KNOWLEDGE
Oral Health Care

A PRACTICAL ORAL HEALTH GUIDE FOR CAREGIVERS

BASIC DAILY MOUTH CARE

Content

INTRODUCTION TO ORAL HEALTHCARE TRAINING

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

Vulnerable groups in particular Learning Disabilities are certainly more at risk from poor oral health. We know that children and adults with disabilities and people with mental illness tend to have fewer teeth, more untreated decay and more periodontal (gum) disease than society at large.

For people of learning disabilities, for some, this requires that additional action and support is in place to improve oral health.

Oral health needs to become integrated into holistic health policy at all levels and should be included in every individual care plan. Effective integration of oral health into the mainstream health agenda is required to ensure that oral health issues are not omitted or dealt with separately and seen as 'the dentist's problem'. Oral health is everyone's business.

It is important to acknowledge that certain circumstances can render an individual more susceptible to developing oral health problems.

UNDERSTANDING WHY A HEALTHY MOUTH IS IMPORTANT PART OF PERSONAL CARE

A good practice guide for improving the oral health of disabled children and adults Oral diseases and conditions are not only painful and distressing, they have an impact on a person’s ability to eat and speak and are increasingly linked to a number of other health problems, some of which are serious. It is essential, therefore, that management and staff understand the importance of good oral hygiene and, importantly, know how to deliver this aspect of personal care effectively and confidently to the people they look after.

Providing good oral care for people with learning disabilities can sometimes be challenging. However, to safeguard the health and wellbeing of vulnerable older people, good daily oral care is crucial.

KEY POINTS STAFF SHOULD BE AWARE OF

Good oral health will contribute positively to overall health and wellbeing.

• Dental decay and gum disease are entirely preventable.

• Effective daily oral care can prevent oral disease.

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

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

• Oral care is the responsibility of every member of the care staff. Care is required 24 hours a day,

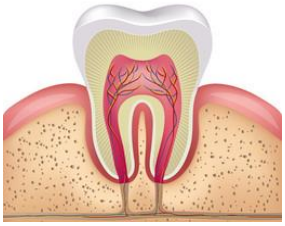
so this includes both night and day staff.

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

• Oral care should be enhanced if ‘less abled’ people need or prefer a higher intake of food or drinks containing sugar.
• Oral health risk assessments, care plans and documentation of daily care should be carried out for every resident
• When a resident becomes uncooperative and won’t let you near their mouth – think! Are they in pain?
• Swallowing problems are common among people with learning disabilities and require special assessment and care.
• In palliative and end-of-life care, mouth care must be carried out regularly to ensure a person is kept as comfortable as possible

THE MOUTH

TOOTH STRUCTURE



ENAMEL

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

DENTINE

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

NERVES (pulp)

Located in the centre of the tooth and provides blood supply and nerve sensation to each tooth. The teeth are held in the jaws in bone. It is important that we keep the supporting structures healthy.

As the aging population’s awareness of the importance of good oral health increases we find people are keeping their teeth for longer. Residents may present at care homes having had advanced and complex treatment carried out previously and it is important to recognise that it exists.

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

WHAT IS PLAQUE?

Dental plaque is a sticky film of **BACTERIA which s**tarts forming just hours after brushing

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

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

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

Dental plaque is a sticky film of **BACTERIA which s**tarts forming just hours after brushing

If it is not removed it can cause:

- Bad breath
- Gum disease
- Tooth decay
- Loose teeth and eventually tooth loss

BLEEDING GUMS (GINGIVITIS)

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

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

Healthy Gums do *not* bleed when brushed.

Plaque irritates the gums if not removed by brushing.

Gingivitis is reversible - unhealthy gums can become healthy again.

If a resident's gums bleed when brushing them **do not** be alarmed. This is an indication that plaque has been collecting at the gum margins and caused inflammation. Gently brush the gum margins to remove the plaque; you will notice that after 2-3 days of thorough brushing in the area the bleeding will stop.

