Best Practice Standards in Saskatchewan* and finish off by completing another quiz for you to check how much you have learnt.

Note: At this stage you should break out into smaller groups if participant numbers are more than 10.

Oral Health Scenario

Instructions

- As the facilitator, guide the discussions using the staged scenario description and questions.
- Read out aloud the scenario description (read slowly and clearly, use an interesting tone in your voice).
- Give the group about 2 minutes to think about the scenario description.
- Concentrate on one question at a time.
- Read out aloud the question and ask participants to respond.
- Your role is not to give right answers but to encourage discussion.
- Encourage discussion by using open questions e.g. Why do you think so? What makes you think that? What do you know about?
- Ask participants to identify knowledge and skills they have related to the scenario.
- Record responses on paper (you can do this or ask someone to record).
- Once participants have explored the situation ensure that the key message for each question has been reached, if it has not – **state the key message as a summary for the section.**

Time management is important – make sure you follow the time allocation nominated for each stage of the scenario descriptions.

Guidelines for working in groups:

When working in small groups the facilitator needs to set the scene by encouraging staff to:

- Speak openly
- Contribute to the group
- Coach others and allow everyone time to have their say
- Ensure responses are not ridiculed or judged
- Encourage cooperation not competition
- Support a safe and non-threatening environment
- Ask why participants say/feel the way they do
- Ask if there is anything else the group would like to discuss.

Facilitator Notes

Scenario Description Part 1: New Resident

10 min



Mr Osmond is a new resident.

He was diagnosed with Parkinson's disease and found to be quite frail. He is at ease with the staff.

Mr Osmond has settled well into his new surroundings.

He has a good appetite and loves sweet foods and treats. He likes to drink coffee with two teaspoons of sugar.

Mr Osmond is sometimes forgetful but he is able to manage his activities of daily living with standby assistance and occasional prompting.

The family physician has recently put him on several new medications.

On admission, an Oral Health Assessment was performed. Mr Osmond has natural teeth and an upper partial denture. His oral health was found to be 'healthy'.

Based on this, an Oral Health Care Plan was written for Mr Osmond.

Guided Questions

1. What information about Mr Osmond is relevant to his oral health care?
2. What oral health care would you provide to Mr Osmond?

Key Messages

His oral health assessment is satisfactory, no dental follow up required

Need to care for both natural teeth and partial denture

He can self manage with stand by assist

He is forgetful, needs prompting

He has a good appetite, loves sweet food

Medications – implications for dry mouth

He is diagnosed with Parkinson's disease

He is at ease with staff

Six best ways to maintain a resident's oral health

1. brush teeth and partial denture morning and night
2. fluoride toothpaste on teeth
3. soft toothbrush
4. antibacterial product after lunch
5. keep mouth moist
6. reduce sugar

Care of partial denture (metal components)

- daily cleaning of denture – soap and water
- weekly disinfection – to reduce risk of thrush – chlorhexidine
- take out overnight and soak in water

Facilitator Notes

Scenario Description Part 2: Responsive Behaviour

10 min



Several months have passed.

Mr Osmond's behaviour has changed. He has recently become confused and uncooperative.

The family physician is treating him for a suspected urinary tract infection.

Mr Osmond is not cleaning his teeth and he won't let you help him. If you try, he won't open his mouth.

When Mr Osmond is like this it is easier to leave him and not do his oral hygiene care. This seems to be happening a lot. Other staff members have been doing the same and leaving out his oral hygiene care.

You notice his breath smells and it is unpleasant to be around him.

You also notice Mr Osmond is having difficulty eating his food.

Guided Questions

1. What could or might be happening here?
2. How might this have happened?
3. What could you do to encourage Mr Osmond to open his mouth?

Key Messages

Oral infection (bad breath) rather than urinary tract infection
Dental pain (refusal of oral care and not eating)

Daily oral hygiene not being maintained. Continual refusal of oral care not being reported

Effective Communication:

- Caring attitude
- Talk clearly
- Right environment
- Body language
- Working with the resident's family

Techniques to gain access to mouth:

- Overcoming fear of being touched
- Bridging
- Modelling
- Hand over hand
- Distraction
- Alternative provider

Facilitator Notes

Scenario Description Part 3: Daily Checking and Reporting

10 min



You have been able to get Mr Osmond to open his mouth and you take out his partial upper denture which has metal wires.

You notice his denture is very dirty and one of the metal wires is broken.

When you look at Mr Osmond's mouth, you see the part of the mouth where the partial denture has been is red and sore.

When you brush his teeth his gums begin to bleed.

Guided Questions

1. Who should know about this?
2. What else should you look for and report?
3. What could happen to Mr Osmond if his oral health gets worse?

Key Messages

OHCT should know about:

- Poor oral cleanliness
- Bad breath
- Red inflamed upper palate
- Broken wire
- Bleeding gums

Oral Health Assessment has to be done

Importance of daily checks

Report if:

- Tongue for any coating /change of colour
- Lip blister, sores, cracks
- Sore mouth, gums/teeth
- Mouth ulcer
- Swelling of face or localised swelling
- Difficulty eating
- Excessive food left in mouth
- Continual refusal of oral care

Good oral health is essential for overall health

Quality of life:

- Appearance, self esteem, social interaction
- Speech and swallowing
- Ability to eat, nutritional status and weight loss
- Pain and discomfort
- Responsive behaviour

Impact on General health:

- Aspiration pneumonia
- Heart attack
- Stroke
- Lowered immunity
- Poor diabetic control

Facilitator Notes

Scenario Description Part 4: Follow Up Oral Health Assessment and Treatment 10 min



You assist the OHCT to do an oral health assessment.
The OHCT arranges for Mr Osmond to see a dentist.
Treatment is prescribed and the Oral Health Care Plan is updated.

Guided Questions

Before asking this question

Tell participants the oral health assessment findings are:

- oral thrush
- gingivitis (gum disease) as indicated by bleeding gums
- confirms partial denture needs repair

1. What additional oral care could be required?
2. List the various ways you can apply the different types of oral care products?
3. List the types of care staff / health professions who have been involved in providing oral health care for Mr Osmond.

Key Messages

Treatment of thrush

- Oral medication for thrush
- Disinfection of partial denture
- Replacement of toothbrush/denture brush

Bleeding Gums

- Sign of gingivitis
- Best way to heal is to remove dental plaque by brushing twice a day with a soft toothbrush
- Should resolve within a week
- Repair of partial denture
- Antibacterial product – chlorhexidine gel

Application techniques

- Resident if able to apply with finger
- Use of toothbrush to apply, can also use a backward bent toothbrush as a retractor
- Spray bottle, can also use a backward bent toothbrush as a retractor

Team approach

- Oral health professionals
- Nurses
- Care aides
- Physicians

Facilitator Notes

Conclusion

Summarize 5 min



Note: At this stage if you have broken out into smaller groups bring participants back together as one group.

Explain the scenario has highlighted the fact that:

- As residents become more frail they are at high risk of their oral health worsening in relatively short time periods if their daily oral hygiene is not adequately maintained.
- Simple daily protective oral health practices are important because they will maintain good oral health.
- A team approach is the best way to enhance evidence based practice for *Better Oral Health in LTC - Best Practice Standards for Saskatchewan*

As a summary (refer to poster 3 It takes a team approach to maintain a healthy mouth and the flowchart in the Staff Portfolio module 3) and reiterate the following:

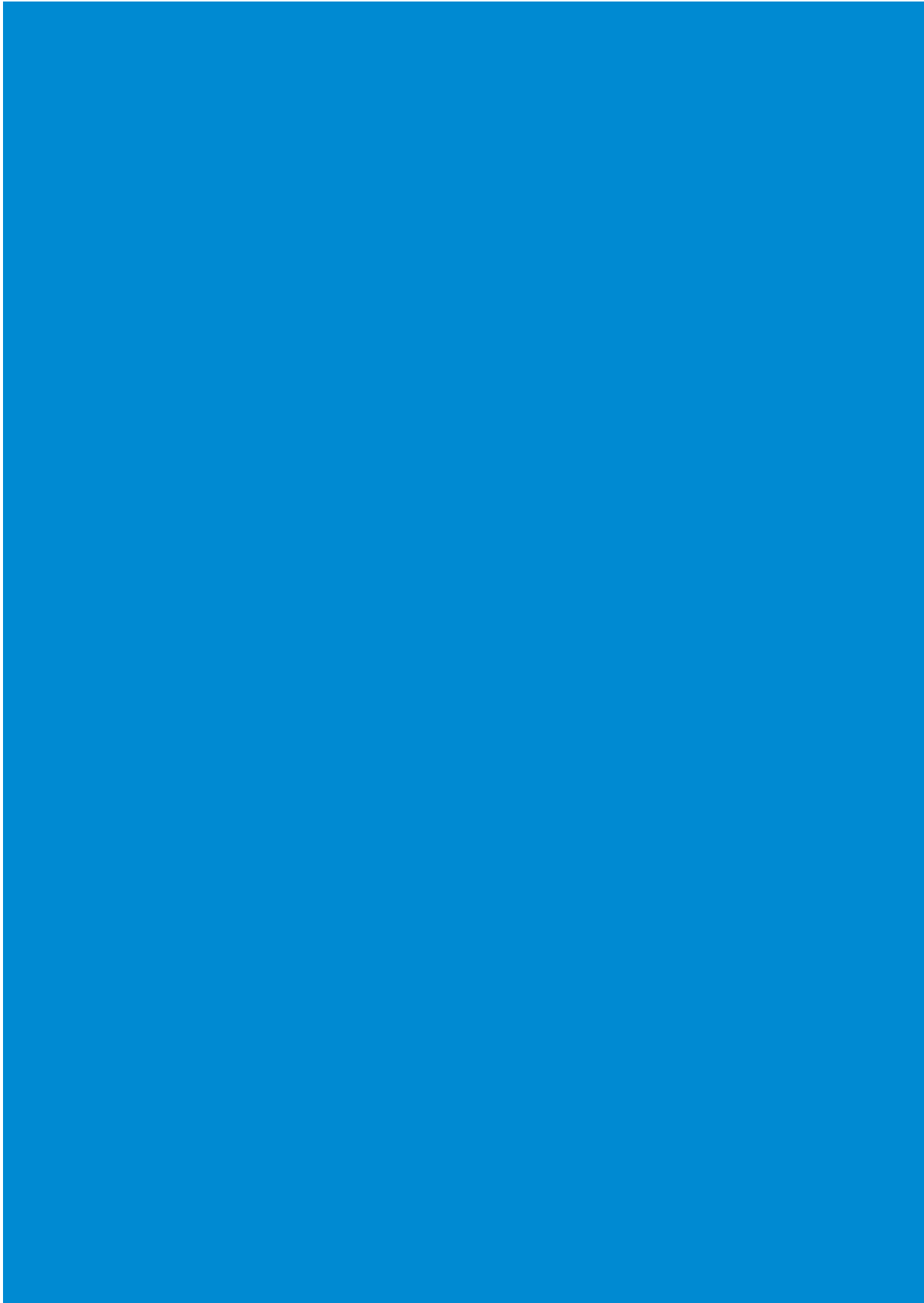
It takes a team approach to maintain a healthy mouth. There are four key processes:

1. **Oral Health Assessment**
This is performed by a licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses
2. **Oral Health Care Plan**
OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen:
 - brush morning and night
 - use fluoride toothpaste morning and night
 - use a soft toothbrush on gums, tongue and teeth
 - apply antibacterial product daily after lunch
 - keep the mouth moist
 - cut down on sugar intake.
3. **Daily Oral Hygiene**
Care aides maintain daily oral hygiene according to the oral health care plan.
4. **Dental Treatment**
Referral to a oral health professional for a more detailed dental examination and treatment are made on the basis of an oral health assessment. (It is recognised that residents may be best treated at the Long Term Care home).

Quiz

10 min

Finish off session by asking participants to complete a post education and training quiz and provide answer sheet.



Staff Portfolio Resource

Module 3



Module 3

It Takes a Team Approach to Maintain a Healthy Mouth

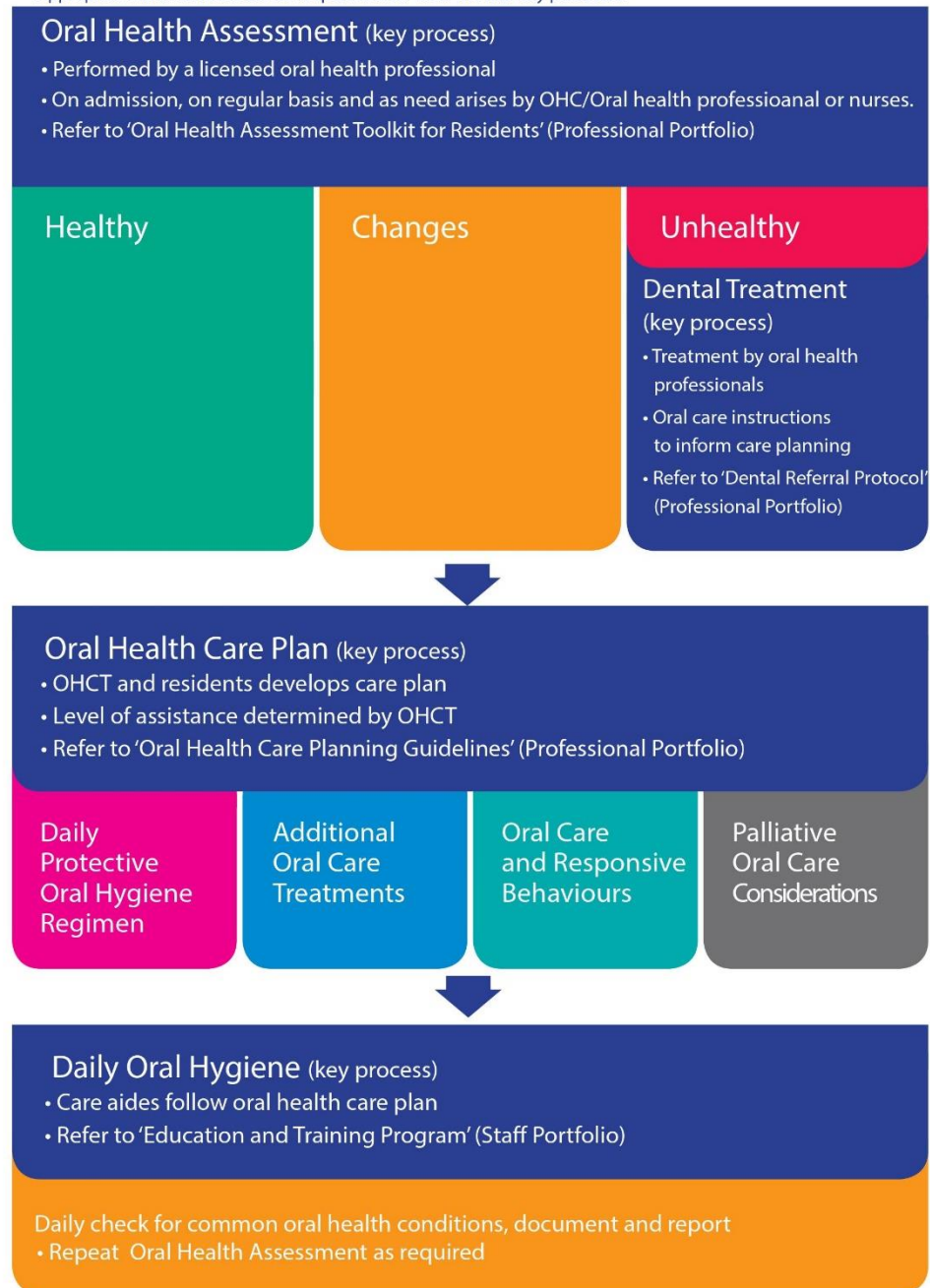
Staff Portfolio Resource | Module 3 | 97

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Model

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.





Better Oral Health Reflective Practice

Module 3 brings together the content from Module 1 (knowledge) and Module 2 (skills) in a guided learning approach conducted in small groups.

The module uses clinically-based situations and guided questions to encourage reflection on and application to everyday practice.

The aim is to help Long Term Care home staff members to address situations they meet in their everyday practice and to enhance evidence based practice for better oral health in Long Term Care home.

Guided Questions	Working in Groups
<p>Guided questions are provided in a sequential order to encourage discussion and reflection in the following way:</p> <ul style="list-style-type: none"> • think about the scenario presented • respond to the questions provided • identify what knowledge and skills you have already to respond to this scenario. 	<p>When working in small groups:</p> <ul style="list-style-type: none"> • take time to think and reflect before responding • work together and help one another • share ideas and respect each other's views • it is OKAY to disagree but do not be judgmental • speak one person at a time.

Oral Health Scenario – Part 1



Description

Mr Osmond is a new resident.

He is diagnosed with Parkinson's disease and found to be quite frail. He is at ease with the staff.

Mr Osmond has settled well into his new surroundings.

He has a good appetite and loves sweet foods and treats. He likes to drink coffee with two teaspoons of sugar.

Mr Osmond is sometimes forgetful but he is able to manage his activities of daily living with standby assistance and occasional prompting.

The family physician has recently put him on several new medications.

On admission, an Oral Health Assessment was performed. Mr Osmond has natural teeth and an upper partial denture. His oral health was found to be 'healthy'.

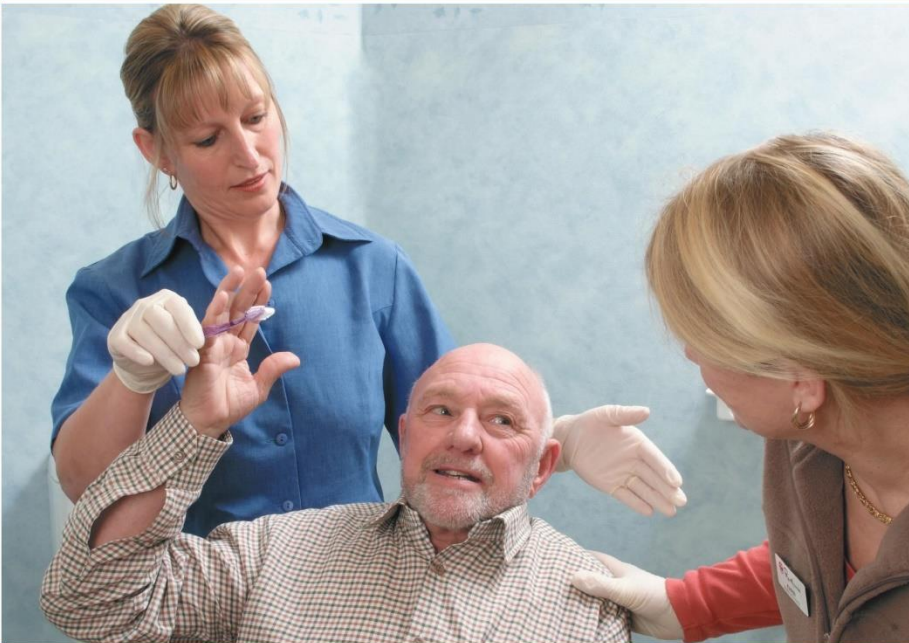
Based on this, an Oral Health Care Plan was written for Mr Osmond.

Guided Questions

What information about Mr Osmond is relevant to his oral health care?

What oral health care should you provide to Mr Osmond?

Oral Health Scenario – Part 2



Description

Several months have passed.

Mr Osmond's behaviour has changed. He has recently become confused and uncooperative.

The family physician is treating him for a suspected urinary tract infection.

Mr Osmond is not cleaning his teeth and he won't let you help him. If you try, he won't open his mouth.

When Mr Osmond is like this it is easier to leave him and not do his oral hygiene care. This seems to be happening a lot. Other staff members have been doing the same and leaving out his oral hygiene care.

You notice his breath smells and it is unpleasant to be around him.

You also notice Mr Osmond is having difficulty eating his food.

Guided Questions

What could be happening here?

How might this have happened?

What could you do to encourage Mr Osmond to open his mouth?

Oral Health Scenario – Part 3



Description

You have been able to get Mr Osmond to open his mouth and you take out his partial upper denture which has metal wires.

You notice his denture is very dirty and one of the metal wires is broken.

When you look at Mr Osmond's mouth, you see the part of the mouth where the partial denture has been is red and sore.

When you brush his teeth his gums begin to bleed.

Guided Questions

Who should know about this?

What else should you look for and report?

What could happen to Mr Osmond if his oral health gets worse?

Oral Health Scenario – Part 4



Description

You assist the OHCT to do an Oral Health Assessment.

The OHCT arranges for Mr Osmond to see a dentist.

Treatment is prescribed and the Oral Health Care Plan is updated.

Guided Questions

What additional oral care could be required?

List the various ways you can apply the different types of oral care products?

List the types of Long Term Care staff and health professionals who have been involved in the oral health care of Mr Osmond.

Conclusion



Facts

As residents become frailer, they are at high risk of their oral health worsening in a relatively short time if their daily oral hygiene is not adequately maintained.

A simple daily oral health care regimen will maintain good oral health.

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Model

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists. Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by a licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses

2. Oral Health Care Plan

OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen:

- brush morning and night
- use fluoride toothpaste morning and night
- use a soft toothbrush on gums, tongue and teeth
- apply antibacterial product daily after lunch
- keep the mouth moist
- cut down on sugar intake.

3. Daily Oral Hygiene

Nurses and care aides maintain daily oral hygiene according to the oral health care plan.

4. Dental Treatment

Referrals for more comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized that residents may be best treated at the Long Term Care home.

Staff Portfolio (p. 52) | Module 3 | Better Oral Health Reflective Practice | 105

Poster

Time the distribution of the Poster to coincide with the delivery of the Module.

Place it staff room areas in the Long Term Care home to reinforce participant learning.



Oral Health Professionals



Nurses



Physicians



Residents



Care aides



Speech Language Pathologist



Dietitians

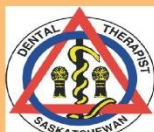
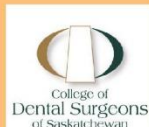


It takes a team approach to maintain a healthy mouth

Work together to protect your residents' oral health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*



Post-Quiz

The post-quiz can be downloaded from the accompanying CD. Print off the required number of copies and distribute at the completion of Module 3. Encourage participants to compare their results with the pre-quiz.