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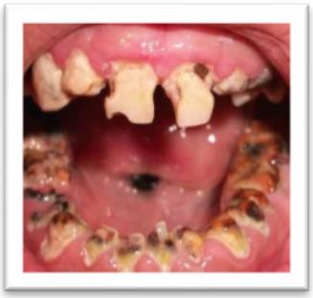
DECAYED AND BROKEN TEETH

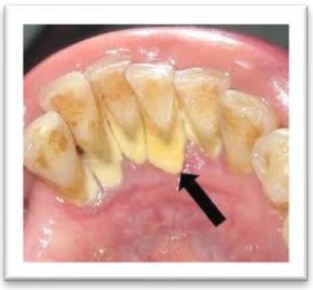
Some residents will have broken teeth (this should be noted at the oral assessment visit).

It is important that these areas get brushed as they are more likely to trap plaque.

If a resident is complaining of any oral discomfort this must be noted and the care manager informed.



CALCULUS (TARTAR)



Calculus is calcified plaque and you will not be able to remove this with a toothbrush.

Calculus can be removed by scaling but it is the plaque that can build up on the surface of the calculus that causes damage and disease.

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

LOOSE TEETH

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

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

DROOLING

We produce saliva all the time. What prevents drooling is keeping our lips closed and swallowing 600 times a day. Chronic drooling can be difficult to manage (also known as ptyalism). It can be defined as the involuntary spillage of saliva over the lower lip. People with drooling are at increased risk of inhaling saliva, food or fluids into the lungs especially with the body's normal reflex mechanisms such as gagging and coughing are also impaired.

What causes drooling in people with disability?

The 3 main causes of drooling are:

2. Producing too much saliva

3. Enlarged tongue (esp Downs Syndrome)

4. Difficulty keeping the saliva in the mouth (keeping lips closed)

5. Difficulty swallowing or not swallowing often enough

TIP

Encourage the use of a straw for drinking to strengthen the muscles of the lips, mouth and throat.

An upright head position and straight posture is best as stooping encourages drooling.

Dysphagia is a difficulty with swallowing, where there is a problem with the passage of food and liquids from the mouth, into the throat and down the oesophagus.

Some people with dysphagia are more anxious about oral care and dental treatment because they believe it could cause them to choke. They may also lack confidence in their ability to swallow.

Body position is very important. Ensure safe body and head positioning before carrying out any mouth care procedures. If a person is supine, the head and body should be raised to a position of 30- 45 degrees or the head tilted carefully to one side.

Has difficulty swallowing

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

- Use a ½ pea-sized amount of toothpaste.
- Have the person tilt head forward (over the bowl) to encourage spitting / dribbling of saliva, food residue and toothpaste.
- Do not give person any liquid for rinsing; clean away any residue with a damp brush, then dab lips dry gently.
- Apply a smear of mouth moisturising gel to the lips, tongue and cheeks if they are very dry. Use a tool such as a ‘moutheze' brush rather than your finger if there is any risk of the person biting down.

Sponge swabs

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

• They do not remove plaque from tooth surfaces. If they are used, it should only be to moisten the mouth or clean the soft tissues.

They must never be left to soak as this increases the risk of detachment. See Medical Device Alert no. MDA/2012/020 (13 April 2012)

Pink sponge swabs are banned in Wales!!

• If they are used, it should only be to moisten the mouth or clean the soft tissues.

See Medical Device Alert no. MDA/2012/020 (13 April 2012)

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

DENTAL PAIN

The majority of people with a learning disability have poor verbal skills and are restricted in their

ability to communicate their needs (Howells, 1986), possibly only being able to manifest their discomfort or pain through changes in behaviour. Very young children also lack verbal skills and so may not be able to explain toothache or complain of pain (Low et al., 1999).

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

FOR SOMEONE UNABLE TO EXPRESS DISCOMFORT THEY MAY EXHIBIT A CHANGE IN BEHAVIOUR

WHICH MIGHT INCLUDE ANYONE OF THE FOLLOWING:

• LOSS OF APPETITE

• UNWILLINGNESS TO PARTICIPATE IN USUAL ACTIVITIES

• DISTURBED SLEEP

• IRRITABILITY

• SELF INJURY

DIET

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

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

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

• Number of food/drink intakes per day

• Number of sugar containing intakes (excluding those found in whole fruit)

• How many sugar foods consumed between meals

• How many sugar foods consumed within one hour of bedtime

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

SUGAR SUBSTITUTE

xylitol - is a sugar alternative which is generally manufactured from birch and other hardwood trees.

The benefits of xylitol is on dental health as it has been found to neutralize plaque acid and repair enamel.

Studies show that Xylitol can reduce decay as much as 30- 85%. Excessive consumption may have a laxative effect.

Unfortunately this sugar substitute is not readily available in supermarkets but can be purchased in health shops or online

TOOTH DECAY (CAVITY)

PLAQUE + SUGAR = DECAY

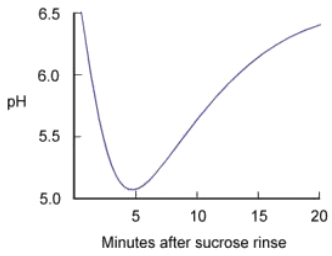
When sugar is eaten it causes the environment of the mouth to become acidic.

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

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

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

STEPHAN'S CURVE



Stephan's curve demonstrates the drop in pH in the mouth following a 'sugar attack' and the time it takes for the saliva to neutralize the acidic environment.

THE EFFECTS OF POOR ORAL HEALTH ON THE BODY

Poor oral health will impact on an individual:

- **Nutrition**
- **Communication**
- **Appearance**
- **Overall health**

Research has shown there to be a link between poor oral health and its effect on the body.

If bacteria are not removed from the mouth it can escape into the bloodstream.

Ensuring that plaque is removed from the teeth and dentures on a daily basis will not only help prevent teeth and gum problems but it will help reduce the risk of other health complications.

DRY MOUTH (XEROSTOMIA)

Causes of reduced saliva flow:

- Old age
- Medications
- Stress
- Cancer therapy

Consequences:

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

A person needs regular sips of water and beverages in order to keep the mouth well lubricated and tissues healthy.

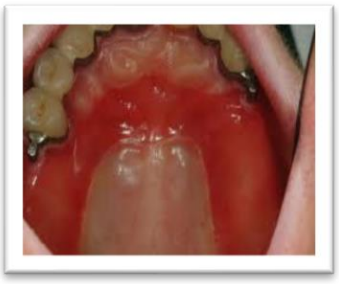
Saliva substitutes are available as gels, sprays, rinses and lozenges.

COMMON CONDITIONS (ORAL FINDINGS)

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

DENTURE STOMATITIS

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



The palate appears red and spongy.

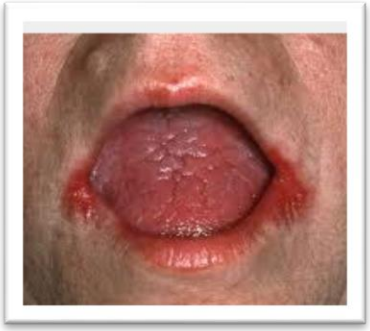
It is not often associated with pain. Encourage residents to leave dentures out overnight to avoid this.

ANGULAR CHELITIS

This is a bacterial or fungal infection which appear as cracks or sores in the corners of the mouth.

It is recommended to clean the corners of the mouth daily with antibacterial soap and keep dry.

It can be resolved by topical medication (cream) prescribed by a medical or dental professional.

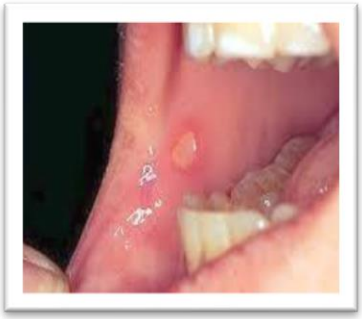


MOUTH ULCERS

Mouth ulcers have various causes (often traumatic due to broken teeth).

All ulcers must be recorded in the resident's care plan.

If an ulcer does not heal within **2 weeks** it must be reported to the Care Manager for referral to a Dental Care Professional.



ORAL (MOUTH) CANCER

- Record any soft tissue abnormality in the resident's care plan
- Report suspicious ulcers and swellings (non-healing, painful, large) to the Care Manager

ORAL CARE FOR THE DEPENDENT PERSON

Oral care should be carried out as an integral aspect of personal care. This oral care guide is designed for care staff that deliver daily oral care to dependent people in care homes. It gives practical skills required to deliver good oral care.