A quiz answer sheet is also available for participants and can be printed off from the CD.



Education and Training Program

Name

Date

Post - Quiz	Yes	No	Don't Know
1 When a resident refuses dental care it could mean they are experiencing dental pain			
2 When brushing a resident's teeth it is important to focus on the gum line.			
3 If a resident's gums bleed you should stop brushing the gums.			
4 It is important to rinse a resident's mouth with water after brushing their teeth.			
5 A resident with dementia may start brushing their teeth after holding a toothbrush for a few minutes.			
6 Residents' teeth or dentures, gums and tongues should be brushed morning and night.			
7 It is a good idea to have residents drink water after eating.			
8 When brushing a resident's teeth, apply a strip of toothpaste across the top surface of the brush.			
9 Chest infections may be caused by a build up of plaque in the mouth.			
10 Bad breath should be reported.			
11 Oral integrity is as important as skin integrity in protecting the body against infection.			
12 Dentures should be cleaned with toothpaste.			
13 The choice of denture disinfection product is important for partial dentures.			
14 The presence of stringy saliva in a resident's mouth is normal.			
15 Chlorhexidine products and toothpaste can be used at the same time.			
16 Drinking a lot of caffeine can affect a resident's oral health.			
17 It is best to try to reduce snacking on sugary foods between meal times.			
18 Toothbrushes should be replaced with the change of season (every three months).			
19 The daily application after lunch of an antibacterial product helps to prevent gum disease.			
20 Dentures should be taken out at night, cleaned and soaked in cold water.			



Education and Training Program

Quiz-Answers

<p>1 When a resident refuses dental care it could mean they are experiencing dental pain.</p> <p>A resident may not be able to say he or she is in pain. This is particularly so with residents who have dementia. Often a change in behaviour is a sign which should be reported. An oral assessment should be done to check if there is a problem in the mouth that may be causing pain.</p>	Yes	
<p>2 When brushing a resident's teeth it is important to focus on the gum line.</p> <p>When brushing it is important to brush the front, back and chewing surfaces of the teeth and gums in a circular motion giving particular attention to the gum line. Bacteria in the dental plaque accumulates on the gum line at the base of the tooth and causes gum disease (gingivitis). Gum disease gets worse and more common with age. If it progresses to severe gum disease (periodontitis), this condition can impact seriously on general health and wellbeing.</p>	Yes	
<p>3 If a resident's gums bleed you should stop brushing the gums.</p> <p>Bleeding gums is usually caused by a build up of dental plaque. Brushing is the best way to remove the dental plaque and heal the gums. Continue to brush teeth, paying particular attention to the gum line with a soft tooth brush twice a day. This should resolve in a week. Bleeding gums should be reported as it may also be a sign of a general health problem.</p>		No
<p>4 It is important to rinse a resident's mouth with water after brushing their teeth.</p> <p>Encourage the resident to spit and not rinse the mouth after brushing so the fluoride soaks into the teeth. Fluoride is important as it helps to protect the teeth from decay.</p>		No
<p>5 A resident with dementia may start brushing their teeth after holding a toothbrush for a few minutes.</p> <p>This is referred to as bridging. Bridging aims to engage the resident's senses especially sight and touch and to help the resident to understand the task you are trying to do for him or her.</p>	Yes	
<p>6 Residents' teeth or dentures, gums and tongues should be brushed morning and night.</p> <p>Brushing morning and night is the most effective and economic method of physically removing dental plaque. Dental plaque forms continuously and sticks to all surfaces of the teeth, including spaces between the teeth and the gums and must be removed by regular brushing. Poor oral hygiene allows the bacteria in the dental plaque to produce acids and other substances that damage the teeth, gums and surrounding bone.</p>	Yes	
<p>7 It is a good idea to have residents drink water after eating.</p> <p>Water reduces the acid that causes tooth decay and helps to keep the mouth clean. Encourage the resident to drink water to rinse the mouth after meals, medications and other drinks and snacks. A small drink of water before bed is also encouraged.</p>	Yes	
<p>8 When brushing a resident's teeth, apply a strip of toothpaste across the top surface of the brush.</p> <p>Only use a small pea-sized amount of toothpaste.</p>		No
<p>9 Chest infections may be caused by a build up of plaque in the mouth.</p> <p>The bacteria in dental plaque can enter airways and cause a chest infection called aspiration pneumonia.</p>	Yes	
<p>10 Bad breath should be reported.</p> <p>Bad breath may indicate the presence of an oral health problem and should be reported. Bad breath can impact on a resident's quality of life.</p>	Yes	



Education and Training Program

Quiz-Answers

<p>11 Oral integrity is as important as skin integrity in protecting the body against infection.</p> <p>When oral integrity is impaired due to poor oral health the bacteria in dental plaque can enter the bloodstream and cause infection of tissues far away from the mouth and may contribute to heart attack, stroke, lowered immunity and poor diabetic control.</p>	Yes	
<p>12 Dentures should be cleaned with toothpaste.</p> <p>Do not use toothpaste to clean dentures as this can be abrasive and over time will abrade and scratch the denture. A scratched denture can be a source of irritation to soft oral tissues and can increase the risk of fungal infections such as thrush. Dentures should be brushed using a denture brush and a mild soap to clean food, dental plaque and any denture adhesive from all surfaces of the denture morning and night.</p>		No
<p>13 The choice of denture disinfection product is important for partial dentures.</p> <p>Take care with the choice of denture disinfection product as some may cause the metal components of a partial denture to corrode. Partial dentures may be disinfected using a chlorhexidine product or a denture tablet identified as being non corrosive.</p>	Yes	
<p>14 The presence of stringy saliva in a resident's mouth is normal.</p> <p>This is a sign of Dry Mouth and should be reported. Saliva is important in maintaining a healthy mouth. This condition can be very uncomfortable for the resident. It can be caused by medications, radiation, chemotherapy or by medical conditions such as Sjogren's syndrome and Alzheimers disease. Dry Mouth (Xerostomia) is also a common condition at the end stage of life.</p>		No
<p>15 Chlorhexidine products and toothpaste can be used at the same time.</p> <p>Chlorhexidine and toothpastes (containing sodium lauryl sulphate) should not be used within two hours of each other as the product effectiveness is reduced.</p>		No
<p>16 Drinking a lot of caffeine can affect a resident's oral health.</p> <p>Caffeine drinks such as coffee and tea can contribute to Dry Mouth (Xerostomia). When the quantity and quality of saliva is reduced oral diseases can develop very quickly.</p>	Yes	
<p>17 It is best to try to reduce snacking on sugary foods between meal times.</p> <p>Tooth decay is directly related to the frequency of sugar intake rather than the amount of sugar eaten. Encourage healthy snacks between meals. Encourage the resident to drink water to rinse the mouth after meals, medications, other drinks and snacks.</p>	Yes	
<p>18 Toothbrushes should be replaced with the change of season (every three months).</p> <p>Toothbrushes carry bacteria and should be replaced every three months (with the change of seasons), when the bristles become worn or following an acute illness such as a bad cold. Toothbrushes should be thoroughly rinsed after use and stored uncovered in a dry place.</p>	Yes	
<p>19 The daily application after lunch of an antibacterial product helps to prevent gum disease.</p> <p>The daily application after lunch of a low strength concentration of chlorhexidine (which is alcohol free and non-teeth staining), can reduce harmful bacteria in the dental plaque and help to prevent gum disease.</p>	Yes	
<p>20 Dentures should be taken out at night, cleaned and soaked in cold water.</p> <p>Encourage the resident to remove dentures overnight to rest the gums. Soak cleaned dentures in a denture container of cold water overnight.</p>	Yes	

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Appendix-3: Professional Portfolio

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Professional Portfolio: for Nurses

The Professional Portfolio and the accompanying CD are designed to assist Nurses to undertake oral health assessment and care planning for people in Long Term Care home. A Dental Referral Protocol is included for referral for a more detailed dental examination and treatment.

This Professional Portfolio forms part of a suite of three Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Portfolios:

- The Professional Portfolio for Nurses.
- The Educators' Portfolio for delivery of the Education and Training Program
- The Staff Portfolio for care aides.

The Portfolios were developed by the Better Oral Health in Residential Care Project funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) Program. This project was led by SA Dental Service with the support of Consortium members during 2008-09.

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Introduction

'Oral diseases and conditions can have social impacts on quality of life, including comfort, eating, pain and appearance, and are related to dentate status... 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.'

Chalmers, JM 2003, 'Oral health promotion for our ageing Australian population', Australian Dental Journal; vol. 48, no.1, pp.2-9

The Facts

More Long Term Care residents have their natural teeth.

Many residents take medications that contribute to dry mouth.

The onset of major oral health problems takes place well before an older person moves into Long Term Care home.

As residents become frailer and more dependent, they are at high risk of their oral health worsening in a relatively short time if their daily oral hygiene is not maintained adequately.

A simple protective oral health care regimen will maintain good oral health.

Quality of Life	Impact on General Health
Poor oral health will significantly affect a resident's quality of life in many ways: <ul style="list-style-type: none">• bad breath• bleeding gums, tooth decay and tooth loss• appearance, self-esteem and social interactions• speech and swallowing• ability to eat, nutritional status and weight loss• pain and discomfort• change in behaviour.	Poor oral health can significantly impact on general health: <ul style="list-style-type: none">• aspiration pneumonia• chronic infection and bacteraemia• cardiovascular disease• complicate management of systemic illnesses.

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan Model*

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists. Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by a licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses

2. Oral Health Care Plan

OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen

3. Daily Oral Hygiene

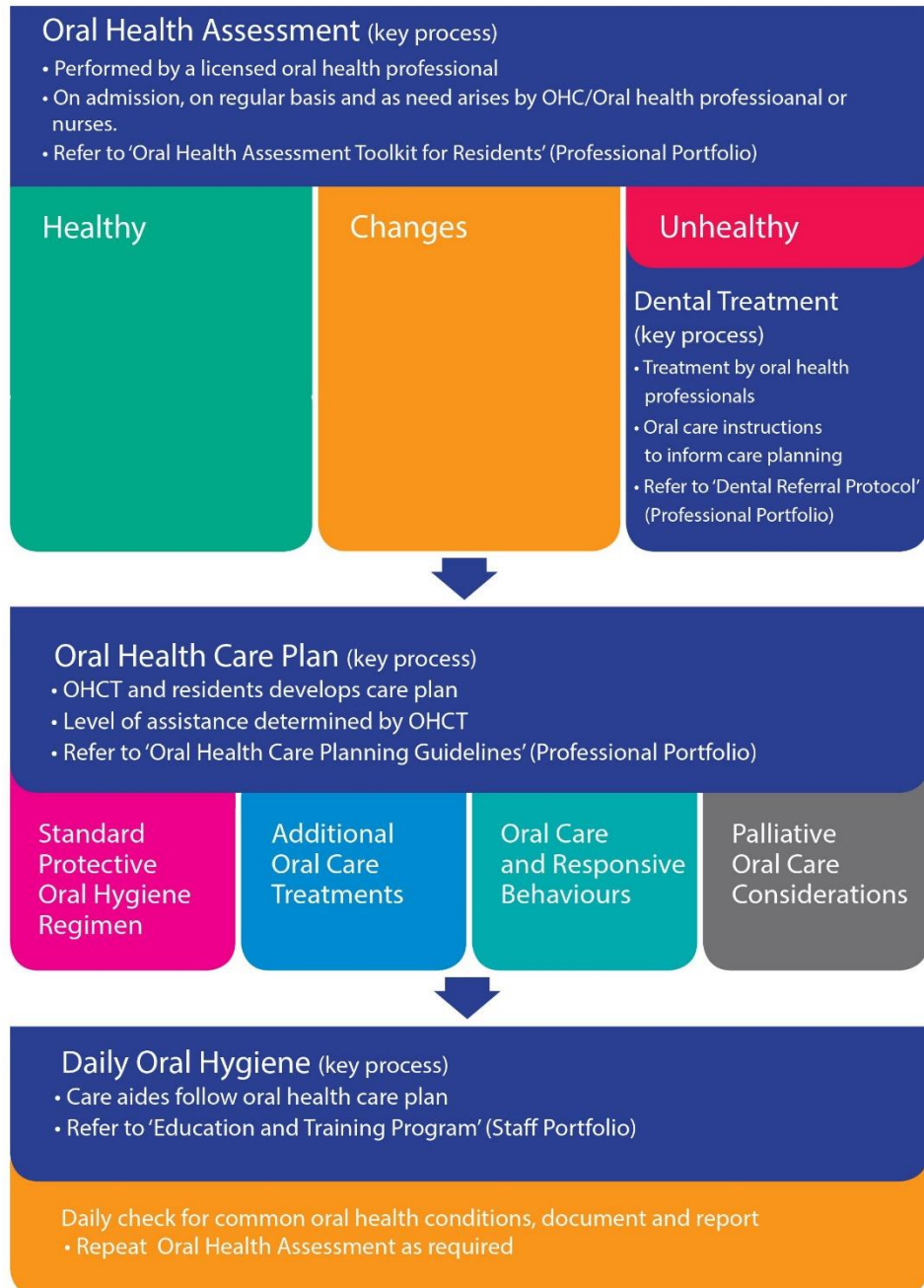
Nurses and care aides maintain daily oral hygiene according to the oral health care plan.

4. Dental Treatment

Referrals for more comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized that residents may be best treated at the Long Term Care home.

Introduction

This flowchart illustrates the Better Oral Health in LTC - *Best Practice Standards for Saskatchewan Model*.





Oral Health Assessment Toolkit for Residents'

The Oral Health Assessment Toolkit for Residents' is described in this section of the Portfolio and includes an interactive CD.

The CD consists of: a video demonstration of how to perform an oral health assessment, a self directed learning module, an oral health assessment tool and other useful documents.

It is recommended a resident should have an oral health assessment performed by licensed oral health professional on a regular basis and as the need arises by OHC/oral health professional or nurses.

Eight categories of oral health (lips, tongue, gums and tissues, saliva, natural teeth, dentures, oral cleanliness and dental pain) are assessed as healthy, changes or unhealthy.

A 'healthy' or 'changes' assessment can be managed by using the Oral Health Care Guidelines whereas an 'unhealthy' assessment generally indicates the need for a comprehensive dental examination and treatment.

The Oral Health Assessment Toolkit for Residents (2009) presented in this Portfolio was modified from the Oral Health Assessment Toolkit for Older People for General Practitioners (2005) developed for the Australian Government Department of Health and Ageing. This was in turn modified from Kayser-Jones, Bird, Paul, Long and Schell (1995) and Chalmers (2004).

Common Oral Health Conditions experienced by Residents



Angular Cheilitis

Bacterial or fungal infection which occurs at the corners of the mouth.

Check for:

- soreness and cracks at corners of the mouth.

Glossitis

This is commonly caused by a fungal infection.

It may be a sign of a general health problem.

Check for:

- a reddened, smooth area of tongue
- a tongue which is generally sore and swollen.

Candidiasis (Thrush)

This is a fungal infection of oral tissues.

Check for:

- patches of white film that leave a raw area when wiped away
- red inflamed areas on the tongue.

Gums and Oral Tissue



Gingivitis

This is caused by the bacteria in dental plaque accumulating on the gum line at the base of the tooth. It gets worse and more common with age.

Check for:

- swollen red gums that bleed easily when touched or brushed
- bad breath.

Periodontitis

This causes gums and bone that support the teeth to break down. This condition can impact seriously on general health and wellbeing.

Check for:

- receding gums
- exposed roots of teeth
- loose teeth
- tooth sensitivity
- bad breath.

Oral Cancers

Oral cancer is a major cause of death. People who smoke and drink alcohol heavily are at higher risk.

Check for:

- ulcers that do not heal within 14 days
- a white or red patch or change in the texture of oral tissues
- swelling
- unexplained changes in speech
- difficulty in swallowing.

Common Oral Health Conditions experienced by Residents

Gums and Oral Tissue (continued)	Saliva
<p>Ulcers & Sore Spots</p> <p>These are caused by chronic inflammation, a poorly fitting denture or trauma.</p> <p>Ulcers may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • sensitive areas of raw tissue caused by rubbing of the denture (particularly under or at the edges of the denture) • broken denture • broken teeth • difficulty eating meals • responsive behaviour. 	<p>Stomatitis</p> <p>Usually, stomatitis is caused by a fungal infection.</p> <p>It is commonly found where oral tissue is covered by a denture. It may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • red swollen mouth usually in an area which is covered by a denture. <p>Xerostomia (Dry Mouth)</p> <p>This can be a very uncomfortable condition caused by medications, radiation and chemotherapy or by medical conditions such as Sjögren's syndrome and Alzheimer's disease.</p> <p>Check for:</p> <ul style="list-style-type: none"> • difficulty with eating and/or speaking • dry oral tissues • small amount of saliva in the mouth • saliva which is thick, stringy or rope-like.

Natural Teeth		
<p>Caries</p> <p>Tooth decay is a diet and oral hygiene related infectious disease which affects the teeth and causes pain.</p> <p>Check for:</p> <ul style="list-style-type: none"> • holes in teeth • brown or discoloured teeth • broken teeth • bad breath • oral pain and tooth sensitivity • difficulty eating meals • responsive behaviour. 	<p>Root Caries</p> <p>Gums recede and the surface of the tooth root is exposed.</p> <p>Decay can develop very quickly because the tooth root is not as hard as tooth enamel.</p> <p>Check for:</p> <ul style="list-style-type: none"> • tooth sensitivity • brown discolouration near the gum line • bad breath • difficulty eating meals • responsive behaviour. 	<p>Retained Roots</p> <p>The crown of the tooth has broken or decayed away.</p> <p>Check for:</p> <ul style="list-style-type: none"> • broken teeth • exposed tooth roots • oral pain • swelling • bad breath • trauma to surrounding tissues from sharp tooth edges • difficulty eating meals • responsive behaviour.

Common Oral Health Conditions experienced by Residents

Dentures



Requiring Attention

The denture is in need of repair or attention.

Check for:

- resident's name on the denture
- chipped or missing teeth on the denture
- chipped or broken acrylic (pink) areas on the denture
- bent or broken metal wires or clips on a partial denture.

Poorly Fitting

A denture can cause irritation and trauma to gums and oral tissues.

Check for:

- denture belonging to resident
- dentures being a matching set, particularly if the resident has several sets of dentures
- denture movement when the resident is speaking or eating
- resident's refusal to wear the denture
- overgrowth of oral tissue under the denture
- ulcers and sore spots caused by wearing the denture.

Oral Cleanliness



Poor Oral Hygiene

Poor oral hygiene allows the bacteria in dental plaque to produce acids and other substances that damage the teeth, gums and surrounding bone.

Dental plaque begins as an invisible film that sticks to all surfaces of the teeth, including the spaces between the teeth and gums. It forms continuously and must be removed by regular brushing. If dental plaque is not removed, it hardens into calculus (tartar).

Check for:

- build up of dental plaque on teeth, particularly at the gum line
- calculus on teeth, particularly at the gum line
- calculus on denture
- unclean denture
- bleeding gums
- bad breath
- coated tongue
- food left in the mouth.

Oral Health Assessment Tool

Print from CD

Resident: _____ Completed by: _____ Date: _____

Resident: ☐ is independent ☐ needs reminding ☐ needs supervision ☐ needs full assistance

- ☐ Not able to open mouth ☐ Grinding or chewing ☐ Head faces down ☐ Refuses treatment
☐ Has responsive behaviour ☐ Bites ☐ Excessive head movement ☐ Cannot swallow well
☐ Not able to rinse and spit ☐ Does not take dentures out at night

Healthy	Changes	Unhealthy	Dental Referral
Lips			
<input type="checkbox"/> Smooth, pink, moist	<input type="checkbox"/> Dry, chapped or red at corners	<input type="checkbox"/> Swelling or lump, red/white/ulcerated bleeding/ulcerated at corners *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Natural Teeth			
<input type="checkbox"/> No decayed or broken teeth or roots	<input type="checkbox"/> 1-3 decayed or broken teeth/roots, or teeth very worn down	<input type="checkbox"/> 4 or more decayed or broken teeth/roots or fewer than 4 teeth, or very worn down teeth *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tongue			
<input type="checkbox"/> Normal moist, roughness, pink	<input type="checkbox"/> Patchy, fissured, red, coated	<input type="checkbox"/> Patch that is red and/or white/ulcerated, swollen *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentures			
<input type="checkbox"/> No broken areas or teeth, worn regularly, and named	<input type="checkbox"/> 1 broken area or tooth, or worn 1-2 hours per day only or not named	<input type="checkbox"/> 1 or more broken areas or teeth, denture missing /not worn, need adhesive, or not named *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums and Oral Tissue			
<input type="checkbox"/> Moist, pink, smooth, no bleeding	<input type="checkbox"/> Dry, shiny, rough, red, swollen, sore, one ulcer/sore spot, sore under dentures	<input type="checkbox"/> Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral Cleanliness			
<input type="checkbox"/> Clean and no food particles or tartar in mouth or on dentures	<input type="checkbox"/> Food, tartar, plaque 1-2 areas of mouth, or on small area of dentures	<input type="checkbox"/> Food particles, tartar, plaque most areas of mouth, or on most of dentures *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Saliva			
<input type="checkbox"/> Moist tissues watery and free flowing	<input type="checkbox"/> Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth	<input type="checkbox"/> Tissues parched and red, very little/no saliva present, saliva is thick, resident thinks they have a dry mouth *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Pain			
<input type="checkbox"/> No behavioural, verbal or physical signs of dental pain	<input type="checkbox"/> Verbal &/or behavioural signs of pain such as pulling at face, chewing lips, not eating, responsive behaviour.	<input type="checkbox"/> Physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal &/or behavioural signs (pulling at face, not eating, responsive behaviour) *	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Unhealthy signs usually indicate referral to a dentist is necessary

Assessor Comments

Oral Health Assessment Tool | 5

Helpful Hints

Preparation



It is suggested the resident be positioned in the semi-reclined position to facilitate the examination.