FLUORIDE TOOTHPASTE

Fluoride is a mineral and occurs naturally in water in some parts of the world.

Fluoride toothpaste has been shown to help **reduce** the incidence of cavities and help **arrest** (stop) decay from progressing.

Fluoride is added to toothpaste to help strengthen the enamel.

A dentist may prescribe toothpaste which has a higher concentration of fluoride – Duraphat 2,800 and 5,000ppm or prescribe fluoride varnish to be applied to the teeth as a preventive measure every 3 months for high dental risk individuals.

POSITIONING

If the resident is able to sit up ask them to sit in a high-backed chair and lean your own body weight against the back of the chair and approach the resident from behind as seen in this picture.

If you are unfamiliar to the resident or if you are assisting a resident with dementia it is important to approach them from the front so that they can see you.

TIPS FOR RESIDENTS THAT RESIST ORAL CARE

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

1. ENCOURAGE PEOPLE TO BE AS INDEPENDENT AS POSSIBLE

as people are less resistant when they can carry out their own mouth care

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

You may need to show them what you will do – on yourself.

2. PEOPLE REFUSING MOUTH CARE

▪ Try to find out why the person does not want you to carry out mouthcare.

▪ Respond to this.
Lack of wellbeing/tiredness? – come back later when the person may be more receptive.
Pain – check for soreness, infection, broken teeth, etc. and take appropriate action.
Fear – provide reassurance; explain and if necessary what you are going to do on yourself.
Develop a routine (e.g. same time/same carers).

▪ Try not to carry out all personal care procedures at once. Carry out mouth brushing after sitting up and washing face, but before full wash.

▪ Give a reason, e.g. 'I can see some food around your teeth, I'll clean it away so you'll be more comfortable'.

3. IF SOMEONE REFUSES TO OPEN

▪ Be patient and reassuring.
▪ Soften the brush by running it under warm water and soft toothbrush will help
▪ Say what you are going to do before you do it.
▪ Touch the mouth, or teeth gently with the brush to prompt opening.
▪ Place the back of the toothbrush against the lips and gently twist it so it opens the lips and touches the front teeth.
▪ Start by cleaning the outer surfaces of the front teeth. Then move to the outer surfaces of the back teeth.
▪ Give positive feedback and encouragement at each step.

4. BITING THE TOOTHBRUSH

This may be a sign that the person's face, mouth and throat have become abnormally sensitive. In this case the biting (bite reflex) may be accompanied by gagging, withdrawing, grimacing and crying out.

1. Gently rub cheek to relax jaw muscle.
2. Start by cleaning the outer surfaces of the front teeth. Then move to the outer surfaces of the back teeth.
3. Ask the person to say ‘ah’ for cleaning the biting and inside surfaces.
4. Give positive feedback and encouragement at each step.

● DO NOT PUT YOUR FINGERS IN THE BITING SURFACES AT ANY TIME

5. IF SOMEONE SHOWS PHYSICAL AGGRESSION

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

▪ Try another carer with whom the person is more familiar/relaxed.

▪ Explain what you are going to do and why you are going to do it.

▪ Be patient, take time and be reassuring. Do not talk about the person but always to the person.

▪ Stay calm and quiet yourself.

▪ Look in the mouth for any signs of soreness, infection, broken teeth etc.
Notify nurse and refer to dentist as appropriate. Use a second carer to distract, reassure or hold the person’s hand, and for risk management.

DENTURE CARE

Dentures should be removed from the mouth at night and soaked in water.

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

All dentures should be cleaned twice daily; morning and night.

While the dentures are out of the mouth, the person should rinse their mouth with water to remove any food debris.

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

- Offer a rinse with water before removing dentures as this will make taking the dentures out more comfortable if the resident has a dry mouth
- Remove plaque and debris from denture/s using a toothbrush with mild soap and water
- Rinse denture/s well after brushing with soap
- Dentures should be removed after eating and rinsed with water
- Place the denture/s in a denture pot with cold water to soak overnight
- **Denture marking is advisable**

DEMENTIA

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

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

BRUSHING INDEPENDENTLY

Residents are encouraged to brush independently for as long as they are able to do so.

It is important to keep a person's independence for as long as possible. Reminding a person to brush is sometimes what is needed.