The use of a hands-free light source or LED flashlight is recommended to assist in viewing the oral cavity.

Assistance with the recording aspect of the assessment may help to decrease the amount of time required.

Using a Modified Toothbrush



A backward bent toothbrush can be used to retract the cheek and provide better access to the mouth.

Clear plastic toothbrushes are the easiest to bend. Some can be bent (without having to soften the plastic) to a 45 degree angle by simply using your hands.

Others will need to be softened by placing the toothbrush in a cup of hot water. Apply gentle downward pressure on the toothbrush until it bends to a 45 degree angle.

Managing Responsive Behaviours



Getting the resident's attention

Touch a neutral place such as the hand or lower arm.

Firstly, focus on building a good relationship with the resident before you start the oral health assessment.

Speak clearly and at the resident's pace giving one instruction at a time.

Mime what you want the resident to do and allow the resident to inspect the items you are going to use.

If the resident walks away allow the resident to perch against a bench or table rather than sit during the assessment.



Counteracting grabbing or hitting out

Approach the resident from the diagonal front and at eye level. By standing directly in front you can look big and are more likely to be grabbed or hit.

If the resident holds onto items you are using and does not let go stroke the resident's forearm in long, gentle rhythmic movements as a distraction and to help relax the resident.

Helpful Hints

Managing Responsive Behaviours (continued)



Counteracting grabbing or hitting out (continued)

If the resident grabs out at you or grabs your wrist, pull back and give the resident space. Ask if the resident is OKAY. Offer the resident something to hold while you do the oral health assessment.

Think about what may have caused the resident's behaviour. Did something hurt? Was the resident trying to help but the message was mixed?

Improving access

If the resident does not open his or her mouth or keeps turning his or her face away try to stimulate the resident's root reflex by stroking the cheek.

If the resident bites the items you are using ask the resident to release and distract the resident with gentle strokes to the head or shoulder, using soothing words.

Medication Issues

Xerostomia (Dry Mouth)

A variety of drugs, especially those with anticholinergic effects, can cause xerostomia (dry mouth), particularly with issues of polypharmacy and the elderly. When the quality and quantity of saliva is reduced oral diseases can develop very quickly.

The following drug classes can contribute to xerostomia (dry mouth), some generic examples are listed but this is not comprehensive:

- **Tricyclic antidepressants** (amitriptyline, doxepin, dothiepin)
- **Selective serotonin reuptake inhibitors** (citalopram, paroxetine)
- **Monoamine oxidase inhibitors** (moclobemide, phenelzine)
- **Anticholinergic agents** (oxybutynin, tolterodine, hyoscine, inhaled tiotropium)
- **Opioids** (codeine, morphine, oxycodone, methadone)
- **Diuretics** (frusemide, hydrochlorothiazide)
- **Antipsychotic drugs** (chlorpromazine, haloperidol, olanzapine)
- **Antihistamines** (promethazine, dexchlorpheniramine)
- **Lithium**
- **Proton pump inhibitors** (omeprazole, lansoprazole)
- **ACE inhibitors** (captopril, enalapril, lisinopril)
- **Oral retinoids** (isotretinoin, tretinoin)
- **Benzodiazepines** (diazepam, temazepam)
- **Chemotherapy** (capecitabine; many drugs cause mucositis)
- **Other miscellaneous agents** (carbamazepine, sibutramine, tramadol)

Note that incidence of xerostomia (dry mouth) may vary greatly between agents. For example, within the antipsychotic class of drugs, chlorpromazine, is more likely to produce a dry mouth whereas haloperidol will produce more tardive dyskinesia.

Other Considerations

Multiple drug interactions also need to be monitored. For example, warfarin often interacts with oral antifungals or azoles used to treat stomatitis in residents with poorly controlled INR levels.

The use of local anaesthetics, sedation and general anaesthesia may be complicated or negated with specific medication combinations.

Medication compliance must be considered. For example, poor compliance with insulin or blood pressure medications can result in complications with tooth extractions.

Medical history and duration of use can affect oral health. For example, a resident may have taken an antipsychotic medication and have ongoing tardive dyskinesic movement disorders.

Residents who take bisphosphonate agents may be at risk of developing bisphosphonate-related osteonecrosis of the jaws, especially following invasive dental procedures such as tooth extractions.

Further information

If you have questions about the medications taken by a particular resident, ?

Or refer to the latest edition of: ???

Helpful Hints

Removing Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own dentures.

If the resident requires assistance, it is easier to take out the lower denture first by holding the lower front teeth with the thumb and index finger and lifting out.

To remove upper dentures, break the seal by holding front teeth with the thumb and index finger and rocking

the denture up and down until the back is dislodged.

Remove the denture at a sideways angle.

If you are unable to break the seal, use a backward bent toothbrush to carefully push down on the side of the denture towards the back of the mouth until the denture is loosened and can be easily removed.

Putting Upper Denture In



Putting Lower Denture In



Encourage the resident to insert his or her own dentures.

If the resident requires assistance, insert the upper denture first followed by the lower denture.

Ask the resident to open his or her mouth. Hold the denture at a sideways angle as it enters the mouth and then rotate into position.

Helpful Hints

Removing Partial Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own partial denture.

If the resident requires assistance, place your fingertips

under the clasps that cling onto the natural teeth and push down carefully.

Gently grasp the plastic part of the denture and lift it out of the resident's mouth, taking care not to bend the wire clasps.

Putting Partial Denture In



Encourage the resident to insert his or her own dentures.

If the resident requires assistance ask the resident to open the mouth, hold the denture at a sideways angle as it enters the mouth and then rotate and click into position.



Oral Health Care Planning Guidelines

The Oral Health Care Planning Guidelines are designed to be used in conjunction with the Oral Health Assessment Toolkit for Residents' to assist with oral health care planning for residents.

It provides information on a standard protective care regimen, additional oral care treatment, oral care and change behaviour and palliative care considerations.

An Oral Health Care Plan guide is included and can be downloaded from the CD.

Standard Protective Oral Hygiene Regimen

This is recommended for all residents

Strengthen Teeth

Rationale

Fluoride protects teeth by remineralising tooth enamel.

Adequate concentrations of fluoride can inhibit the growth of bacteria in dental plaque.

Frail and dependent older people are considered at high risk of poor oral health.

Protective Oral Health Care

Use a pea-size amount of fluoride toothpaste when brushing teeth in the morning and at night.

Encourage the resident to spit but not to rinse the mouth after brushing, so the fluoride soaks into the teeth.

Use neutral fluoride toothpaste.

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Brushing – Natural Teeth

Rationale

Brushing is the most effective and economic method of physically removing dental plaque.

A soft toothbrush is gentle on oral tissues and gums.

Protective Oral Health Care

Use a soft toothbrush to brush teeth, gums (giving particular attention to the gum line) and tongue in the morning and at night.

Use a soft toothbrush

Brushing – Dentures

Rationale

Residents who wear dentures are at high risk of developing fungal infections (such as thrush).

Dentures must be taken out and brushed to remove dental plaque.

Gums and tongue should be brushed to remove dental plaque.

Gum tissue needs time to rest from wearing dentures.

Protective Oral Health Care

Use a soft toothbrush to brush gums and tongue in the morning and night.

Use a denture brush and mild soap to brush dentures morning and night.

Do not use toothpaste as this is abrasive to the denture.

Leave cleaned denture out of the mouth overnight and soak in cold water.

Disinfect denture once a week.

Wash and dry the denture storage container daily.

Ensure the denture and the denture storage container are labelled with the resident's name.

Use a soft toothbrush for gums and tongue.

Use a denture brush.

Use a mild soap (liquid or foam) to clean dentures.

Use a denture storage container.

Soak denture in cold water overnight.

Dentures are best permanently named by a dental professional. Dentures can be temporarily labelled by using a Denture Labelling Kit or by:

- lightly sandpapering the pink acrylic on the outside (cheek side) of the denture
- writing the resident's name in pencil
- applying several coats of sealing liquid or clear nail polish to cover the name.

Disinfect denture

Take care with the choice of denture disinfection products as some may cause metal components of partial dentures to corrode. The following may be used.

- Chlorhexidine (with or without alcohol).
- Commercial denture cleaning tablet.

The denture tablet used should clearly identify whether it is suitable for full plastic or metal partial dentures or both.

Remove calculus

To remove calculus on a full plastic denture, soak dentures in full strength white vinegar for 8 hours to soften calculus and then scrub off using a denture brush (not suitable for partial dentures).

For heavy staining and for stain removal on partial dentures, cleaning by a dental professional is advised.

Caution

Excessive soaking in chlorhexidine may cause discolouration.

Allergy Alert

Persulphate (persulfate), a denture cleaning ingredient, may cause an allergic reaction. This may happen quickly or after many years, even with correct use.

Symptoms include; irritation, tissue damage, gum tenderness, breathing problems and low blood pressure.

If symptoms occur remove dentures and refer to an oral health professional.

Prevention of Gingivitis

Rationale

The long-term daily application of a low strength antibacterial product helps to reduce the incidence of gingivitis for persons considered at high risk of poor oral health, such as frail and dependent older people.

Protective Oral Health Care

Use a soft toothbrush to apply a pea-size amount of a low-strength chlorhexidine gel to gums daily after lunch.

If the resident wears a denture, remove it and apply the chlorhexidine gel to gums or the fitting surface of a rinsed denture.

Use a low strength chlorhexidine product (alcohol free and non-teeth staining)

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Relief of Xerostomia (Dry Mouth)

Rationale

Keeping the mouth moist provides relief of xerostomia (dry mouth).

When the quantity and quality of saliva is reduced, oral diseases can develop very quickly.

Protective Oral Health Care

Keep the mouth moist by frequent rinsing or sipping water (and increase water intake if appropriate).

Keep the lips moist by frequently applying a water-based moisturiser.

Discourage the resident from sipping fruit juices, cordial or sugary drinks.

Reduce intake of caffeine drinks.

Stimulate saliva production with xylitol based products as required.

Seek a medical review of medications.

A variety of xylitol based products are available.

Use a water-based lip moisturiser; for example, water based products.

Caution

Petroleum-based lip moisturisers may increase the risk of inflammation and aspiration pneumonia and are contraindicated during oxygen therapy.

Reduce Tooth Decay

Rationale

Tooth decay is directly related to the frequency of sugar intake rather than the total amount of sugar eaten.

Protective Oral Health Care

Reduce the frequency of sugar intake between meals.

Encourage selection of tooth friendly alternatives in food, drinks and medications.

Encourage a drink of water after meals, other drinks or snacks and after taking medications.

Use tooth friendly sugar substitute products. Xylitol products are recommended.

Caution

Excessive consumption of sugar substitutes may cause diarrhea.

Additional Oral Care Management

As identified and prescribed by the oral health professionals

Additional Tooth Remineralisation

Rationale

Amorphous calcium phosphate is used to increase remineralisation of decayed teeth.

Oral Health Care

After brushing teeth with fluoride toothpaste morning and night, smear the amorphous calcium phosphate product over the teeth and leave on.

Use an amorphous calcium phosphate product as prescribed by the oral health professional.

Caution

This product is not suitable for residents with a milk protein allergy. However, it can be used for residents who are lactose intolerant.

Treatment of Xerostomia (Dry Mouth)

Rationale

Saliva substitutes are the preferred treatment for xerostomia (dry mouth).

Oral Health Care

Apply dry mouth product to oral tissues, teeth and the fitting surface of rinsed dentures:

- before bed
- upon awakening
- before eating
- as required.

A dry mouth product best suited to the resident can be recommended by the oral health professional. There are a variety of products available.

Bleeding Gums - An Indication of Gingivitis

Rationale

Bleeding gums are a sign of dental plaque build up.

Continued brushing is the best method to remove dental plaque and reduce gum disease.

Oral Health Care

Continue to brush teeth and gums with high fluoride toothpaste morning and night.

Gum bleeding should stop as the dental plaque build up is removed. If it does not resolve after seven days, seek physician referral as it may be an indication of a general health problem.

If gum inflammation is severe, seek physician or dental referral for additional antibacterial treatment.

Use a soft toothbrush to apply a pea-size amount of high-strength chlorhexidine daily after lunch.

Use a soft toothbrush

Use a high strength chlorhexidine product (alcohol free and non-teeth staining)-

Caution

Do not use chlorhexidine and toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Ulcers and Sore Spots

Rationale

Normal saline promotes healing and granulation of tissue.

Oral Health Care

Rinse or swab the mouth with warm normal saline three to four times a day until healed.

Assess if the denture is the cause of irritation. If so, remove it until the oral tissue is healed.

If the ulcer does not resolve after seven days, seek a physician referral as it may be an indication of a general health problem.

Avoid acidic or spicy foods and foods with sharp edges until the oral tissue is healed.

Offer cold, soft foods.

Seek physician referral for pain relief as required.

Offer a warm normal saline mouth toilet three to four times a day.

Give oral pain relief medication as prescribed by the physician or oral health professional.

Fungal Infections - Glossitis, Thrush, Denture Stomatitis, Angular Cheilitis

Rationale

Treat fungal infection and prevent re-infection.

Oral Health Care

Seek a physician or dental referral for antifungal medication.

If the infection is localised, remove the denture while administering a lozenge or application of oral antifungal gel to the affected area.

Antifungal gel can also be applied to the fitting surface of a rinsed denture.

If the tongue is coated, brush it with a soft toothbrush to clean the surface.

Replace the toothbrush before treatment commences and again when treatment is completed.

Remove denture at night or at least for several hours during the day.

Disinfect denture and denture container daily, until infection is resolved.

If treating angular cheilitis, apply an antifungal gel as prescribed to corners of the mouth. Once resolved, maintain health of the corners of the mouth by regularly applying a water-based lip moisturiser.

Provide treatment as prescribed by the physician or oral health professional.

Fungal Infections - Glossitis, Thrush, Denture Stomatitis, Angular Cheilitis (Continued)

Disinfect Denture

Take care with the choice of denture disinfection products as some may cause metal components of partial dentures to corrode.

The following may be used.

- Chlorhexidine (with or without alcohol).
- Commercial denture cleaning tablet.

—The denture tablet used should clearly identify whether it is suitable for full plastic or metal partial dentures or both.

Caution

Excessive soaking in chlorhexidine may cause discolouration.

Allergy Alert

Persulphate (persulfate), a denture cleanser ingredient, may cause an allergic reaction. This may happen quickly or after many years, even with correct use.

Symptoms include irritation, tissue damage, gum tenderness, breathing problems and low blood pressure. If symptoms occur remove dentures and refer to a physician or oral health professional.

Poorly Fitting Dentures

Rationale

Poorly fitting dentures can cause sore spots and ulcers and may interfere with talking and eating.

Check and seek treatment for dry mouth, as it can contribute to poorly fitting dentures.

Oral Health Care

Add a small amount of denture adhesive cream, strips or powder to the underside of the denture.

Denture adhesive must be cleaned off the gums and denture at each oral hygiene session, before being reapplied.

Seek a dental referral if the denture continues to be poorly fitting.

Use a denture adhesive product best suited for the resident and recommended by the oral health professional.

Dental Pain

Rationale

It is quite common for residents to suffer pain from a dental origin but they are unable to articulate the cause.

Assess oral health to identify the cause of oral pain.

Assess for responsive behaviour and whether it is related to the oral pain.

Commence a pain chart.

Provide pain relief as per the medication chart.

Seek a physician or dental referral for further treatment options.

Oral Health Care

Treat the oral condition (ulcer/sore spot), if appropriate.

Provide pain relief and treatment options as prescribed by the physician or oral health professional.

Oral Care and Responsive Behaviour

Responsive Behaviour

Rationale

Some resident behaviour, particularly involving dementia, makes it difficult for staff to provide oral health care.

Oral Health Care

Establish effective verbal and non-verbal communication.

Develop ways to improve access to the resident's mouth.

Develop strategies to manage responsive behaviour.

Use oral aids such as a modified toothbrush or mouth prop.

Use modified oral care application techniques as short-term alternatives to brushing.

Seek physician or dental referral to review oral care.

Use a soft toothbrush suitable for bending.

Use a brightly coloured toothbrush.

Use mouth props (but only if trained in their use).

Use modified oral health care application techniques.

Use a chlorhexidine mouthwash (alcohol free and non-teeth staining) as prescribed by the physician or oral health professional.

Palliative Oral Care Considerations

Palliative Oral Care

Rationale

Refer to Palliative Care Protocols as endorsed by the residential aged care facility.

Xerostomia (dry mouth) is common at the end stage of life.

Oral Health Care

Use the standard protective oral hygiene regimen and any additional treatment as prescribed, as long as it is appropriate, and then use modified oral health care application techniques.

Apply dry mouth products.

Use spray bottle application for products such as a chlorhexidine (alcohol free and non-teeth staining) mouthwash. Follow the Long Term Care home's infection control guidelines for decanting the solution or have a pharmacist do this.

Apply water-based lip moisturisers.

Caution

Petroleum-based lip moisturisers may increase the risk of inflammation and aspiration pneumonia and are contraindicated during oxygen therapy.

Do not use mouthwashes and swabs containing the following as they may damage oral tissues and may increase the risk of infection:

- alcohol
- hydrogen peroxide
- sodium bicarbonate (high-strength)
- lemon and glycerine.

The use of pineapple and other juices may also damage oral tissues.

Oral Health Care Plan

Oral Health Assessment (OHA) Date: _____ (OHA) Review Date: _____

Oral Health Care Considerations

Problems: ☐ difficulty swallowing ☐ difficulty moving head ☐ difficulty opening mouth ☐ fear of being touched

Interventions: ☐ bridging ☐ modelling ☐ hand over hand ☐ distraction (activity board/toy) ☐ alternative provider
☐ other _____

Daily Activities of Oral Hygiene

	Morning	After Lunch	Night
Natural Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist Replace toothbrush (once every 3 months) Date: _____	<input type="checkbox"/> clean teeth, gums, tongue	<input type="checkbox"/> rinse mouth with water <input type="checkbox"/> antibacterial product (teeth & gums)	<input type="checkbox"/> clean teeth, gums, tongue
Denture <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Upper <input type="checkbox"/> Lower Inserted / removed by: <input type="checkbox"/> Self <input type="checkbox"/> Staff Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture	<input type="checkbox"/> rinse mouth with water <input type="checkbox"/> rinse denture <input type="checkbox"/> antibacterial product (gums)	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture with mild soap <input type="checkbox"/> leave dentures out overnight <input type="checkbox"/> soak denture in cold water Disinfect dentures (weekly) Specify day: _____

Oral Hygiene Aids

☐ soft toothbrush ☐ modified toothbrush ☐ toothbrush grip ☐ denture brush ☐ spray bottle (labelled)

Oral Health Care Products

☐ mild soap (denture) _____ ☐ antibacterial product _____ ☐ saliva substitute _____
☐ lip moisturiser _____ ☐ fluoride toothpaste _____

Additional Oral Care Instruction

☐ antifungal gel _____ ☐ denture adhesive _____
☐ interproximal brush ☐ tongue scraper ☐ normal saline solution

Check daily, document and report:

- bad breath
- bleeding gums
- lip blisters/sores/cracks
- tongue for any coating/change in colour
- sore mouth or gums
- mouth ulcer
- swelling of face/mouth
- broken / lost denture
- difficulty eating
- refusal of oral care
- denture not named
- excessive food left in mouth
- broken teeth

Signed: _____

Date: _____





Dental Referral Protocol

The Dental Referral Protocol provides information on how to support a dentist visiting the Long Term Care home.

This section of the Portfolio identifies the breakdown of responsibilities amongst the Long Term Care home, the oral health professional and the resident and their family.

Suggested guides for Consent and Medical History forms are included and can be downloaded from the CD.

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Appendix-4: Staff Portfolio

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*

Staff Portfolio: care aides Education and Training Program

The Staff Portfolio is designed to be given to Long Term Care staff attending oral health education and training. It is part of a suite of three Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Portfolios:

- The Professional Portfolio for Nurses
- The Educators' Portfolio for delivery of the Education and Training Program
- The Staff Portfolio for care aides

The Portfolios were developed by the Better Oral Health in Residential Care Project funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) Program. This project was lead by SA Dental Service with the support of Consortium members during 2008-09.

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Module 1 | Good Oral Health is essential for Overall Health

Module 1

Good Oral Health is Essential for Overall Health

Module 1 | Good Oral Health is Essential for Living | 1

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*

Oral diseases and conditions can have social impacts on quality of life, including comfort, eating, pain and appearance, and are related to dentate status... 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.

Chalmers, JM 2003, 'Oral health promotion for our ageing Australian population', Australian Dental Journal; vol. 48, no.1, pp.2-9.

The Facts

More LTC home residents have their natural teeth.

Many residents take medications that contribute to dry mouth.

The onset of major oral health problems takes place well before an older person moves into Long Term Care home.

As residents become frailer and more dependent, they are at high risk of their oral health worsening in a relatively short time if their daily oral hygiene is not maintained adequately.

A simple protective oral health care regimen will maintain good oral health.

Quality of Life

Poor oral health will significantly affect a resident's quality of life in many ways:

- bad breath
- bleeding gums, tooth decay and tooth loss
- appearance, self-esteem and social interactions
- speech and swallowing
- ability to eat, nutritional status and weight loss
- pain and discomfort
- change in behaviour.

Impact on General Health

Oral integrity is as important as skin integrity in protecting the body against infection.

When this defence barrier is broken because of poor oral health, the bacteria in dental plaque can enter airways and the bloodstream. This can cause infection of tissues far away from the mouth and may contribute to:

- aspiration pneumonia
- heart attack
- stroke
- lowered immunity
- poor diabetic control.

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by the licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses.

2. Oral Health Care Plan

OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen.

3. Daily Oral Hygiene

Care aides maintain daily oral hygiene according to the oral health care plan.

4. Dental Treatment

Referrals for more comprehensive dental examination and treatment are made on the basis of an oral health assessment. It is recognized many residents may be best treated at the Long Term Care home.



Common Oral Health Conditions experienced by Residents

This section examines common oral health conditions experienced by residents.

When doing a resident's oral hygiene, nurses and care aides should check daily for signs of the following conditions. Changes should be documented and reported.

Daily Check, Document and Report		
Lips <ul style="list-style-type: none"> • sore corners of mouth (angular cheilitis) Tongue <ul style="list-style-type: none"> • sore tongue (glossitis) • thrush (candidiasis) 	Gums and Tissues <ul style="list-style-type: none"> • gum disease (gingivitis) • severe gum disease (periodontitis) • oral cancers • ulcers and sore spots • sore mouth (stomatitis) Saliva <ul style="list-style-type: none"> • dry mouth (xerostomia) 	Natural Teeth <ul style="list-style-type: none"> • tooth decay (caries) • root decay (root caries) • retained tooth roots Dentures <ul style="list-style-type: none"> • requiring attention • poorly fitting Oral Cleanliness <ul style="list-style-type: none"> • poor oral hygiene



Lips

Sore Corners of Mouth (Angular Cheilitis)

Bacterial or fungal infection which occurs at the corners of the mouth.

Check for:

- soreness and cracks at corners of the mouth.

Tongue

Sore Tongue (Glossitis)

This is commonly caused by a fungal infection.

It may be a sign of a general health problem.

Check for:

- a reddened, smooth area of tongue
- a tongue which is generally sore and swollen.

Thrush (Candidiasis)

This is a fungal infection of oral tissues.

Check for:

- patches of white film that leave a raw area when wiped away
- red inflamed areas on the tongue.

Gums and Tissues



Gum Disease (Gingivitis)

This is caused by the bacteria in dental plaque accumulating on the gum line at the base of the tooth.

It gets worse and more common with age.

Check for:

- swollen red gums that bleed easily when touched or brushed
- bad breath.

Severe Gum Disease (Periodontitis)

This causes gums and bone that support the teeth to breakdown.

This condition can impact seriously on general health and wellbeing.

Check for:




- receding gums
- exposed roots of teeth
- loose teeth
- tooth sensitivity
- bad breath.

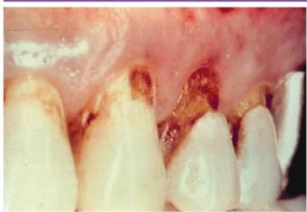


Oral Cancers

Oral cancer is a major cause of death. People who smoke and drink alcohol heavily are at higher risk.

Check for:

- ulcers that do not heal within 14 days
- a white or red patch or change in the texture of oral tissues
- swelling
- unexplained changes in speech
- difficulty in swallowing.

Gums and Tissues (Continued)	Saliva
 	
<p>Ulcers & Sore Spots</p> <p>These are caused by chronic inflammation, a poorly fitting denture or trauma.</p> <p>Ulcers may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • sensitive areas of raw tissue caused by rubbing of the denture (particularly under or at the edges of the denture) • broken denture • broken teeth • difficulty eating meals • responsive behaviour. 	<p>Sore Mouth (Stomatitis)</p> <p>Usually, this is caused by a fungal infection.</p> <p>It is commonly found where oral tissue is covered by a denture.</p> <p>It may be a sign of a general health problem.</p> <p>Check for:</p> <ul style="list-style-type: none"> • red swollen mouth usually in an area which is covered by a denture. <p>Dry Mouth (Xerostomia)</p> <p>This can be a very uncomfortable condition caused by medications, radiation and chemotherapy or by medical conditions such as Sjögren's syndrome and Alzheimer's disease.</p> <p>Check for:</p> <ul style="list-style-type: none"> • difficulty with eating and/or speaking • dry oral tissues • small amount of saliva in the mouth • saliva which is thick, stringy or rope-like.

Natural Teeth		
		
<p>Tooth Decay (Caries)</p> <p>Tooth decay is a diet and oral hygiene related infectious disease which affects the teeth and causes pain.</p> <p>Check for:</p> <ul style="list-style-type: none"> • holes in teeth • brown or discoloured teeth • broken teeth • bad breath • oral pain and tooth sensitivity • difficulty eating meals • responsive behaviour. 	<p>Root Decay (Root Caries)</p> <p>Gums recede and the surface of the tooth root is exposed.</p> <p>Decay can develop very quickly because the tooth root is not as hard as tooth enamel.</p> <p>Check for:</p> <ul style="list-style-type: none"> • tooth sensitivity • brown discolouration near the gum line • bad breath • difficulty eating meals • responsive behaviour. 	<p>Retained Roots</p> <p>The crown of the tooth has broken or decayed away.</p> <p>Check for:</p> <ul style="list-style-type: none"> • broken teeth • exposed tooth roots • oral pain • swelling • bad breath • trauma to surrounding tissues from sharp tooth edges • difficulty eating meals • responsive behaviour.

Dentures



Requiring Attention

The denture is in need of repair or attention.

Check for:

- resident's name on the denture
- chipped or missing teeth on the denture
- chipped or broken acrylic (pink) areas on the denture
- bent or broken metal wires or clips on a partial denture.



Poorly Fitting

A denture can cause irritation and trauma to gums and oral tissues.



Check for:

- denture belonging to resident
- dentures being a matching set, particularly if the resident has several sets of dentures
- denture movement when the resident is speaking or eating
- resident's refusal to wear the denture
- overgrowth of oral tissue under the denture
- ulcers and sore spots caused by wearing the denture.

Oral Cleanliness



Poor Oral Hygiene

Poor oral hygiene allows the bacteria in dental plaque to produce acids and other substances that damage the teeth, gums and surrounding bone.



Dental plaque begins as an invisible film that sticks to all surfaces of the teeth, including the spaces between the teeth and gums. It forms continuously and must be removed by regular brushing. If dental plaque is not removed, it hardens into calculus (tartar).



Check for:

- build up of dental plaque on teeth, particularly at the gum line
- calculus on teeth, particularly at the gum line
- calculus on denture
- unclean denture
- bleeding gums
- bad breath
- coated tongue
- food left in the mouth.



Oral Health Care and Responsive Behaviour

Responsive Behaviour

Residents, especially residents suffering dementia, can behave in a way that makes it difficult to provide oral health care. They may display responsive behaviour, such as the following:

- fear of being touched
- not opening the mouth
- not understanding or responding to directions
- biting the toothbrush
- grabbing or hitting out.

Oral Health Care

Establish effective verbal and non-verbal communication.

Develop ways to improve access to the resident's mouth.

Develop strategies to manage responsive behaviour.

Use oral aids such as a modified toothbrush or mouth prop.

Use modified oral care application techniques as short-term alternatives to brushing.

Seek dental referral to review oral care.

Oral Hygiene Products & Aids



- Use a soft toothbrush suitable for bending.
- Use a brightly coloured toothbrush.
- Use mouth props (but only if trained in their use).
- Use modified oral health care application techniques; for example, spray bottle.
- Use a chlorhexidine mouthwash (alcohol free and non-teeth staining) as prescribed by the GP or dentist.

Effective Communication



Talk Clearly

- Speak clearly and at the resident's pace.
- Speak at a normal volume.
- Always explain what you are doing.
- Use words the resident can understand.
- Ask questions that require a yes or no response.
- Give one instruction or piece of information at a time.

Use reassuring words and positive feedback.

Use words that impart an emotion; for example, 'lovely' smile or 'sore' mouth.

Observe the resident closely when you are talking with him or her. A lack of response, signs of frustration, anger, disinterest or inappropriate responses can all suggest the communication being used is too complex.

Effective Communication Strategies (continued)



Caring attitude

- Firstly, focus on building a good relationship with the resident before you start oral care.
- Use a calm, friendly and non-demanding manner.
- Smile and give a warm greeting using the resident's given name. Using the given name is more likely to engage the resident.
- Allow plenty of time for the resident to respond.
- If you cannot remain calm, try again at another time or get assistance.



The Right Environment

- Choose the location where the resident is most comfortable. This may be the bedroom where there are familiar things or the bathroom because this is the usual place for oral care.
- Maintain regular routines.
- Ensure there is good lighting as residents with dementia need higher levels of lighting.
- Use a brightly coloured toothbrush so it can be seen easily by the resident.
- If possible, turn off competing background noise such as the television or radio.



Body Language

- Approach the resident from the diagonal front and at eye level. By standing directly in front you can look big and are more likely to be grabbed or hit.
- Touch a neutral place such as the hand or lower arm to get the resident's attention.
- Position yourself at eye level and maintain eye contact if culturally appropriate.
- Be aware that the personal spaces of residents can vary.
- Be consistent in your approach and maintain a positive expression and caring language.

Improve Access



Overcoming Fear of Being Touched

The resident may respond fearfully to intimate contact when the relationship with you has not been established.

Firstly, concentrate on building up a relationship with the resident. Once you have engaged the resident, gently and smoothly stroke the resident's face. The aim is to relax the resident and create a sense of comfort and safety.

This process may need to be staged over time until the resident becomes trusting and ready to accept oral care.



Bridging

Bridging aims to engage the resident's senses, especially sight and touch, and to help the resident understand the task you are trying to do for him or her.

Undertake this method only if the resident is engaged with you.

Describe the toothbrush and show it to the resident.

Mimic brushing your own teeth so the resident sees physical prompts, and smile at the same time.

Place a brightly coloured toothbrush in the resident's preferred hand (usually the right hand).

The resident is likely to mirror your behaviour and begin to brush his or her teeth.



Modelling

If the resident does not initiate brushing his or her teeth through bridging, gently bring the resident's hand and toothbrush to his or her mouth, describing the activity and then letting the resident take over and continue.

Improve Access (Continued)



Hand over hand

If modelling does not work, then place your hand over the resident's hand and start brushing the resident's teeth so you are doing it together.



Distraction

If the hand over hand method is not successful, place a toothbrush or a familiar item (such as a towel, cushion or activity board) in the resident's hand while you use the other toothbrush to brush the resident's teeth.

Familiar music may also be useful to distract and relax the resident during oral care.



Alternative provider

If your relationship with the resident is not working and attempts at oral care are not going well, then tell the resident that you will leave it for now. Ask for help and have someone else take over the oral care.

Manage Responsive Behaviour (First Stage Dementia)

Responsive Behaviour

The resident has delusions.

The resident may think:

- you are not who you are
- you are trying to hurt or poison him or her
- he or she has cleaned their teeth already

What To Do

Mime what you want the resident to do.

Allow the resident to inspect the items.

Take the resident to another room; for example, move from the bedroom to the bathroom.

Manage Responsive Behaviour (Second Stage Dementia)

Responsive Behaviour

The resident grabs out at you or grabs your wrist.

What To Do

Pull back and give the resident space.

Ask if the resident is OK.

Offer the resident something to hold and restart oral care.

Responsive Behaviour

The resident hits out.

What To Do

Think about what may have caused the resident's behaviour.

Was the resident startled?

Did something hurt?

Was the resident trying to help but the message was mixed?

Was the resident saying 'stop'?

Did the resident feel insecure or unsafe?

Responsive Behaviour

The resident walks away.

What To Do

Allow the resident to perch rather than sit.

Perching is resting the bottom on a bench or table.

Manage Responsive Behaviour (Third Stage Dementia)

Responsive Behaviour

The resident does not open his or her mouth.

What To Do

Stimulate the resident's root reflex with your finger by stroking the resident's cheek in the direction of the mouth.

Place toothpaste on the top lip to prompt the resident to lick his or her lips.

Responsive Behaviour

The resident keeps turning his or her face away.

What To Do

Reposition yourself.

Sit the resident upright.

Stimulate the resident's root reflex with your finger by stroking the resident's cheek in the direction of the mouth. The resident's head will turn to the side which is being stroked.

Responsive Behaviour

The resident bites the toothbrush.

What To Do

Stop moving the toothbrush.

Ask the resident to release it.

Distract the resident with gentle strokes to the head or shoulder, using soothing words.

Responsive Behaviour

The resident holds onto the toothbrush and does not let go.

What To Do

Stroke the resident's forearm in long, gentle rhythmic movements as a distraction and to help relax the resident.

Responsive Behaviour

The resident spits.

What To Do

Ensure you are standing to the side or diagonal front.

Place a face washer or paper towel on the resident's chest so you can raise it to catch the spit.

Modified Oral Hygiene Methods



Wipe fluoride toothpaste onto teeth

Instead of brushing teeth, try wiping a smear of toothpaste along the teeth with a toothbrush.

Alternatively, a chlorhexidine gel can be applied the same way.

This does not replace brushing but is a short-term alternative.



Mouth props

Mouth props can be used for residents who clench or bite or who have difficulty opening their mouth. Use mouth props only if you have been trained to do so.

Caution

Never place your fingers between the teeth of a resident.

Modified Oral Hygiene Methods (Continued)



Modified Soft Toothbrush

A backward bent toothbrush can be used to retract the cheek, while another brush is used to brush the resident's teeth.

Use one hand in a 'pistol grip' to support the chin and roll down the lower lip while you insert a backward toothbrush and retract the cheek. Release your grip to hold the backward bent brush and use another toothbrush in your other hand to brush the resident's teeth.

To bend a soft toothbrush handle:

- place the brush in a cup of hot water to soften the plastic
- apply downward pressure on the brush until it bends to a 45 degree angle
- take care as some brands of toothbrush may snap
- clear plastic toothbrushes are the easiest to bend.



Use of a Spray Bottle

If it is difficult to brush or smear fluoride toothpaste or chlorhexidine gel onto the teeth, a chlorhexidine mouthwash can be sprayed into the mouth.

This does not replace brushing but is a short-term alternative.

The mouthwash should be placed undiluted into a spray bottle. You must follow the residential aged care facility's infection control guidelines for decanting the mouthwash, or have a pharmacist do this for you.

The spray bottle must be labelled with the resident's name and the contents.

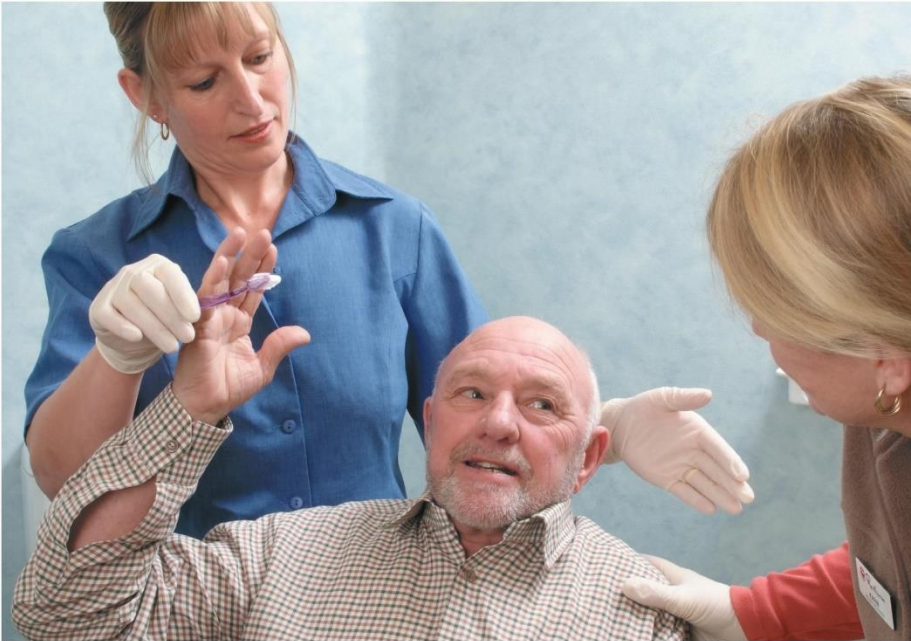
Spray four squirts directly into the mouth. Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Do not use chlorhexidine and fluoride toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Refusal of Oral Care



Review what you are doing

Are you using the right oral hygiene aids?

Are you approaching with a caring attitude?

Is your language and expression effective?

Is the resident not concentrating or participating because of the environment?

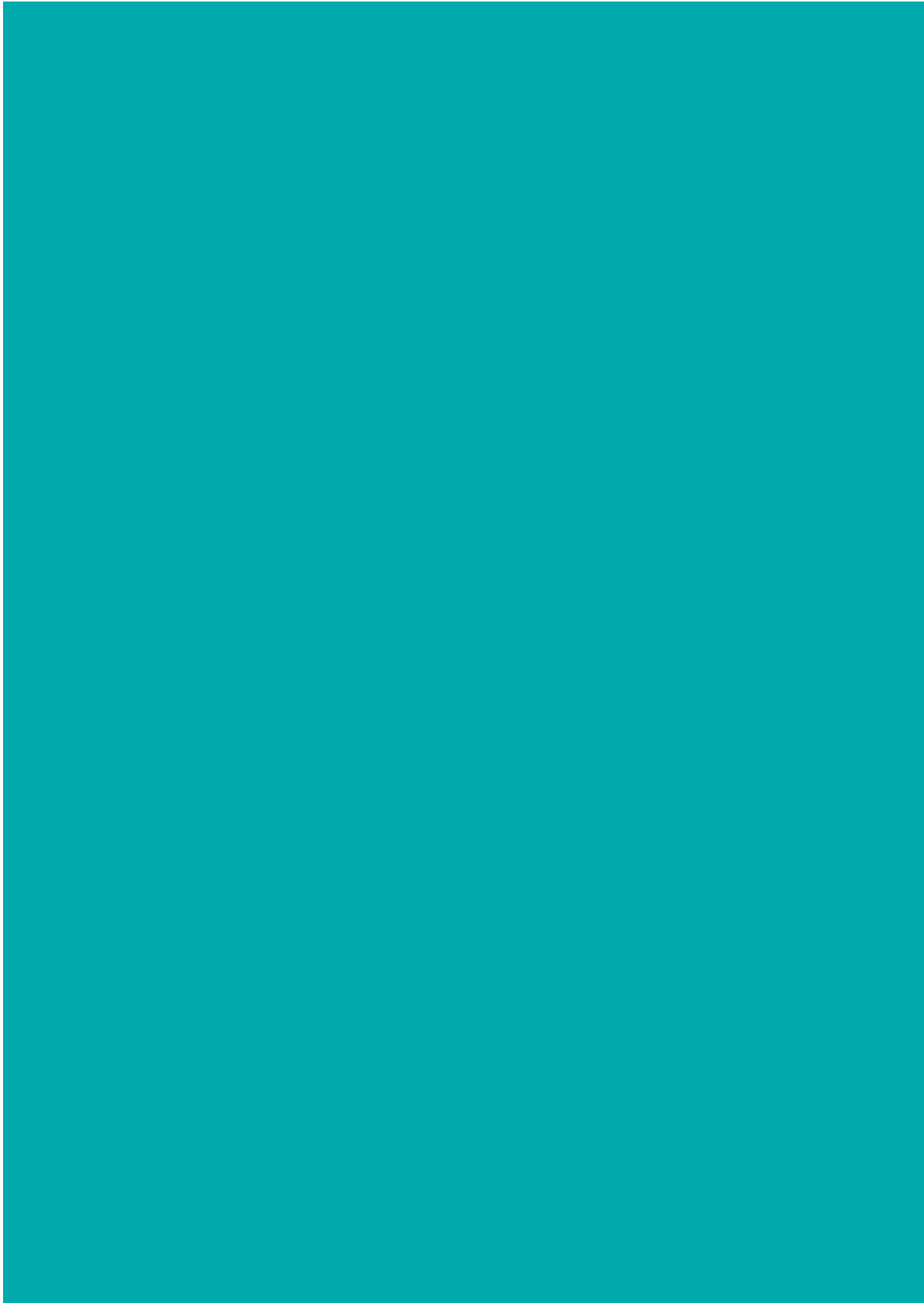
Is it the right room or location for the resident?

Is your approach familiar to the person?

Is the time of the day best for the person, such as morning versus evening?

Ask others, including family, for ideas.

Ask for help.





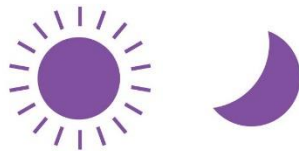
Module 2

Protect your Residents' Oral Health

Six of the Best Ways to Maintain a Healthy Mouth

Protect your Residents' Oral Health

Brush Morning and Night



Fluoride Toothpaste on Teeth



Soft Toothbrush on Gums, Tongue and Teeth



Antibacterial Product After Lunch



Keep the Mouth Moist



Cut Down on Sugar





Care of Natural Teeth

Teeth are mainly made up of minerals including calcium. Bacteria in dental plaque convert sugars into acid, which can dissolve the minerals out of teeth. If the teeth are not cleaned, this can lead to decay (caries) in the teeth and lead to tooth infections and pain. Good oral hygiene is extremely important to help avoid tooth decay. Fluoride toothpaste helps strengthen teeth as well as reverse the effects of the acid produced by the bacteria in dental plaque.

Rationale	Recommended Oral Health Care
<p>Strengthen Teeth</p> <p>Fluoride toothpaste strengthens teeth.</p> <p>Encourage the resident to spit and not rinse the mouth after brushing so the fluoride can soak into the teeth.</p> <p>Brushing</p> <p>Brushing is the best way to remove dental plaque.</p> <p>A soft toothbrush is gentle on oral tissues and is more comfortable for the resident.</p> <p>Brushing before bed is important as bacteria can grow in number by as much as 30 times overnight.</p>	<p>Use fluoride toothpaste morning and night. (presence of Canadian Dental Association symbol denotes fluoride in toothpaste)</p>  <p>Use a soft toothbrush to brush teeth, gums and tongue morning and night.</p> <p>Encourage the resident to spit and not to rinse the mouth after brushing, so the fluoride can soak into the teeth.</p> <p>Encourage the resident to drink water after meals, medications, other drinks and snacks to keep the mouth clean.</p>

Oral Hygiene Aids & Products



Use a fluoride toothpaste (presence of Canadian Dental Association symbol denotes fluoroide in toothpaste)



Use a soft toothbrush suitable for bending

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Protective eyewear/face shields
- Protective clothing
- Mask

Toothbrush Alternatives



ModifiedSoftToothbrush

A soft toothbrush can be bent to give better access to the mouth.

A forward bent toothbrush can be used to brush the inner upper and lower teeth.

A backward bent toothbrush can be used to retract the cheek, while another brush is used to brush the resident's teeth.