ORAL CHAMPION

NICE and Community Dental Services encourage care homes to appoint an Oral / Dental Champions – a member of staff that can take the lead with oral health matters and champion the cause of improving oral healthcare locally.

ORAL HEALTH ASSESSMENT AND CARE PLANS

NICE guidelines recommend all residents (new and existing) should have an oral assessment completed and a care plan outlining daily mouth care should be created following the assessment.

To conduct an oral assessment you will need;

Essential

- ✓ Gloves
- ✓ Toothbrush
- ✓ Oral Health Assessment form

Desirable

- ✓ Torch
- ✓ Mouth mirror

Oral Health Assessments must include thorough examination of the hard and soft tissues and take note of if the resident wears dentures or has any complex dental work that carers should be mindful of when delivering daily mouth care. Dentures MUST be removed during an oral health assessment to ensure examination of the palate and gums underneath can be carried out.

ORAL HEALTH ASSESSMENTS

When carrying out an Oral Assessment you need to assess the lips, teeth, tongue, palate, floor of the mouth (under the tongue).

Oral assessments need be carried out upon admission and a care plan must be created accordingly..

Any changes in the mouth (for example a broken tooth or ulcer) must be recorded in the resident's notes and reported to the care manager if causing pain, discomfort or does not heal within 2 weeks refer to a GDP or dentist.

• highlights those who are particularly at risk of future problems because of physical or cognitive impairment or poor oral care habits

• allows the development and implementation of an individual oral care plan which indicates the daily oral care assistance required.

Oral care plans

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

Daily documentation of oral care

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

SYSTEMIC LINKS

Infections from the mouth can affect general health and vice versa.

Oral bacteria can cause specific heart damage (endocarditis) in people who have pre-existing heart valve problems

Poor oral hygiene is a key risk factor for pneumonia and respiratory tract infections in vulnerable people.

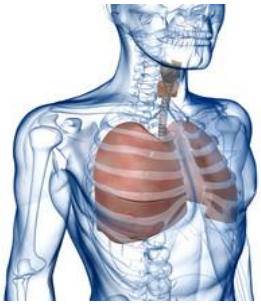
Oral bacteria has been linked to:

- Heart disease
- Diabetes
- Rheumatoid Arthritis
- Dementia

ASPIRATION PNEUMONIA

Aspiration pneumonia is a life-threatening condition where plaque and food debris from around the teeth and dentures get inhaled into the lungs and cause an infection.

This can be avoided by simply removing plaque from the teeth and dentures daily.



GUIDANCE ON PALLIATIVE ORAL CARE

MOUTH CARE ADVICE FOR PALLIATIVE/END OF LIFE CARE RESIDENTS

Everyone should be able to live well until they die. The death rate has been declining for decades as people are living longer and consequently there has been an increase of more people at the end of life with complex needs dying in institutions.

Critically ill people are usually totally dependent on care staff for their oral care, it is therefore important that effective and evidence-informed guidance for health and care professionals exists, in order that oral care is managed appropriately as part of palliative care. The aim is to promote comfort, oral hygiene, hydration, nutrition, and overall quality of life.

Staff generally have inadequate tools for mouth care and often use mouthwash and foam swabs rather than toothbrushes. These revised guidelines summary is aimed at giving caregivers and nurses a quick reference guidance in best practice Palliative/End of life mouth care regime.

This guidance reviews the management of mouth care in palliative care, with focus on the following guidelines:

- NICE Clinical Knowledge Summary: Palliative care – oral (National Institute for Health and Care Excellence)[1]
- Scottish Palliative Care Guidelines – Mouth Care (Healthcare Improvement Scotland and NHS Scotland)[2]
- Palliative Care Wales: Palliative Care (Adult) Network Guidelines

ORAL CARE POLICY

Care homes and community care centres should **establish links with local dental teams** and a **reliable dental referral system or protocol**. This should improve dental access for patients and ensure that referrals are feasible and more efficient. Links should be established with local general dental practices, the local Community Dental Service and any local Special Care Dentistry departments and specialists.

PREVENTION SUMMARY OF USEFUL RECOMMENDATIONS:

1. **Consider oral care in line with 'Delivering Better Oral Health':**

   Clean teeth using a soft, small-headed toothbrush and fluoride toothpaste after each meal and at bedtime. Keep any dentures scrupulously clean. State importance of mechanical plaque removal in addition to toothpaste Brush tongue when furred. Take adequate fluids. Patients should be encouraged to spit out excess toothpaste but avoid rinsing after toothbrushing if possible.

2. **Ensure the patient and their carers are educated about how and when to carry out the patient's preventive care regime**. Establish which health and care professionals have responsibility to ensure this. Record preventive care regimes in the patient's notes

3. The practice of **chewing pineapple and sucking on frozen tonic water should be discouraged** in dentate patients

4. **Foam swabs should not be used as a method of plaque removal**. Consider stating this in future guidance. MouthEze sticks are a safer alternative, though a toothbrush should be used ideally as toothbrushing remains the most effective method of plaque control. There is a risk that **sponges may detach from sponge sticks** if the adhesive fails. This poses a choking risk to patients. **Consider safe alternatives to moisten or clean patients' mouths**.

5. **Damp gauze** (non-fraying type, which has been thoroughly wetted in clean running water) wrapped around a gloved finger may be used if the resident is unconscious or unable to tolerate a toothbrush.

6. **Lubricate lips** Apply water-based saliva replacement gels or aqueous cream to lips

7. **Hydration and nutrition status should be assessed** as part of mouth care

[1] NICE (2016) NICE Clinical Knowledge Summary: Palliative care – oral [Online] Available at: https://cks.nice.org.uk/palliative-care-oral (Accessed May 2017)

[2] NHS Scotland (2017). Scottish Palliative Care Guidelines – Mouth Care. [Online] Available at: (Accessed May 2017)

8. **Dentures** As part of denture care guidance, it should be made clear that cleaning dentures with denture cleaning solution is an adjunct to mechanical cleaning with a soft brush (Denture Care Guidelines Sept 2018 PDF Oral Health Foundation www.dentalhealth.org/FAQs/denture-guidelines)

9. Consider highlighting the importance of **removing and cleaning away debris, secretions and plaque regularly** as part of mouth care, to maintain good oral hygiene and prevent pain and infection.

10. Dentate patients with dry mouth are at high risk of tooth decay. A **high concentration fluoride toothpaste** should be prescribed and a fluoride mouthwash may be recommended.[3] **Regular dental review** is advised so that a dentist can advise further on a patient specific preventive regime and any necessary interventions.

11. **Dry mouth**. Carers should be mindful that dry mouth may make it more difficult for certain **oral medications** to dissolve intra-orally or be swallowed by patients. This may require address, for example if medication gets stuck to the mucosal lining of the patient's mouth.

12. Assess daily for changes.

DRY MOUTH

The Scottish guidance relating to dry mouth point out that all secretions, debris and plaque should be regularly removed as part of mouth care. Additionally it recommends a high fluoride toothpaste and mouthwash regime, as patients experiencing dry mouth will be at higher risk of decay.

END OF LIFE CARE

The focus is on oral hygiene, alleviation of symptoms and ensuring the patient is appropriately hydrated. It is recommended that management of dry mouth is included in the patient's care plan.

All aspects of **mouth care that will provide comfort and improve quality of life** should be included in the patient's **care plan** (for example, pain relief, management of dry mouth, removing dry secretions, frequency of mouth rinsing). This should ensure continuity of care between care settings and amongst different carers. Families and friends should also be made aware of the mouth care regime at the end of life to ensure they can support the patient and have greater involvement in their last days of life.

OTHER ASPECTS OF MOUTH CARE: TRAINING, DENTAL ACCESS, AND PRODUCTS, TOOLS AND SUPPORT FOR PATIENTS

Health and care professionals involved in the day-to-day care of patients should be **trained and have access to training to deliver appropriate mouth care** for palliative patients. There is currently very limited training available for staff and health and care professionals may not prioritise mouth care as part of palliative care. Training should contribute to improved mouth care and consistent advice.

For more details, advice or enquiries about oral healthcare matters please do not hesitate to contact us on **T|01243 710119 E| info@kohc.co.uk W| www.kohc.co.uk**

[3] Public Health England (2017). Delivering better oral health: an evidence-based toolkit for prevention. Third edition. [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf (Accessed June 2017)