Electric Toothbrush

An electric toothbrush may help residents with limited manual dexterity, due to stroke or arthritis for example, to manage brushing by themselves.

Vibration can be a problem for some residents.

Cost and maintenance can be a barrier.

This type of brush is recommended if the resident is currently using one.



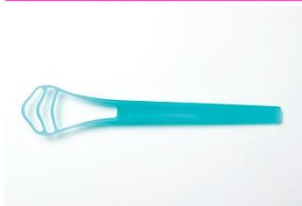
Interproximal Brush

This type of brush is ideal for cleaning the larger spaces between teeth, underneath bridges, around crowns and between tooth roots where gum recession has occurred.

The brush can also be used to apply antibacterial gels between the teeth.

Interproximal brushing does not replace normal toothbrushing. The brushing of teeth, gums and tongue must still take place with a soft toothbrush.

Additional Oral Hygiene Aids



Tongue Scraper

This can be used as an alternative when a toothbrush is not able to clean the surface of the tongue sufficiently; for example, when thrush is present.



Hand Grip

This is useful for residents with reduced grip strength.

Toothpaste Application



Use fluoride toothpaste morning and night.

Only a small pea-sized amount of toothpaste is required.

Positioning



When the resident requires assistance, try different positions to suit the situation.

Standing in front position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrushing Technique Lower Teeth



Tooth brushing Technique Upper Teeth



Toothbrushing

Place the toothbrush at a 45 degree angle to the gum line.

Gently brush front, back and chewing surfaces of the teeth and gums in a circular motion. Give particular attention to the gum line.

If some teeth are missing, make sure all surfaces of single teeth are cleaned.

Encourage the resident to spit and not rinse the mouth after brushing, so the fluoride soaks into the teeth.


Bleeding Gums

Report this as it may be a sign of a general health problem.

Bleeding is usually caused by the build up of dental plaque. Brushing is the best way to remove the dental plaque and heal the gums.

Continue to brush teeth (with particular attention to the gum line) with a soft toothbrush twice a day. The bleeding should resolve in a week.

Tongue Cleaning	Alternative Toothbrushing Techniques	
		
<p>Ask the resident to stick out the tongue. Scrape the tongue carefully from back to front.</p> <p>Do not go too far back as it will cause the resident to gag.</p>	<p>Electric Toothbrush</p> <p>Turn the brush on and off while it is in the mouth, to limit toothpaste splatter. Use the vibrating brush to reach all surfaces of the teeth and gums.</p>	<p>Interproximal Brush</p> <p>Brush into the space between the teeth at the level of the gum and gently move back and forth to remove dental plaque and food.</p> <p>An interproximal brush can also be used to apply antibacterial product between the teeth.</p>

Toothbrush Care		
		
<p>After Brushing</p> <p>Thoroughly rinse the toothbrush under running water.</p> <p>Tap the toothbrush on the sink to remove excess water.</p> <p>Store the toothbrush uncovered in a dry place.</p> <p>Replace the toothbrush with a new one when:</p> <ul style="list-style-type: none"> • bristles become worn • with the change of seasons (every three months) • following a resident's illness such as a 'bad cold'. 		<p>When a resident is being treated for a fungal infection (such as thrush), replace the toothbrush when the treatment starts and again when the treatment finishes.</p> <p>If a toothbrush grip is used, remove the grip and wash and dry the toothbrush handle and grip after each use.</p>

Refusal of Oral Care	Check Daily, Document and Report	
<p>Refer to Module 1 for more information on how to manage oral care and responsive behaviour.</p>	<ul style="list-style-type: none"> • Lip blisters/sores/cracks • Tongue for any coating/change in colour • Sore mouth/gums/teeth • Swelling of face or localised swelling • Mouth ulcer • Bleeding gums • Sore teeth 	<ul style="list-style-type: none"> • Broken or loose teeth • Difficulty eating meals • Excessive food left in mouth • Bad breath • Refusal of oral care



Care of Dentures

Many problems can occur in residents with dentures. If dentures are not removed, allowing for the tissues to rest, infections such as thrush, or denture sore mouth can develop. Poorly fitting dentures can also lead to soreness or cracking at the corners of the mouth. Over time, dentures can wear out and the shape of the gums and jaws can change. Because of this, dentures may need to be relined or re-made to cater for these changes. Reduced saliva flow can also affect the ability to wear dentures comfortably.

Daily Oral Hygiene	Recommended Oral Health Care
Residents who wear dentures are at high risk of developing fungal infections (such as thrush).	Label dentures with the resident's name.
Dentures must be taken out and brushed to remove dental plaque.	Brush dentures with a denture brush morning and night, using a mild soap.
Gums and tongue should be brushed to remove dental plaque.	Rinse dentures well under running water.
Gum tissue needs time to rest from wearing dentures.	Brush gums and tongue with a soft toothbrush morning and night.
	Take dentures out of the mouth overnight, clean and soak in cold water.
	Disinfect dentures once a week.
	Encourage the resident to drink water after meals, medications, other drinks and snacks to keep the mouth clean.

Oral Hygiene Aids & Products



Use a soft toothbrush suitable for bending to brush gums, tongue and partial dentures.

Use a denture brush for full dentures.

Use mild soap (liquid or foam) for cleaning dentures – handwashing soap as supplied by the Long Term Care home should be suitable.

Provide a denture storage container (disposable or non-disposable).

Use a denture disinfection product (suitable for full or partial denture or both).

Soak dentures in white vinegar for calculus removal (not suitable for partial dentures).

Use a denture adhesive (if required).

Provide a denture labelling kit (if required).

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Mask
- Protective eyewear/face shields
- Protective clothing

Denture Care



Label Dentures

Dentures must be labelled with the resident's name.

Dentures are best named permanently by a dental professional, ideally when the denture is made.

To temporarily name dentures:

- lightly sandpaper the pink acrylic on the outside (cheek side) of the denture
- write the resident's name in permanent marker
- using several coats of sealing liquid or clear nail polish to cover the name.

The denture storage container should also be labelled with the resident's name.

Daily Denture Care

Either remove dentures after each meal and rinse mouth and denture with water or encourage the resident to drink water after meals to help keep the mouth clean.

Brush dentures morning and night.

Encourage the resident to remove dentures overnight to rest the gums.

Soak cleaned dentures in a denture container of cold water.

Do not let dentures dry out completely.

Denture storage containers should be washed and dried daily.

Removing Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own dentures.

If the resident requires assistance, it is easier to take out the lower denture first by holding the lower front teeth with the thumb and index finger and lifting out.

To remove upper denture, break the seal by holding front teeth with the thumb and index finger and rocking the

denture up and down until the back is dislodged.

Remove the denture at a sideways angle.

If you are unable to break the seal, use a backward bent toothbrush to carefully push down on the side of the denture towards the back of the mouth until the denture is loosened and can be easily removed.

Removing Partial Denture



Before you start, ask the resident to take a sip of water to moisten the mouth.

Encourage the resident to remove his or her own partial denture.

If the resident requires assistance, place your finger tips

under the clasps that cling onto the natural teeth and push down carefully.

Gently grasp the plastic part of the denture and lift it out of the resident's mouth, taking care not to bend the wire clasps.

Brush Gums, Tongue and Teeth (Partial Denture)



Use a soft toothbrush to brush the gums morning and night. This will remove dental plaque, any food particles and stimulate the gums.

Ask the resident to stick out the tongue and brush the tongue carefully from the back to the front.

Do not go too far back as it will cause the resident to gag.

For residents who wear a partial denture, give particular attention to the teeth that support the denture clasps. Make sure all surfaces of single teeth are cleaned (including back, front and sides) with fluoride toothpaste.

Residents Who Have No Teeth and Do Not Wear Dentures

For residents who have no teeth and do not wear dentures, it is still important to brush the gums and tongue morning and night to maintain good oral health.

Use a soft toothbrush to brush the gums morning and night. This will remove dental plaque, any food particles and stimulate the gums.

Ask the resident to stick out the tongue and brush the tongue carefully from the back to the front.

Do not go too far back as it will cause the resident to gag.

Cleaning Dentures



Cleaning Technique

Clean the denture over a sink with a bowl filled with water or place a wash cloth in the base of the sink to protect the denture from breakage if dropped.

Use a denture brush and a mild soap (liquid or foam) to clean food, dental plaque and any denture adhesive from all surfaces of the denture. The handwashing soap as supplied by the Long Term Care home should be suitable for denture cleaning purposes.

Do not use normal toothpaste as it may be abrasive and over time will abrade and scratch the denture. A scratched denture can be a source of irritation and increase the risk of fungal infections.

Support the denture while cleaning as it can break very easily if dropped.

Holding a lower denture from end to end may apply force and cause the denture to break.

Cleaning Lower Denture



Cradle the lower denture between the thumb and the base of the index finger for a stable hold.

Brush all surfaces to remove dental plaque and any denture adhesive.

If the denture has been relined with a soft cushion liner, use a soft toothbrush to clean it gently.

When denture is relined, it cannot be soaked or disinfected.

Cleaning Upper Denture



Support the upper denture between the thumb and fingers for a stable hold.

Brush all surfaces to remove dental plaque and any denture adhesive.

If the denture has been relined with a soft cushion liner, use a soft toothbrush to clean it gently.

When denture is relined, it cannot be soaked or disinfected.

Cleaning Partial Denture



Use a soft toothbrush to clean metal clasps.

Gently brush around the metal clasps, taking care not to bend or move them as this will affect the denture fit.

Denture Adhesives



Residents with poorly fitting dentures, should be referred. Denture adhesives can be used to hold dentures more firmly in place and prevent dentures from rubbing. Denture adhesives come as a paste, powder or sticky strips.

Follow the product instructions for directions on how to apply the denture adhesive.

Thoroughly remove all traces of the denture adhesive from both the denture and gums morning and night.

Putting Upper Denture In



Putting Lower Denture In



Dentures must always be rinsed well under running water before being placed in the resident's mouth.

Encourage the resident to insert his or her own dentures.

If the resident requires assistance, insert the upper denture first followed by the lower denture.

Ask the resident to open his or her mouth. Hold the denture at a sideways angle as it enters the mouth and then rotate into position.

Putting Partial Denture In



Partial dentures must always be rinsed well under running water before placing them in the resident's mouth.

Encourage the resident to insert his or her own dentures.

Ask the resident to open the mouth, hold the denture at a sideways angle as it enters the mouth and then rotate and click into position.

Denture Disinfection



Disinfect dentures once a week and as directed if the resident is being treated for a fungal infection (such as thrush).

Always rinse dentures well under running water before placing in the resident's mouth.

Take care with the choice of denture disinfection products as some may cause the metal components of a partial denture to corrode. The following may be used.

Chlorhexidine solution with or without alcohol:

- This is suitable for both full plastic and partial dentures.
- Alcohol content is acceptable for this purpose as it is not in direct contact with the mouth.
- Chlorhexidine has a low allergy risk.
- Disinfect by using enough solution to cover the denture, soak for no more than 30 minutes, then rinse well.
- Follow the Long Term Care Home's infection control guidelines for decanting the solution.

Commercial denture cleansing tablet:

- The product used should clearly identify whether it is suitable for either full plastic or metal partial dentures or both.
- Follow the manufacturer's instruction for soaking time.

Caution

Excessive soaking in chlorhexidine may cause discolouration.

Allergy Alert

Persulphate (persulfate), a denture cleanser ingredient, may cause an allergic reaction. This may happen quickly or after many years, even with correct use.

Symptoms include irritation, tissue damage, gum tenderness, breathing problems and low blood pressure. If symptoms occur remove dentures and refer to an oral health professional.

Removing Calculus and Stains



Calculus (tartar) is dental plaque that has been hardened by the minerals in saliva.

Thorough daily brushing should stop calculus from forming on the denture.

To remove calculus from a full acrylic denture, soak denture in full strength white vinegar for 8 hours to soften calculus and then scrub off using a denture brush.

Caution

Vinegar has corrosive properties and is not suitable for partial dentures.

For heavy calculus, staining and for stain removal on partial dentures, cleaning by an oral health professional is recommended.

Denture Brush and Toothbrush Care



After Brushing

Thoroughly rinse the toothbrush and denture brush under running water.

Tap the brushes on the sink to remove excess water.

Store the brushes uncovered in a dry place.

Replace the brushes when:

- bristles become shaggy
- with the change of seasons (every three months)
- following a resident's illness such as a 'bad cold'

When a resident is being treated for a fungal infection (such as thrush), replace the toothbrush and denture brush when the treatment starts and again when the treatment finishes.

If a toothbrush grip is used, remove the grip and wash and dry the toothbrush handle and grip after each use.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and changed behaviour.

- Lip blisters/sores/cracks
- Tongue for any coating/change in colour
- Sore mouth/gums/teeth
- Swelling of face or localised swelling
- Mouth ulcer
- Bleeding gums
- If partial denture, sore or broken teeth
- Broken denture or partial denture
- Lost denture

Check Daily, Document & Report

- Denture not named
- Poorly fitting denture
- Stained denture
- Difficulty eating meals
- Excessive food left in mouth
- Bad breath
- Refusal of oral care



Prevention of Gum Disease (Gingivitis)

Dental plaque is the major contributor to the two main dental diseases, tooth decay and gum disease. It forms continuously on the teeth and, if left on the teeth over a period of time, it can harden to become calculus (tartar).

Severe gum disease (periodontitis) results in the break down of the gums and bone that support the teeth. This condition affects general health and wellbeing.

Daily Oral Hygiene

Antibacterial Control of Dental Plaque

Daily application of an antibacterial product can reduce harmful bacteria in the dental plaque and help to prevent gum disease. Chlorhexidine is a safe and effective antibacterial product.

Use an alcohol free product because alcohol can dry out the mouth and damage oral tissue.

Recommended Oral Health Care

Use a low-strength (0.12%) chlorhexidine product (alcohol free and non-teeth staining) applied daily after lunch for all residents.

Note

Higher-strength chlorhexidine products are used as a treatment for severe gum disease and are prescribed by the family physician or dentist.

Oral Hygiene Aids & Products



Use a soft toothbrush suitable for bending.

Use a low-strength (0.12%) chlorhexidine product (alcohol free and non-teeth staining).

Use an interproximal brush (as directed).

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Protective eyewear/face shields
- Protective clothing
- Mask

Application Techniques for Chlorhexidine Product



Resident Self Application

Before you start, ask the resident to have a drink of water or rinse the mouth with water before applying the chlorhexidine gel.

If the resident is able, put a small pea-size amount of gel on the finger and ask him or her to rub it over the teeth and gums.

If the resident has dentures, remove and rinse the dentures, apply a small pea-size amount of gel to the gums, and replace dentures.

Alternatively, the gel can be applied to the fitting side of the denture.

Caution

Do not use chlorhexidine and fluoride toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Application Techniques for Chlorhexidine Product (Continued)



Use a Toothbrush to Wipe over Teeth

If the resident requires full assistance, apply a small pea-size amount of gel to a toothbrush and wipe over the teeth and gums.

In severe cases of gum disease, an interproximal brush can be used to apply the gel into the space between the teeth at the level of the gum.

Caution

Do not use chlorhexidine and fluoride toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Never place your fingers between the teeth of a resident.

Application Techniques for Chlorhexidine Product (Continued)



Use of a Spray Bottle

If it is difficult to apply the chlorhexidine gel, an alternative is to spray a chlorhexidine mouthwash into the mouth.

The mouthwash should be placed undiluted into a spray bottle.

You must follow the residential aged care facility's infection control guidelines for decanting the mouthwash or a pharmacist may do this for you.

The spray bottle must be labelled with the resident's name and the contents.

Spray four squirts directly into the mouth. Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Do not use chlorhexidine and fluoride toothpaste (containing sodium lauryl sulphate) within 2 hours of each other, as the product effectiveness is reduced.

Some chlorhexidine mouthwashes, for example Curasept rinses, require an opaque spray bottle because the non-teeth staining formula is light sensitive.

Positioning



When the resident requires assistance, try different approaches or different positions to suit the situation.

Standing in Front Position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrush Care after Application of Chlorhexidine



After use, thoroughly rinse the toothbrush under running water.

Tap the toothbrush on the sink to remove excess water.

Store the toothbrush uncovered in a dry place.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document and Report

If a chlorhexidine product has not been applied according to the oral health care plan, document this and report.



Relief of Dry Mouth (Xerostomia)

Reduced saliva flow is known as dry mouth or xerostomia and is common in Long Term Care home. Relief from dry mouth also reduces tooth decay, gum disease and other oral diseases.

Daily Oral Hygiene	Recommended Oral Health Care
<p>Relief of Dry Mouth</p> <p>Saliva is the key to maintaining a healthy mouth.</p> <p>Medications taken by residents contribute to dry mouth.</p> <p>When the quantity and quality of saliva is reduced, oral diseases can develop very quickly.</p> <p>Dry mouth increases the incidence of mouth ulcers and oral infection.</p> <p>Dry mouth can be very uncomfortable for the resident.</p>	<p>Keep the mouth moist by frequent rinsing and sipping with water (and increase water intake if appropriate).</p> <p>Keep the lips moist by frequently applying a water-based lip moisturiser.</p> <p>Discourage the resident from sipping fruit juices, cordial or sugary drinks.</p> <p>Reduce the intake of caffeine drinks.</p> <p>Stimulate saliva production with xylitol based products as required.</p> <p>Encourage the resident to drink water after meals, medications, other drinks and snacks, to keep the mouth clean.</p>

Oral Hygiene Aids & Products



A dry mouth product best suited to the resident can be recommended by the dentist.

There are a variety of products available; for example:

- Dry Mouth gel
- Mouth spray.

Apply water-based lip moisturiser; for example, water based products or Gel.

A variety of tooth friendly xylitol based products are available.

Infection Control



Wash hands before and after oral care.

Consistent and universal use of Personal Protective Equipment includes:

- Gloves
- Protective eyewear/face shields
- Protective clothing
- Mask

Keep Mouth Moist



Encourage the resident to frequently sip cold water especially after meals, medications, other drinks and snacks.

Reduce intake of caffeine drinks such as coffee, tea.

Apply saliva substitutes according to the oral health care plan to teeth, gums, inside of cheeks, roof of mouth and the fitting surface of dentures.

Saliva substitutes are especially useful before bed, upon awakening and before eating.

If appropriate, xylitol based products may be used to stimulate saliva.

Keep Lips Moist



Apply a water-based lip moisturiser before and after mouth care and as required.

If the resident is able, put a small pea-size amount of lip moisturiser on the finger and ask him or her to rub it over the lips.

If the resident requires full assistance, apply a small pea-size amount of lip moisturiser to your gloved finger or use a swab and rub it over the lips.

Caution

Petroleum-based lip moisturisers may increase the risk of inflammation and aspiration pneumonia and are contraindicated during oxygen therapy.

Never place your fingers between the teeth of a resident.

Protect Oral Tissue



Take care when choosing oral care products as some ingredients, in particular alcohol, can dry out the mouth and damage oral tissue.

Pineapple, lemon and other citric juices may over-stimulate and exhaust the salivary glands causing the dry mouth condition to worsen.

Dry mouth products are recommended and are particularly soothing for residents receiving palliative care.

Caution

Do not use mouthwashes and swabs containing the following as they may damage oral tissues and may increase the risk of infection:

- alcohol
- hydrogen peroxide
- sodium bicarbonate (high-strength)
- lemon and glycerine.

Application Techniques for Saliva Substitutes



Resident Self Application

Before you start, ask the resident to have a drink of water or rinse the mouth with water before applying the dry mouth gel.

If the resident is able, put a small pea-size amount of gel on the finger and ask him or her to rub it over the teeth and gums.

If the resident has dentures, remove and rinse the dentures, apply a small pea-size amount of gel to the gums, and replace dentures.

Alternatively, the gel can be applied to the fitting side of the denture.

Use a Toothbrush to Wipe over Teeth

If the resident requires full assistance, apply a small pea-size amount of dry mouth gel to a toothbrush and wipe over the teeth and gums.

Use a Spray Bottle

If it is difficult to apply a gel, an alternative is to use a dry mouth spray.

Follow the manufacturer's instructions.

Take care not to spray the resident's face.

If appropriate, a backward bent toothbrush can also be used to retract the cheek, so you can gain greater access as you spray the mouth.

Caution

Never place your fingers between the teeth of a resident.

Positioning



When the resident requires assistance, try different approaches or different positions to suit the situation.

Standing in Front Position

Sit the resident in a chair facing you.

If the resident is in bed you will need to support the resident's head with pillows.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Good eye contact between you and the resident is maintained with this position.

Cuddle Position

Stand behind and to the side of the resident.

Rest the resident's head against the side of your body and arm.

Support the resident's chin with your index finger and thumb, being careful not to place pressure on the resident's throat with your remaining fingers. This is sometimes referred to as a 'pistol grip'.

The thumb holding the chin can be used to roll down and hold the lower lip for better vision and access.

Greater head control is achieved by using this position.

Toothbrush Care after Application of Saliva Substitutes



After use, thoroughly rinse the toothbrush under running water.

Tap the toothbrush on the sink to remove excess water.

Store the toothbrush uncovered in a dry place.

Refusal of Oral Care

Refer to Module 1 for more information on how to manage oral care and responsive behaviour.

Check Daily, Document and Report

If saliva substitutes have not been given as per the oral health care plan, document this and report.



Reduce Tooth Decay

Tooth decay is directly related to the frequency of eating and drinking food and drinks containing sugar. Many foods contain sugar including bread and cereals. Foods and drinks containing sugar should be limited to meal times.

Consider sugar substitutes between meals.

Daily Oral Hygiene	Recommended Oral Health Care
<p>Reduction of Sugar in Diet</p> <p>Sugars that are harmful to teeth include ordinary sugar (sucrose) which is added to many manufactured foods and fruit juice, and honey.</p> <p>Tooth decay is directly related to the frequency of sugar intake rather than the total amount of sugar eaten.</p> <p>Encourage the use of natural chemical free sweeteners such as xylitol, made from fruit and vegetables.</p>	<p>Encourage the resident to drink water to rinse the mouth after meals, medications, other drinks and snacks.</p> <p>Provide xylitol sugar substitute products. Eating too many sugar substitute products may have a laxative effect or cause flatulence.</p> <p>Encourage tooth friendly products between meals.</p>

Rinse Mouth



Water reduces the acid that causes tooth decay.
Encourage the resident to drink water to rinse the mouth after meals, medications, other drinks and snacks.
A small drink of water before bed is also encouraged.

Sugar Substitute



Use xylitol instead of sugar for sweetening tea and coffee between meals.

Normal sugar may be used for drinks and cooking at meal times.

Xylitol does not leave an after-taste like other substitute sweeteners.

Xylitol also acts like other dietary fibre and improves the health of the digestive tract. However, if it is used in excessive amounts it may cause similar discomfort as other high fibre foods, such as diarrhea.

Sugar Substitute (Continued)



Foods labelled 'no added sugar' or 'sugar free' do not necessarily mean they are tooth friendly.



Encourage residents' families to bring tooth friendly treats.
Xylitol products are safe for all consumers including children.

Caution
Foods containing xylitol may be harmful to pets.



Oral Health Care Kit

An Oral Health Care Kit should be placed in every residents wahroom.

Some of the oral health care tools may include tooth brush, toothpaste, interdental brush, mouth wash. These tools should be labelled and be placed in a metal or plastic kit.

The content of the kit will vary , depending on the type of dentition.

Natural Teeth	Natural Teeth and Denture	Complete Denture
<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash 	<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash • Non-foaming toothpaste • long handled toothbrush • Denture kits 	<ul style="list-style-type: none"> • Toothbrush • Fluoride Toothpaste • Interdental Brush • Mouthwash • Non-foaming toothpaste • long handled toothbrush • Denture kits

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Module 3

It Takes a Team Approach to Maintain a Healthy Mouth

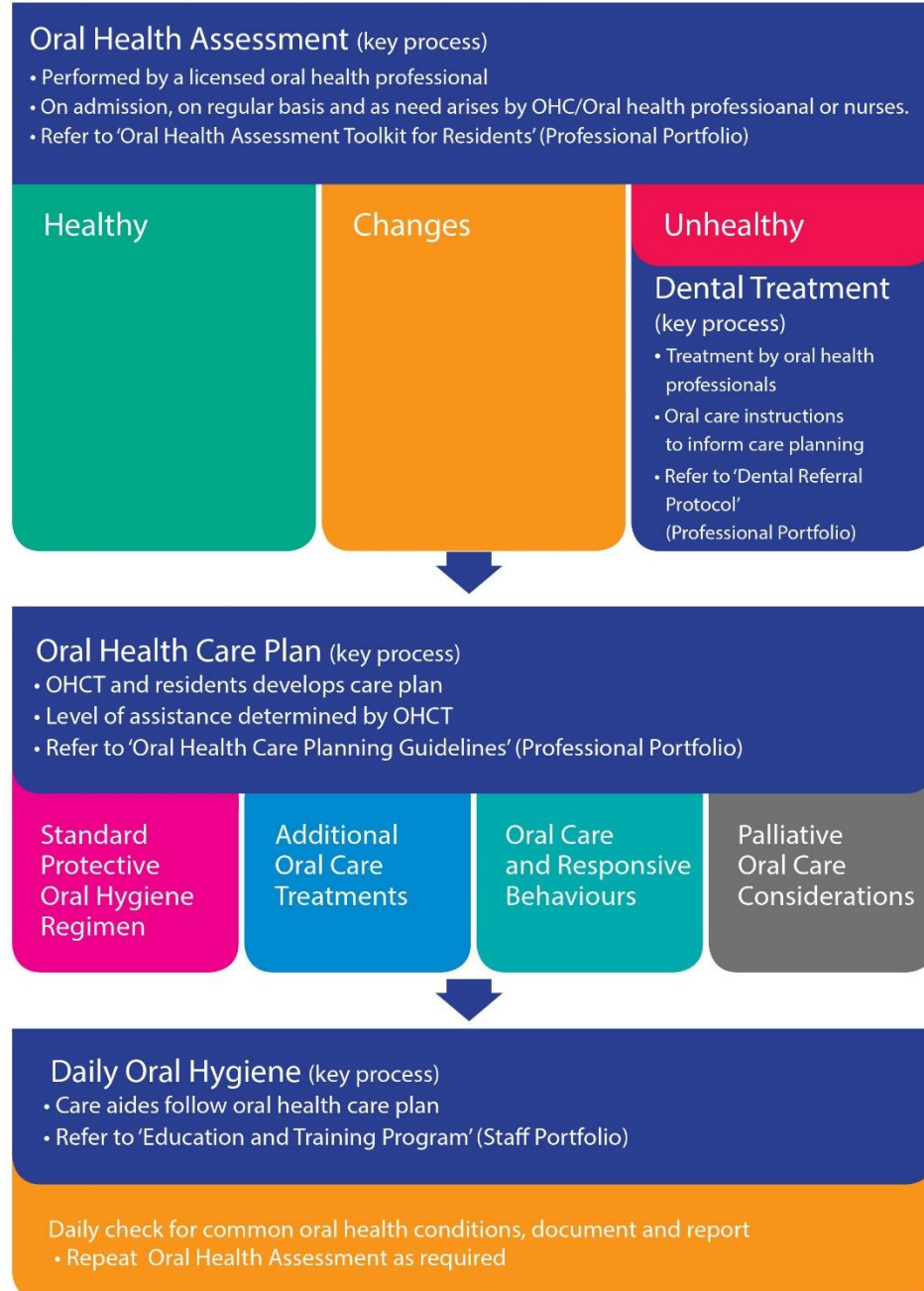
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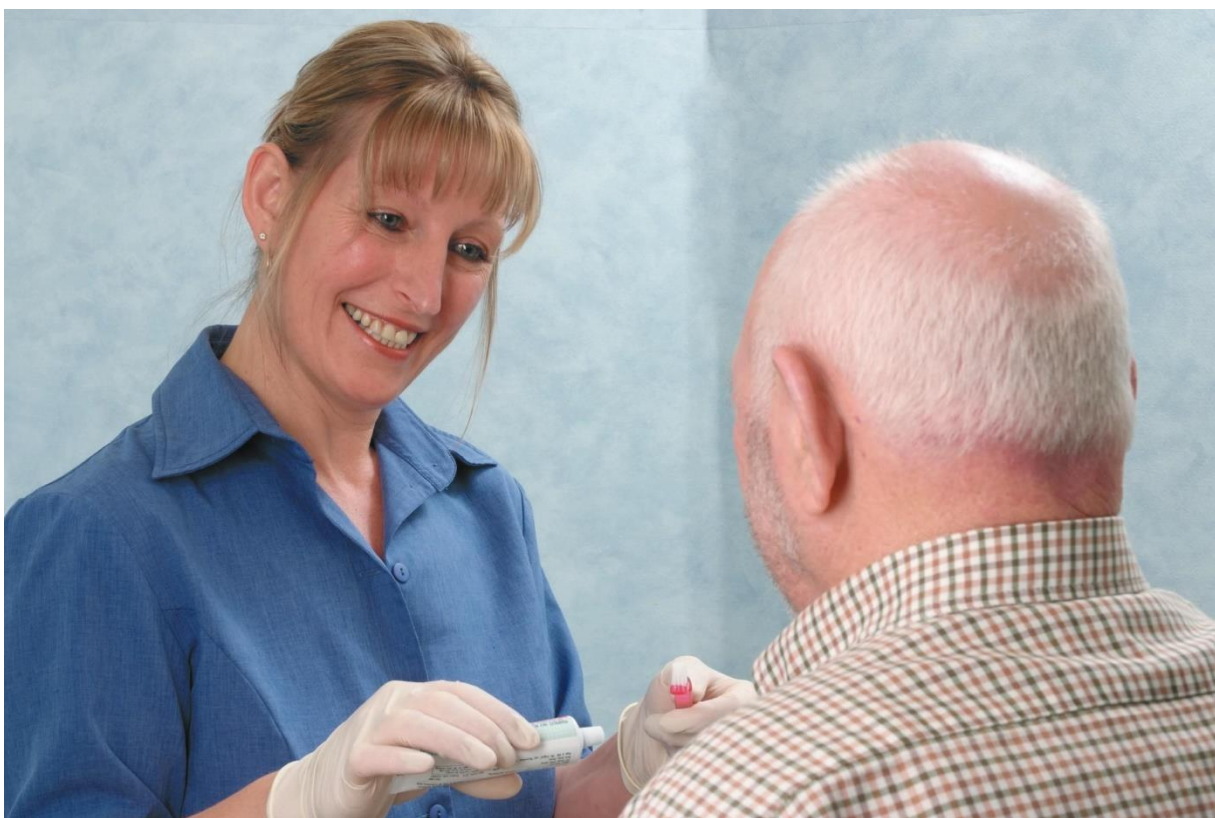
Better Oral Health in LTC - *Best Practice Standards for Saskatchewan Model*

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists).

Appropriate team members will be responsible for all of the four key processes.





Better Oral Health Reflective Practice

Module 3 brings together the content from Module 1 (knowledge) and Module 2 (skills) in a guided learning approach conducted in small groups.

The module uses clinically-based situations and guided questions to encourage reflection on and application to everyday practice.

The aim is to help Long Term Care home staff members to address situations they meet in their everyday practice and to enhance evidence based practice for better oral health in Long Term Care home.

Guided Questions

Guided questions are provided in a sequential order to encourage discussion and reflection in the following way:

- think about the scenario presented
- respond to the questions provided
- identify what knowledge and skills you have already to respond to this scenario.

Working in Groups

When working in small groups:

- take time to think and reflect before responding
- work together and help one another
- share ideas and respect each other's views
- it is OKAY to disagree but do not be judgmental
- speak one person at a time.

Oral Health Scenario – Part 1



Description

Mr Osmond is a new resident.

He is diagnosed with Parkinson's disease and found to be quite frail. He is at ease with the staff.

Mr Osmond has settled well into his new surroundings.

He has a good appetite and loves sweet foods and treats. He likes to drink coffee with two teaspoons of sugar.

Mr Osmond is sometimes forgetful but he is able to manage his activities of daily living with standby assistance and occasional prompting.

The family physician has recently put him on several new medications.

On admission, an Oral Health Assessment was performed. Mr Osmond has natural teeth and an upper partial denture. His oral health was found to be 'healthy'.

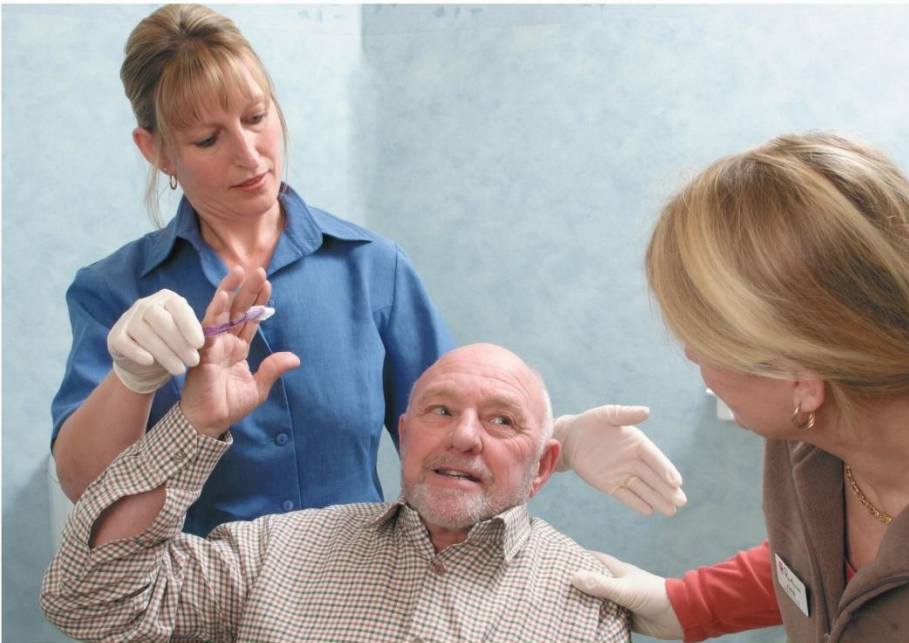
Based on this, an Oral Health Care Plan was written for Mr Osmond.

Guided Questions

What information about Mr Osmond is relevant to his oral health care?

What oral health care should you give to Mr Osmond?

Oral Health Scenario – Part 2



Description

Several months have passed.

Mr Osmond's behaviour has changed. He has recently become confused and uncooperative.

The family physician is treating him for a suspected urinary tract infection.

Mr Osmond is not cleaning his teeth and he won't let you help him. If you try, he won't open his mouth.

When Mr Osmond is like this it is easier to leave him and not do his oral hygiene care. This seems to be happening a lot. Other staff members have been doing the same and leaving out his oral hygiene care.

You notice his breath smells and it is unpleasant to be around him.

You also notice Mr Osmond is having difficulty eating his food.

Guided Questions

What could be happening here?

How might this have happened?

What could you do to encourage Mr Osmond to open his mouth?

Oral Health Scenario – Part 3



Description

You have been able to get Mr Osmond to open his mouth and you take out his partial upper denture which has metal wires.

You notice his denture is very dirty and one of the metal wires is broken.

When you look at Mr Osmond's mouth, you see the part of the mouth where the partial denture has been is red and sore.

When you brush his teeth his gums begin to bleed.

Guided Questions

Who should know about this?

What else should you look for and report?

What could happen to Mr Osmond if his oral health gets worse?

Oral Health Scenario – Part 4



Description

You assist the OHCT to do an Oral Health Assessment.

The OHCT arranges for Mr Osmond to see a dentist.

Treatment is prescribed and the Oral Health Care Plan is updated.

Guided Questions

What additional oral care could be required?

List the various ways you can apply the different types of oral care products?

List the types of Long Term Care staff and health professionals who have been involved in the oral health care of Mr Osmond.

Conclusion



Facts

As residents become frailer, they are at high risk of their oral health worsening in a relatively short time if their daily oral hygiene is not adequately maintained.

A simple protective oral health care regimen will maintain good oral health.

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* Model

Better Oral Health in LTC - *Best Practice Standards for Saskatchewan* requires a team approach to maintain a resident's oral health care.

The Oral Health Care Team (OHCT) may comprise of Oral Health Coordinator (OHC), Nurses, Care aides, physicians, and Oral Health Professionals (dentists, dental therapists, dental hygienists, dental assistants and denturists. Appropriate team members will be responsible for all of the four key processes.

1. Oral Health Assessment

This is performed by a licensed oral health professional on admission and, subsequently, on a regular basis and as the need arises by OHC/oral health professional or nurses

2. Oral Health Care Plan

OHCT and residents develop an oral care plan which is based on a simple protective oral health care regimen:

- brush morning and night
- use fluoride toothpaste morning and night
- use a soft toothbrush on gums, tongue and teeth
- apply antibacterial product daily after lunch
- keep the mouth moist
- cut down on sugar intake.

3. Daily Oral Hygiene

Nurses and care aides maintain daily oral hygiene according to the oral health care plan.

4. Dental Treatment

Referrals for more comprehensive dental examination and treatment are made on the basis of an oral health

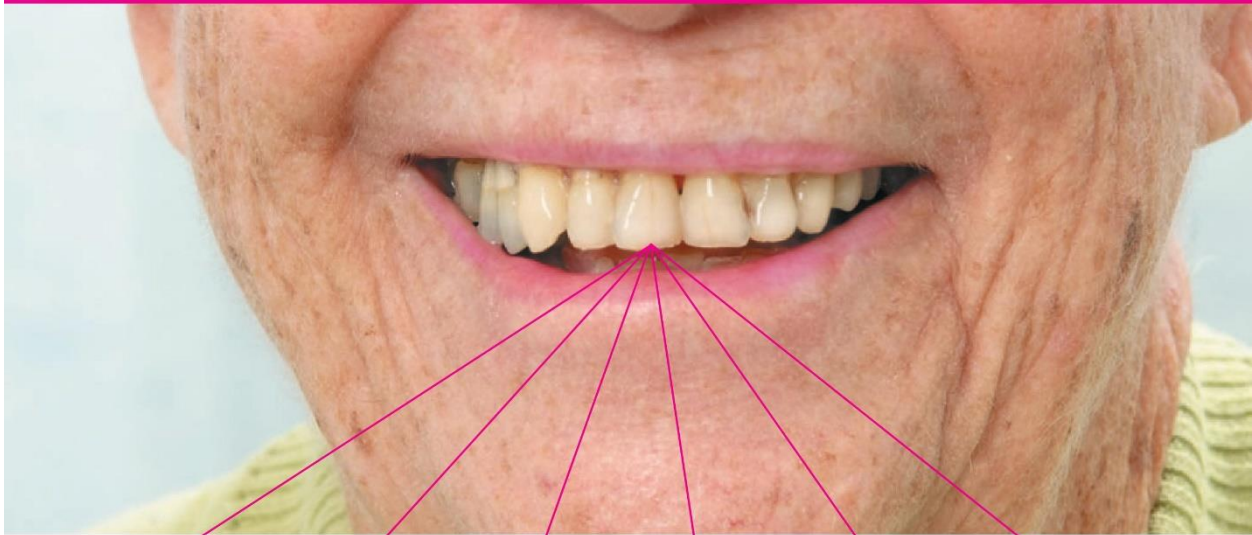
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Appendix-5: Posters, Pamphlets, Brochures

Did you know????



Reduce risk of
Diabetes

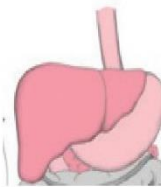
Help prevent
Heart Disease

Avoid
Pneumonia

Reduce risk of
Stroke

Prevent
Tooth Decay

Reduce
Gum Disease
& Bad Breath



A healthy mouth will improve overall health and well-being

Good oral health is essential for overall health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*



(Adapted from Australia's Better Oral Health in Residential Care)



Brush morning
and night

Fluoride
toothpaste
on teeth

Soft toothbrush
on gums, tongue
& teeth

Antibacterial
product after
lunch

Keep the
mouth moist

Cut down
on sugar



Six of the best ways to maintain a healthy mouth

Protect your residents' oral health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*



(Adapted from Australia's Better Oral Health in Residential Care)



Oral Health Professionals



Nurses



Physicians



Residents



Care aides



Speech Language Pathologist



Dietitians



It takes a team approach to maintain a healthy mouth

Work together to protect your residents' oral health



Better Oral Health in LTC - *Best Practice Standards for Saskatchewan*



(Adapted from Australia's Better Oral Health in Residential Care)

Six of the best ways to maintain a healthy mouth



Clean your mouth every morning and every night.



Use only a pea-sized amount of fluoride toothpaste to protect your teeth

Spit - do not rinse after brushing so the fluoride can soak into your teeth.



Use a soft toothbrush to brush your teeth and to clean your gums and tongue.

If you require help, a care giver may sometimes use an extra toothbrush, so that they can see inside your mouth.

Replace your toothbrush with a new one with the change of seasons (every three months).

If you wear dentures clean them by brushing with a denture brush using soap and water. Rinse well. Disinfect dentures once a week. Dentures should have your name on them.



If you wear dentures take your dentures out overnight to rest your gums. Soak your cleaned dentures in a container with cold water



Keep your mouth moist by sipping water.

A lip moisturiser may be helpful

Try to reduce the amount of sugary drinks, juices and coffee you drink



Cut down on sugary foods and beverages, particularly between meals.

A healthy mouth will improve overall health and well-being

When your mouth is not clean, germs from the mouth may enter the airways and cause chest infections such as **pneumonia**.

The same blood that goes through infected gums also goes through the **rest of the body**.

This may cause infections far away from the mouth and may increase the risk of having a heart attack or even a **stroke**.

When oral health is poor, it can lead to:

- bad breath
- bleeding gums
- dental pain and infection
- inability to eat
- low self-esteem
- poor/impaired speech
- tooth decay
- change in behavior when pain or infection is present

Simple daily mouth care and regular checks will help protect you



Best Practice Standards for Saskatchewan



Good Oral Health is essential for Overall Health

(Adapted from Australia's Better Oral Health in Residential Care)

Appendix-6: Oral Health Assessment Tool

Better Oral Health in Long Term Care – Best Practice Standards for Saskatchewan

Oral Health Assessment Tool (OHAT)

Resident: ☐ is independent ☐ needs reminding ☐ needs supervision ☐ needs full assistance

☐ not able to open mouth ☐ grinding or chewing ☐ head faces down ☐ refuses treatment
☐ has responsive behaviour ☐ bites ☐ excessive head movement
☐ not able to rinse and spit ☐ cannot swallow well ☐ does not take dentures out at night

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Exterior of face	Healthy Both sides of face/neck are symmetrical, no lumps or bumps, swallowing normal, lips open and close								
	Changes Asymmetrical changes to face/neck, presence of lumps or bumps, swallowing challenging, lips do not open or close								
	Unhealthy * Asymmetrical changes to face/neck, presence of lumps or bumps, painful swallowing, lips do not open and close *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Lips	Healthy Smooth, pink, moist								
	Changes Dry, chapped or red at corners								
	Unhealthy * Swelling or lump, red/white/ulcerated bleeding/ulcerated at corners *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Tongue	Healthy Normal moist, roughness, pink								
	Changes Patchy, fissured, red, coated								
	Unhealthy * Patch that is red and/or white/ulcerated, swollen *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Gums and Oral Tissue	Healthy Moist, pink, smooth, no bleeding								
	Changes Dry, shiny, rough, red, swollen, sore, one ulcer/sore spot, sore under dentures								
	Unhealthy * Swollen, bleeding, ulcers, white/red patches, generalized redness under dentures *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Saliva	Healthy Moist tissues watery and free flowing								
	Changes Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth								
	Unhealthy * Tissues parched and red, very little/no saliva present, saliva is thick, resident thinks they have a dry mouth *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Natural Teeth	Healthy No decayed or broken teeth or roots								
	Changes 1-3 decayed or broken teeth/roots, or teeth very worn down, mobile								
	Unhealthy * 4 or more decayed or broken teeth/roots or fewer than 4 teeth, or very worn down teeth, mobile *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Dentures	Healthy No broken areas or teeth, worn regularly, and named								
	Changes 1 broken area or tooth, or worn 1-2 hours per day only or not named								
	Unhealthy * 1 or more broken areas or teeth, denture missing/not worn, need adhesive or not named *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Oral Cleanliness	Healthy Clean and no food particles or tartar in mouth or on dentures								
	Changes Food tartar, plaque 1-2 areas of mouth, or on small area of dentures								
	Unhealthy * Food particles, tartar, plaque most areas of mouth or on most of dentures *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Date – dd/mm/yyyy (Re-assessment every 6 months)									
Dental Pain	Healthy No verbal behavioral signs or physical signs of dental pain								
	Changes Verbal &/or behavioral signs of pain such as pulling at face, chewing lips, not eating, responsive behavior								
	Unhealthy * Physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal &/or behavioral signs (pulling at face, not eating, responsive behavior) *								
	Dental referral Y – Yes * N – No								

***Unhealthy signs usually indicate referral to a dentist is necessary**

Date	Assessor Comments

Appendix-7: Oral Health Care Plan

Oral Health Care Plan

Name: _____

Oral Health Assessment (OHA) Date: _____

Challenges: ☐ difficulty swallowing ☐ frequent head movement ☐ difficulty opening mouth ☐ fear of being touched
☐ difficulty eating/nutrition

Interventions: ☐ bridging ☐ modelling ☐ hand over hand ☐ distractions (activity board/toy) ☐ alternative provider
☐ other _____

Daily Activities of Oral Hygiene

	Morning	After Lunch	Night
Natural Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist Replace toothbrush (once every 3 months) Date: _____	<input type="checkbox"/> clean teeth, gums, tongue	<input type="checkbox"/> rinse mouth with water antibacterial product (teeth & gums)	<input type="checkbox"/> clean teeth, gums, tongue
Denture <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Upper <input type="checkbox"/> Lower Inserted/removed by: <input type="checkbox"/> Self <input type="checkbox"/> Staff Cleaned by: <input type="checkbox"/> Self <input type="checkbox"/> Supervise <input type="checkbox"/> Assist	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture	<input type="checkbox"/> rinse mouth with water <input type="checkbox"/> rinse denture <input type="checkbox"/> antibacterial product (gums)	<input type="checkbox"/> clean teeth, gums, tongue <input type="checkbox"/> brush denture with mild soap <input type="checkbox"/> leave dentures out overnight <input type="checkbox"/> soak denture in cold water Disinfect dentures (weekly) Specify day: _____

Oral Hygiene Aids

- ☐ soft toothbrush
- ☐ modified toothbrush
- ☐ toothbrush grip
- ☐ denture brush
- ☐ spray bottle (labelled)

Oral Health Care Products

- ☐ mild soap (denture)
- ☐ antibacterial product
- ☐ saliva substitute
- ☐ lip moisturiser
- ☐ fluoride toothpaste

Additional Oral Care Instructions

- ☐ antifungal gel
- ☐ denture adhesive
- ☐ interproximal brush
- ☐ tongue scraper
- ☐ normal saline solution

Date of next assessment: _____

Signed: _____

Date: _____

Appendix-8: Oral Health Care Policies

PROTOCOL:	FOAM SWAB POLICY
NUMBER:	

STANDARD:

Foam swabs have been widely used in Long Term Care (LTC) facilities. There is evidence which shows that foam swabs do not remove oral plaque effectively when compared with a toothbrush.

Furthermore, foam swabs are not designed for oral hygiene. They offer no mechanical removal of plaque and bacteria what so ever, which can result in other risk factors (aspiration pneumonia, other systemic diseases, choking/biting hazard).

Foam swabs are useful for removing food left in the mouth after a meal or applying moisture to the mouth between brushing. However this is not a substitute for proper oral care. Oral care should always be done with a toothbrush. *Brush to clean, swab in between.*

PURPOSE:

The use of foam swabs for providing oral care is contraindicated in all LTC facilities. They have no mechanical or cleansing value. Swabs lack the mechanical action of a toothbrush and do not meet criteria for safe and effective oral hygiene. Oral swabs are not a replacement for regular tooth brushing.

PROCESS:

1. Use a soft toothbrush to remove plaque and stimulate the gums. The bristles stimulate the tissues in the mouth to initiate natural healing. See policy XXX on procedure for proper oral care.

REFERENCES:

- <http://www.ahprc.dal.ca/projects/oral-care/pdfs/IS-OralSwabs.pdf>

Page 1 of 2

Date Approved:	Date Revised:
Approved by:	

Foam Swab Policy

EVALUATION:

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

Page 2 of 2

Date Approved:	Date Revised:
Approved by:	

PROTOCOL:	LEMON GLYCERIN SWABS
NUMBER:	

STANDARD:

Lemon glycerin swabs, which have been the mainstay of oral hygiene, have no mechanical or cleansing values. There is no clinical or scientific evidence of improved oral hygiene outcomes with their use.

There is evidence that shows glycerin absorbs water and dries out and irritates sensitive oral tissues. With continued use it can exhaust the salivary glands (which in turn will reduce the production of saliva) and lowers the pH of the mouth facilitating opportunities for bacterial and fungal infections.

Furthermore, a swab itself, with or without lemon is in general not designed for oral hygiene. It offers no mechanical removal of plaque and bacteria what so ever, which can result in other risk factors (aspiration pneumonia, other systemic diseases).

PURPOSE:

The use of lemon glycerin swabs is contraindicated in all LTC facilities. They have no mechanical or cleansing value. Swabs lack the mechanical action of a toothbrush and do not meet criteria for safe and effective oral hygiene. Oral swabs are not a replacement for regular tooth brushing.

PROCESS:

1. Use a soft toothbrush to remove plaque and stimulate the gums. The bristles stimulate the tissues in the mouth to initiate natural healing.
2. See Protocol **XXXXXX** on the procedures for proper oral care.

REFERENCES:

- <http://www.ahprc.dal.ca/projects/oral-care/pdfs/IS-OralSwabs.pdf>

EVALUATION:

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

Page 1 of 1

Date Approved:	Date Revised:
Approved by:	

PROTOCOL:	OIL BASED LUBRICANTS
NUMBER:	

STANDARD:

Oil based lubricants are contraindicated for use in and around the mouth because:

- Increase risk of aspiration
- When a patient/resident is on oxygen therapy
- They cause breakage of latex gloves
- Repel water

PURPOSE:

The use of oil based lubricants (eg. petroleum jelly) in and around the mouth is contraindicated in all LTC facilities.

PROCESS:

Use water based lubricant:

1. To protect and moisturize the lips
2. At bed time
3. Before and after oral care
4. As often as required
5. Can be used inside the mouth
6. Can be used if the patient/resident is on oxygen therapy
7. See Protocol XXXXXX on procedures for proper oral care.

REFERENCES:

- <http://www.deerlodge.mb.ca/files/oralPolicy-Dysphagia.pdf>

EVALUATION:

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

Page 1 of 1

Date Approved:	Date Revised:
Approved by:	

PROTOCOL:	ORAL CARE AND TUBE FEEDING
NUMBER:	

STANDARD:

To recognize and provide proper oral care for patients/residents/clients who do not eat or drink orally. This will decrease the bacteria load in their mouths and reduce the risk of developing aspiration pneumonia.

PURPOSE:

Although tube feeding and not eating by mouth (NPO) are established treatment regimens for individuals in whom aspiration of food and fluids has been identified, researchers reviewing this practice have found that people receiving tube feedings have an increased risk of developing aspiration pneumonia as oral and gastric secretions can still be aspirated (Oh et al., 2004).

Oral hygiene is not perceived as needed for residents who do not eat and therefore is often neglected. Salivary flow is also often reduced because there is no food or liquid to stimulate saliva production (Langmore et al., 2002). This in turn increases the concentration of bacteria in the oropharynx. These factors alter the oropharyngeal flora in the mouth and throat. Even if the mouth is not used for food and fluid intake, these individuals will continue to swallow and aspirate their secretions due to poor swallowing ability. If their secretions carry bacteria, they remain at risk of developing aspiration pneumonia.

PROCESS:

1. If recommended, a suction toothbrush is helpful for those who have difficulty swallowing.
2. See Protocol XXXXX on procedures for proper oral care.

REFERENCES:

- Oh et al., 2004
- Langmore et al., 2002

EVALUATION:

Page 1 of 2

Date Approved:	Date Revised:
Approved by:	

Oral Care and Tube Feeding

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

Page 2 of 2

Date Approved:	Date Revised:
Approved by:	

PROTOCOL:	PROPER ORAL CARE IN LONG TERM CARE
NUMBER:	

STANDARD:

1. A Long Term Care (LTC) oral health care team member¹ shall complete an oral assessment using the Oral Health Assessment Tool (OHAT) for each resident, to determine an appropriate oral hygiene care plan.
2. When the OHAT identifies that urgent attention is required, a referral is made to required discipline(s) (i.e. Dentist, Physician, Speech and Language Pathologist, Clinical Dietitian, etc.).
3. The need for oral care increases with age and chronic illness; therefore, LTC staff shall ensure oral care is delivered 2 times daily as per the residents individualized oral hygiene care plan. It is imperative that one of these sessions occur after the last nourishment in the evening. Lips/oral cavity moisturizer may require more frequent application (i.e. every four hours) as identified in the *Oral Care Plan*.
4. Oral hygiene includes the care of the teeth, dentures, and the soft tissues that surround the teeth, roof of the mouth, floor of the mouth, lips, cheeks and tongue.

Note: Brushing with a soft bristled toothbrush is to be the standard for effective cleaning. Use of foam swabs are contraindicated and ineffective in removing plaque and debris from the oral cavity, and are a choking hazard.

5. Staff shall discuss recommended supplies on admission (e.g. toothpaste or non-foaming gel, soft bristled toothbrushes, etc.) the date of last dental visit with the resident and/or their family or substitute decision maker if unavailable, and document this discussion in the OHAT.
6. The nursing staff shall document resident's *Oral Care Plans*.

¹ LTC Oral Health Care Team member: Nurse, Physician, Oral Health Professional, Speech-Language Pathologist, Nutritionist, Special Care Aide, or other designated health professional.

Date Approved:	Date Revised:
Approved by:	

Proper Oral Care in Long Term Care

7. OHAT and reassessment of the *Oral Care Plan* shall occur every six months or when there is a change in oral health status. Changes shall be discussed at each LTC conference with chart documentation as directed by care plan.
8. Documentation in resident's health record(s) shall be completed according to program protocol. All atypical observations and/or client responses must be documented. Completion of oral care can also be recorded on a daily basis in the care plan. (LTC only charts by exception. The expectation of daily recording of oral care may not happen)

PURPOSE:

The need for oral care increases with age, chronic illness and ability. Good oral health is essential for chewing, nutrition, and speech. In addition, oral health plays an important role in self-image and social interaction. These important functions highlight the need for regular oral health services.

Poor oral health can contribute to systemic diseases such as increased risk of stroke, heart disease and pneumonia, as well as malnutrition, impaired speech, and facial deformity. All these consequences detract from their quality of life.

The purpose of this protocol is:

1. To ensure the resident's oral hygiene needs are met according to their individual and clinical needs.
2. To effectively remove plaque and soft debris to ensure the structures and tissues of the mouth are kept in optimal condition.
3. To strive for a clean, functional and comfortable mouth free from infection.
4. To provide oral hygiene using safe and appropriate products.

PROCESS:

Provide oral hygiene based on individualized needs. Refer to:

- **Appendix A: Basic Oral Care for Natural Teeth**
- **Appendix B: Basic Oral Care for the Edentulous (no teeth) Client**

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Date Approved:	Date Revised:
Approved by:	

Proper Oral Care in Long Term Care

- **Appendix C: Oral Hygiene: Dysphagia Care Plan**, when assisting individuals who are unable to participate in their oral care and who have swallowing/secretion management issues.
- **Appendix D: Special Considerations for Oral Care**, ensuring that routine practices are followed.

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Date Approved:	Date Revised:
Approved by:	

Appendix A: Basic Oral Care for Natural Teeth

Supplies, labeled with resident's name if necessary:

- Gloves, protective glasses and mask, or visor mask (PPE)
- 1 soft bristled toothbrush; 2 when the mouth must be propped open
- 1 end tuft toothbrush
- Fluoride toothpaste (when the resident can demonstrate they are able to swish & spit)
- 2 cups, one with water
- 2 face cloths or Shirt Savers

Note: Consider the resident's and mobility circumstances (examples: dementia, dry mouth, dysphasia, wheelchair issues). See Appendix D.

Oral Care Procedure:

1. Sanitize hands, put on PPE (gloves, mask and protective glasses or visor mask)
2. Lay out paper towel, oral care supplies (toothbrush, perivex, toothpaste)
3. Provide oral care for resident
4. Return contaminated supplies to bathroom (toothbrush, perivex, toothpaste)
5. Rinse off toothbrush and place on paper towel
6. Return dental supplies to dental supply kit
7. **REMOVE GLOVES and mask, sanitize hands.**

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Date Approved:	Date Revised:
Approved by:	

Appendix B: Basic Oral Care for the Edentulous (no teeth) Client

Supplies, labeled with resident's name:

- Gloves, protective glasses and mask, or visor mask (PPE)
- 1 soft bristled toothbrush; 2 when the mouth must be propped open
- 1 end tuft toothbrush
- Denture cup
- Non-foaming gel, and/or commercial denture cleaner (not regular toothpaste)
- 2 cups, one with water
- 2 face cloths

Note: Consider the resident's and mobility circumstances (examples: dementia, dry mouth, dysphasia, wheelchair issues).
See Appendix D.

Procedure:

A. Oral Care Infection Control for Residents with Dentures:

1. Sanitize hands, put on PPE (gloves, mask and protective glasses or visor mask)
2. Lay out paper towel, oral care supplies (toothbrush, perivex, toothpaste) and denture cup if necessary
3. Remove resident's denture and place in denture cup
4. Provide oral care for resident
5. Return contaminated supplies to bathroom (toothbrush, perivex, toothpaste and denture cup)
6. Clean denture with perivex and toothbrush, rinse and return denture to cup, remove any denture adhesive that may be on the denture
7. Rinse off toothbrush and place on paper towel
8. Return denture to resident and reinsert
9. Rinse off toothbrush handle and denture cup with water
10. Return dental supplies to dental supply kit
11. **REMOVE GLOVES and mask, sanitize hands.**

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Proper Oral Care in Long Term Care

B. Oral Care Infection Control for Edentulous (have no teeth) Residents or Residents with Natural Teeth:

1. Sanitize hands, put on PPE (gloves, mask and glasses or visor mask)
2. Lay out paper towel, oral care supplies (toothbrush, perivex, toothpaste)
3. Provide oral care for resident
4. Return contaminated supplies to bathroom (toothbrush, perivex, toothpaste)
5. Rinse off toothbrush and place on paper towel
6. Return dental supplies to dental supply kit
7. **REMOVE GLOVES and mask, sanitize hands.**

For residents with natural teeth and a partial denture please follow the “A” guidelines above

Note:

- Replace toothbrushes every three months or sooner if the bristles are worn, splayed, or when at the end of a resident illness (virus, herpes, stomatitis etc.). *Immuno compromised patients should have their brushes replaced more frequently (cancer care, HIV, transplant, dialysis, etc.) therefore on a two monthly basis or when ill.*
- If the gums (gingiva) bleed easily, the reason is not always that the caregiver is too rough; it usually means that the teeth and gums need to be brushed and flossed more frequently and gently to remove plaque. Healthy gums do not bleed.
- Keep in mind that one reason that residents are resistant to oral care by others is that the mouth is a sensitive and intimate part of the body. The mouth should always be treated with respect and a gentle touch.
- Some residents have a sensitivity to hot and cold fluids therefore use room temperature water when doing oral care.

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Appendix C: Oral Hygiene: Dysphagia

This oral care plan is for individuals who:

- Have difficulty swallowing or managing secretions (i.e. risk of aspiration)
- Are unable to participate in their oral care.

Supplies, labeled with resident's name:

- Gloves, protective glasses and mask, or visor mask (PPE)
- 1 soft bristled toothbrush; 2 when the mouth must be propped open
- 1 end tuft toothbrush
- Non-foaming gel
- 2 cups, one with water
- 2 face cloths

Procedure:

- Explain that you are going to clean resident's mouth.
- Perform hand hygiene.
- Wear PPE.
- Place towel/bib under resident's chin.
- Lubricate lips with gel product or water based lubricant.
- Use 2 wide soft handle brushes; prop open one side of the mouth, placing the brush in between the upper and lower teeth/gums.
- Apply pea sized amount of gel product onto the second soft bristled toothbrush and clean the opposite side of the mouth (teeth, gums, cheeks and tongue).
- Remove any food pieces with face cloth; brush and wipe as you work.
- Clean between teeth using end tuft brush.
- Brush inside surfaces and chewing surfaces last; to reduce stimulating gag reflex.
- Take the second brush used to clean mouth and turn it around, now use the handle to prop the mouth open.
- Take out the first brush, apply small amount of gel and use it to clean the other side of the mouth (teeth, gums, cheek and tongue). Clean up saliva and debris with face cloth as you go.
- Clean between teeth using end tuft brush prior to removing tooth brush prop.
- No rinsing of oral cavity is required.

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- Lubricate client's lips using non foaming gel product or a water based lubricant on completion of oral care.
- Remove gloves and mask and perform hand hygiene.
- Put on new gloves.
- Rinse toothbrushes free of debris. Rinse and dry kit holder.
- Tap brush to remove excess water and place toothbrushes in kit holder with head of toothbrushes pointing up resting over the edge of the kit holder.
- *Do not store used brushes in a closed space or container, as this will promote bacterial growth.*
- Replace all kit supplies into kit.
- Remove PPE.
- Perform hand hygiene.

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Approved by:	

Appendix D: Special Considerations for Oral Care

Correct positioning while providing mouth care is important for access to the mouth, for comfort of the resident's head and neck, and for protection of the caregiver's back.

Wheelchair:

- Access to the mouth can be obtained by standing behind the resident if possible and appropriate.
- Support the head so the neck does not become extended during mouth care and make it difficult for the resident to swallow.

Lying down:

- It is more comfortable for the caregiver's back if the mouth is approached from above and behind after adjusting the height of the bed.
- The resident may need to be positioned on their side to drain fluids produced during care.

Uncooperative Residents:

- Uncooperative behavior may be a sign that the resident is in pain, especially if the behavior is new.
- For a resident who clenches or who refuses to open their mouth, the outer surfaces of the front teeth can be cleaned by simply parting the lips with gentle but firm pressure.
- For residents with limited cooperation, brush some of the teeth each day so that the resident will be encouraged to be more cooperative and less fearful of daily oral care.
- Residents with cognitive decline need clear, simple commands. Only one caregiver should be giving directions to the resident to avoid confusion.
- Select a time of day when the resident is most agreeable.
- The key is perseverance, flexibility, and creativity.

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Proper Oral Care in Long Term Care

How to avoid being bitten:

- It is very unusual for a resident to bite a caregiver; however, attention to this risk is needed if a resident seems uncooperative or anxious.
- Retract lips and cheeks with gloved fingers using a tooth brush handle.
- Biting may be an indirect way of expressing a desire to be left alone.
- It may be preferable to postpone oral care until the resident is more relaxed.
- Never place your fingers between the upper and lower teeth.
- A tooth brush handle can be placed between the teeth if the resident is unable to keep their mouth open.

Good Communication is Key: Dealing with Behavior Challenges (i.e. dementia):

- Avoid elder speak – “baby talk” speech patterns (higher pitch, short sentences, sing-song cadence, patronizing tone, use of collective pronouns (i.e. it's time to brush our teeth now), infantilizing terms (baby, honey, dearie)
- Explain what you are doing
- Speak clearly and move slowly
- Position yourself at or below eye level
- Use gesture and pantomime if needed
- Quiet environment
- Work in pairs, with one person giving directions so as to avoid confusion of the resident

Dry Mouth:

- Saliva plays an important role in keeping the teeth and oral tissues healthy.
- There are many medications that will reduce salivary flow, it is important to identify that many residents may be affected by this.
- People affected by dry mouth are more prone to tooth decay and other oral infections. Avoid using products containing alcohol, lemon or glycerin, as they will make a dry mouth drier.
- Under no circumstances should a resident continuously sip a sweetened drink to moisten a dry mouth because of the EXTREME risk of tooth decay. Frequent sips of water or sucking on ice chips is a great alternative.
- Dry mouth should be stated on the oral care plan.
- A product called Oral Balance™ can be ordered by a physician.

Foam Swabs:

- Foam swabs are useful for removing food left in the mouth after a meal or applying moisture to the mouth between brushing. However, this is not a

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substitute for proper oral care. Oral care should always be done with a toothbrush.

- Foam swabs offer no mechanical removal of plaque and bacteria and can result in other risk factors (aspiration pneumonia, other systemic diseases, choking/biting hazard).
- Oral swabs are not a replacement for regular tooth brushing.
- *Brush to clean, swab in between.*

Lemon Glycerin Swabs:

- There is a large body of evidence that shows glycerin absorbs water and dries out and irritates sensitive oral tissues. With continued use it can exhaust the salivary glands (which in turn will reduce the production of saliva) and lowers the pH of the mouth, facilitating opportunities for bacterial and fungal infections.
- A swab itself, with or without lemon, is in general not designed for oral hygiene. It offers no mechanical removal of plaque and bacteria whatsoever, which can result in other risk factors (aspiration pneumonia, other systemic diseases). Do not use lemon glycerin swabs.

Lubricants for Lips:

- Oil based lubricants are contraindicated for use in and around the mouth because:
 - Increase risk of aspiration
 - If the patient/resident is on oxygen therapy
 - Cause breakage of latex gloves
 - Repel water
- Use water based lubricant:
 - To protect and moisturize the lips
 - At bed time
 - Before and after oral care
 - As often as required
 - Can be used inside the mouth
 - Can be used if the patient/resident is on oxygen

Unconscious Residents:

- The same techniques apply for the provision of mouth care, as those outlined for the conscious resident. However, special precautions should be taken to prevent the resident from choking. A toothbrush will help to keep the resident's mouth open during care.
- Always explain what you are doing to the resident, even if unconscious.
- Lubricate dry lips (oil based lubricants are contraindicated, use water based lubricant) to prevent further cracking when the mouth is open.

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Turn the resident's head to the side to prevent aspiration, place the prop in the mouth on the side resting on the pillow to allow access to the other side of the mouth.

- Clean the side of the mouth that is not resting on the pillow. Reposition the resident and clean the other side of the mouth. Soak up excess moisture with face cloth or a towel or a suction unit/toothbrush if available.
- Once the oral care process is completed, let the resident know that the procedure is over, and reposition them into a comfortable position.

REFERENCES:

<http://www.bsdh.org.uk/guidelines/longstay.pdf>

<http://www.canada.com/reginaleaderpost/news/story.html?k=18446&id=d1c6278c-1fe4-4892-857d-2e731dfd6f05>

<http://www.elders.dentistry.ubc.ca>

http://umanitoba.ca/dentistry/ccoh/ccoh_longTermCareFacts.html

<http://www.deerlodge.mb.ca/files/oralCDNNurseArticle.pdf>

<http://www.deerlodge.mb.ca/files/oralPolicy-Hygiene.pdf>

<http://www.deerlodge.mb.ca/files/oralCDNNurseArticle.pdf>

<http://www.deerlodge.mb.ca/files/bulletin110603.pdf>

<http://www.jdentaled.org/cgi/content/abstract/69/9/1058>

<http://www.surgeongeneral.gov/news/testimony/ageism09222003.htm>

EVALUATION:

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

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Date Approved:	Date Revised:
Approved by:	

PROTOCOL:	THE PROVISION OF ORAL CARE
NUMBER:	

STANDARD:

As health professionals, we are responsible for supervising and providing quality daily oral care. The need for oral care increases with age, chronic illness, and handicap. Individuals should be encouraged to remain independent and to attend to their own oral care as much as possible. As we age, tooth brushing can become a more complicated task than tying shoes. If an individual is ill, has limited dexterity, poor eyesight, dementia, or are depressed, they may require additional help with their daily oral care. Working collaboratively with staff, patients/residents/clients, the Oral Care Program aims to provide a comprehensive approach to reducing the risks associated with poor oral care.

PURPOSE:

To improve overall health and quality of life of individuals within the Long Term Care facilities by improving oral care standards.

PROCESS:

1. Management
 - Recognize and promote the importance and impact that poor oral care can have on an individual's health and well-being, in addition to the financial burden poor oral care can have on the health system.
 - Ensure that the oral care program is fully implemented and becomes the standard of care.
 - Enforces the responsibilities of the staff to comply with the oral care program in addition to supporting staff in allowing time to do proper oral care.

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The Provision of Oral Care

2. Nursing

- Supervise and ensure that proper oral care is being carried out (see policy XXX).
- Support staff in allowing time to do proper oral care.
- Have the ability to recognize what is normal from abnormal and healthy from unhealthy in the mouth. If an individual is able to do their own oral care, assess the oral cavity every 6 months to ensure there are no oral care concerns. Document findings.
- Refer any oral care concerns on to a physician (i.e. any sore, lump or bump that does not heal/resolve within two weeks).
- If continuing care aides are not available, daily oral care would fall under the scope of practice for nursing staff to provide (as indicated below under Continuing Care Aide section).

3. Continuing Care Aides

- Complete education and hands on training on how to perform proper oral care.
- Remind, assist and/or perform daily oral care at least twice daily based on resident's individualized oral care plan and protocol XXX. Oral care may need to be performed more often if the care plan indicates or if special considerations apply. See protocol XXXX.
- Ensure proper equipment is used based on resident's individualized oral care plan and is replaced as needed.
- Assess the mouth daily when providing oral care – learn to recognize what is normal from abnormal, healthy from unhealthy.
- Complete any documentation or charting indicating that oral care was completed.
- Refer any oral care concerns to the nurse in charge.

REFERENCES:

- <http://canadian-nurse.com/en/articles/issues/2012/november-2012/improving-oral-care-practice-in-long-term-care>

EVALUATION:

This protocol will be reviewed annually during the comprehensive review of all Protocols and as necessary for quality improvement purposes.

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Approved by:	

WORK STANDARD	Name of Activity: Oral Care Routine Assessment Role performing Activity: RN, RPN, LPN, CCA		
	Location: LTC		Department:
	Document Owner:		
	Date Prepared:	Last Revision:	Date Approved:

Purpose: The purpose of this Work Standard is to:

- Identify an oral health problem and document it on the Oral Health Assessment Tool (OHAT)
- Formulate a daily Oral Health Care Plan (OHCP) that meets the resident's individual needs
- Promote comfort, dignity and health through quality daily oral care
- Identify potential life-threatening infections or conditions
- Recognize healthy from unhealthy, normal from abnormal and when to refer a problem for follow up, resolution or further treatment.

Task Sequence	Task Definition
1.	Gather supplies used to do an oral health assessment: Apply PPE - Exam gloves, protective glasses, mask or visor mask, flashlight, face cloth or 2 x 2 gauze and toothbrush.
2.	Working in teams of 2, approach resident calmly , informing them of your intention and asking permission to access their mouth. Inform them that you are going to look at the outside of the face and the inside of the mouth. Ensure that only one person is giving directions and cueing the resident. Avoid using speaking in child-like or sing song tones and use demonstration as much as possible.
3.	Ask resident if they have any concerns or pain in their mouth.
4.	What to look for: <ul style="list-style-type: none"> • Lumps, bumps, swellings or sores on the face, lips, neck or in the mouth • White, red, or dark patches that cannot be rubbed off • Spontaneous areas of bleeding • Numbness, pain, or loss of feeling on the face, neck, head or in the mouth • Dry mouth • Burning sensation • Trouble swallowing or / hoarseness • Pain when swallowing • Loose or broken teeth/roots, lost/broken fillings, obvious tooth decay • Red, swollen gums • Broken or ill-fitting dentures • Denture sores • Visible plaque, tartar

5.	<p>Examine face and neck and record your findings on the OHAT:</p> <ul style="list-style-type: none"> • Wash hands • Apply PPE • Look to see if both sides of the face and neck are symmetrical • Feel for any lumps and bumps along the centre, right and left sides of the neck and under jaw. Also feel along cheekbones and down in front of ears • Ask the resident if they can swallow, observe if they have any discomfort when swallowing • Record observations on the OHAT and add additional comments if any abnormalities are found. <p>Record your findings on the OHAT for each area of examination. Remember to describe any abnormalities in the comments section. Make a referral to the Team Leader if any findings are in the unhealthy category.</p> <p><u>Examine the Mouth:</u></p> <p><u>Lips:</u></p> <ul style="list-style-type: none"> • Examine the exterior of the lips • Look at the inside of the lips by pulling lower lip down and top lip up. <p><u>The tongue:</u></p> <ul style="list-style-type: none"> • Observe the tongue's top surface, • Ask the resident to stick out their tongue and catch it with a 2x2 gauze. Gently pull tongue to the right and left looking at each side of the tongue. • Ask the resident to touch the roof of their mouth with their tongue and observe under the tongue and the floor of the mouth. Gently using the index and pointer finger, palpate the floor of the mouth feeling for lumps, bumps or tenderness. <p><u>The Gums and Oral Tissues:</u></p> <ul style="list-style-type: none"> • Look at the gums for bleeding, redness or signs of infection. • Healthy gums should be coral-pink in color. • Residents with darker skin may have darker pigmented gums. • Observe the cheeks. If necessary use the back of the toothbrush as a prop to retract each side of the cheek. <p><u>Roof of the mouth:</u></p> <ul style="list-style-type: none"> • Have the resident tilt head back and say "Ahaa". Observe the hard and soft palate and the throat. • Using the index and pointer finger, gently sweep the palate feeling for any lumps, bumps or tender areas as reported by the resident. <p><u>Saliva</u></p> <ul style="list-style-type: none"> • Determine if the saliva flow is healthy, or if the mouth is dry. <p><u>Natural Teeth:</u></p> <ul style="list-style-type: none"> • Check for cracked/broken teeth and /or fillings. Note any unhealthy or missing teeth. <p><u>Dentures:</u></p> <ul style="list-style-type: none"> • Examine if dentures are intact, note any broken or missing teeth on the denture. <p><u>Oral Cleanliness:</u></p> <ul style="list-style-type: none"> • Check entire mouth for oral cleanliness. Note any plaque or tartar on teeth. <p><u>Dental Pain:</u></p> <p>Determine if oral pain is present. This can be determined through-out the assessment as you are observing the resident's mouth or by asking the resident and/or other staff.</p>
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6.	Record your findings on the OHAT for each area of examination. Remember to describe any abnormalities in the comments section. Make a referral to the Team Leader if any findings are in the unhealthy category.
7.	Remove PPE and do hand hygiene
8.	Record and follow-up: <ul style="list-style-type: none"> • Record findings on the Oral Health Assessment Tool (OHAT) and put in resident's chart. • Make an Oral Health Care Plan (OHCP) and post in resident's bathroom on the mirror. This OHCP moves with the resident if the room is changed. • Refer any sores, lumps, loose teeth, infections, or suspicious areas to the team leader. • Team Leader will refer resident to the resident's family or dentist for more immediate attention and follow up/ or to the casual unit clerks who assist with the facility's dental program.

Appendix-9: LTC Generic Forms

Medical History Form for Dental Examination/Treatment

Personal Health Information

Long Term Care Home: _____

Name: _____

Room #: _____ Unit Telephone #: _____

Date of Birth: _____ M/F: _____

Dental Benefits/Insurance: _____

Saskatchewan Personal Health #: _____

Social Services #: _____

First Canadian Health #: _____

Person Responsible for Account: _____

Billing Address: _____

Email Address for Family Representative: _____

Dental Information

1. When was your last dental exam? _____

2. When were your last dental x-rays taken? _____

3. Are your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets4. Do you have bad breath or a bad taste in your mouth? ☐ Y ☐ N5. Do your jaws crack, pop or grate when you open or close? ☐ Y ☐ N6. Do you grind or clench your teeth? ☐ Y ☐ N7. Do you have food catch between your teeth? ☐ Y ☐ N

8. Have you ever had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Bridgework | <input type="checkbox"/> Crowns or caps | <input type="checkbox"/> Dental implants |
| <input type="checkbox"/> Gum surgery | <input type="checkbox"/> Complete dentures | <input type="checkbox"/> Root canal treatment |
| <input type="checkbox"/> Partial dentures | | |

9. Are complete dentures and/or partial dentures labelled with resident's name? ☐ Y ☐ N

10. If you wear dentures, do you have any concerns about your current dentures?

☐ Y ☐ N If yes, what? _____

Name: _____

Medical History

1. Name of Physician: _____
2. Have you been hospitalized? ☐ Y ☐ N
If yes, explain: _____
3. Current Medication Administration Review (MAR) list attached? ☐ Y ☐ N
4. Do you have any allergies? ☐ Y ☐ N
5. Have you ever had an allergic reaction to any drug or anesthetic, at the time or later?

6. Do you bruise easily or have prolonged bleeding? ☐ Y ☐ N
7. Have you ever fainted, had shortness of breath or chest pains? ☐ Y ☐ N
8. Do you have a heart or circulatory problem of any kind? ☐ Y ☐ N
9. Are you taking or have you ever taken Bisphosphonate drugs such as Fosamax, Skelid or Actonel (for osteoporosis) or Aredia, Zameta or Didronel (for cancer treatments)? ☐ Y ☐ N
10. If yes to #8, how were the drugs given? ☐ Oral ☐ I.V.
Duration of therapy: _____
11. Are you MRSA, ESBL, or VRE positive (+)? ☐ Y ☐ N
12. Do you have or have had any of the following?

<input type="checkbox"/> Aids	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental disorder
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Head/neck injury	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Antibiotic resistance organisms	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Organ transplant
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation/chemo
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Rheumatic/Scarlet fever
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Heart rhythm disorder	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> High/Low B.P.	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Bulimia	<input type="checkbox"/> HIV	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Implanted Electrical Devices	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Sexually Transmitted Infection

☐ Drug dependence ☐ Liver disease

13. Have you ever had any illness not included above? ☐ Y ☐ N

If yes, explain: _____

Consent for Dental Examination/Treatment

I understand that the information contained in the medical and dental history is important to my dental examination and treatment. I certify that all the information I have completed is correct, and that I have not knowingly omitted information. I authorize the dentist/oral health professional to perform diagnostic procedures and collect personal health information as may be required to determine necessary treatment. This includes consultation with other health professionals as necessary. The collection of health and dental information is consistent with the requirements of our profession and those of *The Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*.

We acknowledge our duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship.

I understand that it is my responsibility to pay for dental treatment.

I understand that if I have provided an email address that correspondence may occur through email.

Signature

Date

Name (Print)

#1 01/16

Oral Assessment Report

Dear Resident and/or Responsible Party,

An oral assessment was performed on _____ by a dentist.
(Resident Name)

Daily mouth (and appliance) care is being recommended. The program is providing:

- Education for the residents and their families, health professionals and caregivers concerning the importance of mouth care to health and well-being.
- Training of caregivers to provide daily oral hygiene for residents.

Labelling of each resident's removable appliances (complete dentures and partial dentures) is recommended for identification purposes.

The following dental problems have been identified based on the oral assessment:

- ☐ Denture/partial denture(s) repair/reline (lower)
- ☐ Denture/partial denture(s) repair/reline (upper)
- ☐ Gum disease
- ☐ Labelling of denture(s)/partial denture(s) (lower)
- ☐ Labelling of denture(s)/partial denture(s) (upper)
- ☐ Oral hygiene
- ☐ Oral sores
- ☐ Tooth decay
- ☐ Tooth/teeth requiring extraction
- ☐ Other: _____.

Dental services provided by the program are based on a fee for service model. The _____ fee guide will be used. Please find enclosed a detailed copy of the:

- Recommended treatment
- Estimate of the cost of the dental treatment

We encourage each resident to see a dentist for treatment of these oral health conditions. If the resident does not have a dentist and/or wishes to receive their dental care at the LTC facility, please complete and sign the *Consent for Dental Treatment/Surgical Operation* and *Consent for Financial Responsibility* and return to:

If you have any questions concerning this oral assessment report, please call
_____ at _____.

#1A _____
date

Annual Dental Examination Consent Form

Resident's Name _____

Long Term Care Home _____

Room # _____

I hereby authorize a dentist who is working with the program to perform an annual examination.

In requesting this examination, I recognize that the dentist accepts my right to choose the treatment of my choice following consideration of the treatment plan provided to me.

I fully understand that:

- The program recommends a dentist's examination at least once a year. An annual examination prior to receiving dental treatment from other oral health professionals is mandatory and important to prevent, minimize and diagnose conditions which could result in complications associated with dental treatment.
- All findings of the examination will be provided to each resident as a treatment plan. The written plan will be presented to the resident and/or care provider. This will include the treatment plan, a fee estimate for the dental treatment, and consent to proceed with the proposed treatment.
- There is a charge for the dental examination, as outlined in the *College of Dental Surgeons of Saskatchewan* current fee guide.

The collection of health and dental information is consistent with the requirements of our profession and those of the *Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*. This includes consultation with health professionals as necessary. We acknowledge our duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship. I understand that it is my responsibility to pay for dental treatment. I understand that if I have provided an email address that correspondence may occur through email.

If you have any questions about these services, or if you have limitations, possible complications or other information, contact _____.

(Name of the authorizing person)

(Relationship to resident)

(Address and postal code of authorizing person)

(Email address of authorizing person)

(Home phone number)

Dental Benefits/Insurance: ☐ Y ☐ N

Name of Insurance Plan: _____

Group Plan Number: _____

ID Number: _____

(Authorizing person's signature)

Please return this form to:

(Date)

1

Resident Name: _____ Room #: _____

[illegible]

Consent for Dental Treatment

Re: _____
Long Term Care Home (Residents Name)

I, the person signed below, give consent for the following dental treatment, procedure or surgical operation as indicated:

_____.

under the direction/supervision of the oral health professionals (dentist, dental assistant, dental hygienist, dental therapist and denturist as required).

The nature, possible effects, risks and alternatives to this treatment have been explained to me and I understand the explanation.

I consent to receiving anesthetic, and to the use of anesthetics as may be considered necessary. I consent that the oral health providers may provide additional treatment if it is considered immediately necessary. I also consent that the oral care providers may be assisted by other oral care providers and that they may perform all or part of the treatment.

The collection of health and dental information is consistent with the requirements of our profession and those of *The Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*. We acknowledge our duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship.

I understand that it is my responsibility to pay for dental treatment.

I understand that if I have provided an email address that correspondence may occur through email.

Signed: _____ Date: _____
(Resident or Responsible Party)

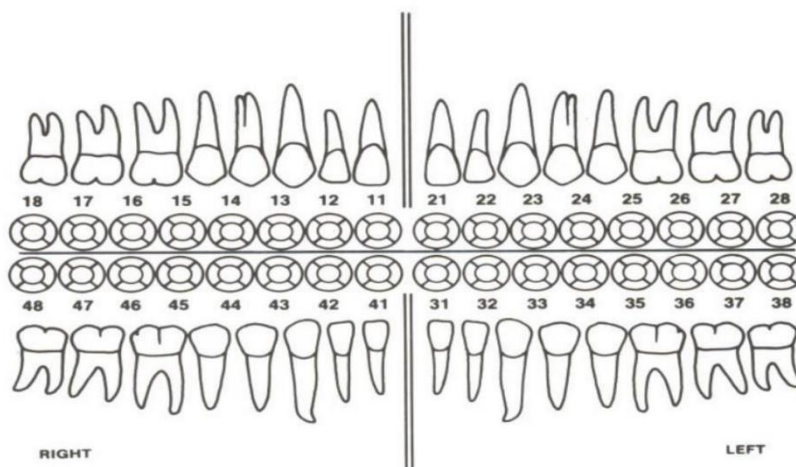
Print Name: _____

Complete and sign the *Consent for Dental Treatment* and return to:

#3 10/15

Oral Services - Resident Tooth Chart

Name: _____ Room #: _____



_____ CUD	_____ labelled
_____ CLD	_____ labelled
_____ URPD	_____ cast _____ acrylic _____ labelled
_____ LRPD	_____ cast _____ acrylic _____ labelled

3A _____
date

Consent for Financial Responsibility for Dental Treatment

Long Term Care Home: _____

Name: _____ Date: _____
(resident full name)

The following treatment has been recommended:

	Cost:		Cost:
<input type="checkbox"/> Professional Oral Hygiene (cleaning) Every: <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 6 months	\$ _____	<input type="checkbox"/> Denture(s) labelling	\$ _____
<input type="checkbox"/> Restorations (fillings)	\$ _____	<input type="checkbox"/> New denture(s) (complete or partial)	\$ _____
<input type="checkbox"/> Tooth/teeth extractions	\$ _____	<input type="checkbox"/> Dental Radiographs	\$ _____
<input type="checkbox"/> Denture repair/reline	\$ _____	<input type="checkbox"/> Other: _____	\$ _____
<p>The estimated cost of the recommended dental treatment is: \$ _____</p> <p>An institutional fee of \$ _____ is charged with each visit.</p>			

The dental procedures will be performed at:

- ☐ Bedside
 ☐ On-site in the Dental Clinic
 ☐ Other: _____

I, the undersigned, will be responsible for the payment of the fees, or payment of fees not covered by insurance, benefits etc., associated with this treatment.

Name: _____ Relation to Resident: _____
 Address: _____ Home Phone: (____) _____
 _____ Business Phone: (____) _____
 Email: _____
 Signed: _____ Date: _____

Complete and sign the *Consent for Financial Responsibility for Dental Treatment* and return to:

#4 _____
01/16

Assessment of Current Oral Hygiene Care

Long Term Care Home: _____

Name: _____ Date: _____

Current oral status (check one or both, and check appropriate description)

- Resident has natural teeth: ☐ Upper ☐ Lower
Resident has removable denture: ☐ Upper ☐ Lower
☐ Resident **DOES** wear denture(s)
☐ Resident **DOES NOT** wear denture(s)

Self-care ability (check one)

- ☐ Can do oral hygiene alone and without reminding
☐ Needs reminding to do own oral hygiene
☐ Remembers to do, but needs assistance
☐ Needs reminding and assistance to complete oral hygiene
☐ Needs all oral hygiene to be done by provider
☐ Needs palliative oral hygiene care

Brushing aids and frequency (natural teeth)

- ☐ Soft toothbrush ___ X/day ☐ Electric toothbrush ___ X/day
☐ Adapted toothbrush ___ x/day ☐ Other: _____ x/day

Flossing (check one) ☐ Yes ☐ No

Denture care (if applicable)

- ☐ Denture cleaner (paste) ___ x/day
☐ Denture solution (tablets) ___ x/day
☐ Denture brush ___x/day

Mouth rinses

- ☐ Fluoride ☐ Mouthwash: _____ ☐ Warm salt water
Name

Saliva stimulant

- ☐ Artificial saliva ☐ Sialagogue pill ☐ Sugar-free gum ☐ Other _____

Challenges with daily care for resident:

#6A 10/15

Denture Assessment

Long Term Care Home: _____

Resident's Name _____

Type of Denture	Maxilla	Mandible	Comments
	<input type="checkbox"/> No denture <input type="checkbox"/> Complete upper <input type="checkbox"/> Partial Upper	<input type="checkbox"/> No denture <input type="checkbox"/> Complete lower <input type="checkbox"/> Partial lower	
Resident's perception	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Dentist's perception	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Retention	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Peripheral seal	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Border extension buccal	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Lingual	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Posterior	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Vertical Dimension	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	

Type of Denture	Maxilla	Mandible	Comments
Esthetics	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Lip Support	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	<input type="checkbox"/> Not applicable <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	
Tissue Condition <input type="checkbox"/> Healthy <input type="checkbox"/> Inflamed <input type="checkbox"/> Hyperplastic <input type="checkbox"/> Flabby <input type="checkbox"/> Tori <input type="checkbox"/> Other			

#7A 10/15

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