CANADIAN DENTAL ASSOCIATION
L'ASSOCIATION DENTAIRE CANADIENNE

Optimal Health for Frail Older Adults: Best Practices Along the Continuum of Care

A resource produced by the
Committee on Clinical and Scientific Affairs

Ottawa, ON
July 2009

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Acknowledgements

The CDA's Committee on Clinical and Scientific Affairs acknowledges the resources and information available on the public websites of the following organizations:

American Dental Association www.ada.org

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

Halton Region Health Department – Dental Health (Ontario) www.halton.ca

Regional Geriatric Program central (Ontario) www.rgpc.ca

Registered Nurses' Association of Ontario www.rnao.org

University of British Columbia ELDERS Group www.elders.dentistry.ubc.ca

University of Manitoba's Centre for Community Oral Health www.umanitoba.ca/dentistry/ccoh

Optimal Oral Health for Frail Older Adults:

Best Practices Along the Continuum of Care

INTRODUCTION

The Canadian Dental Association recognizes that oral health is directly linked to general health. Older adults with complex health conditions are at greater risk for oral diseases, which can have a profound impact on chewing, swallowing and nutrition; increase susceptibility to systemic infectious diseases, especially pneumonia; cause pain; and affect quality of life issues such as self-image, communication and social interaction. As elderly persons become more frail and dependent, with increasing medical comorbidities, multiple medications, physical and/or cognitive impairments, and require greater dependence on caregiver support, the risk for oral diseases increases and the negative effect on general health and well-being accelerates.

Best dental and oral care practices for seniors are needed along the continuum of care, as more seniors and government health agencies embrace an "aging at home" strategy. For aging patients in private dental practice, a common sense or rational approach to oral health care may facilitate their oral care and provide for better oral health in later stages of life, when they are partially or fully dependent on others for daily personal care. Patients who are homebound and cannot attend the dental office may have an increased need for care, yet do not have the level of assistance provided in the long-term care setting. As for seniors residing in long-term care facilities, they are a diverse group that requires initial and ongoing assessment as well as individual care plans based on accepted best care practices. End-of-life or palliative oral care best practices may apply to patients in any of these three settings.

The philosophy of rational provision of oral health services for the elderly extends across the continuum of care, with care plans modified based on the unique circumstances of an individual patient. Some of the resources provided in the section on long-term care may be equally useful in private practice and home settings. For all patients, but especially elderly patients, an interprofessional approach to care is important, with sharing of information and expertise among dental providers, physicians, nurses, pharmacists, dieticians, social workers and others.

Access to care is an essential component of ensuring optimal oral health for frail older adults. Canadians of all ages value fair and equal access to health care as a basic right. The Canadian Dental Association supports this right. This resource was created to help ensure that the elderly continue to have access to care, regardless of their health and living conditions. Inadequate oral health care can have far-reaching consequences. It is important that oral care be viewed within the broader context of health care, and that all care providers work together to promote and ensure the general health and well-being of our aging population.

1. The Aging Population

- The population aged 65 years or older is significant (13%) and increasing. This group of aging adults is a diverse and heterogeneous population with varying dental needs, medical conditions and behavioural characteristics. Approximately 95% of people over the age of 65 live in the community. Of these, 5% are homebound and 17% have mobility limitations. Over 70% can therefore still travel to a dentist. (Ettinger 2006)

- The majority of older adults are relatively healthy and mobile. These "independent older adults" have treatment requirements no different from other adult patients. However, when treating this population, the dentist should be cognizant of approaching older age, the development of associated health issues (e.g., medical problems, use of more medications, reduced dexterity, social issues) and increasing oral disease as older patients become more frail, more dependent and more cognitively impaired. (Chalmers 2006a) Many frail older adults still attend private dental practices but may require special transport and/or be accompanied by a caregiver.

- Currently, no definitive, published, evidence-based clinical guidelines are available for this aspect of dental practice. However, many useful articles and special reviews on the medical and dental problems facing this population of patients provide advice on appropriate care management.

2. The Importance of Prevention

- Changing and increasing caries patterns in aging dentate patients have created more challenges for clinicians. Development of rampant caries is possible even while patients are still living in the community. (Chalmers 2006a) As people live longer and retain more teeth that are often already heavily restored, they will require significantly more complex treatment.

- While the older dentate patient is still relatively healthy, considerable emphasis should be placed on caries prevention education. This should be designed to ensure sound preventive habits are established before problems develop and should include information on oral disease, the importance of an appropriate diet (minimal consumption of fermentable dietary sugars and carbohydrates, particularly between meals), patient-specific oral hygiene methods and techniques, and the prescription of additional patient-specific measures to increase tooth resistance (e.g., in-office fluoride varnish, home fluoride rinses or chlorhexidine). A good preventive regime for the relatively independent older adult with

increasing caries risk involves 3 weeks use of 0.2% fluoride rinse nightly, alternating with 1 week of 0.12% chlorhexidine used twice daily. (Featherstone et al. 2003) In-office caries prevention could also include the regular use of direct application of fluoride varnish on teeth at risk. Sugar substitutes, particularly the use of xylitol (non-acidogenic) chewing gum, can be effective.

- As elderly patients grow more frail, managing their oral care becomes more complex and challenging, and treatment possibilities will depend on a number of modifying factors. (Lindquist and Ettinger 2003)

3. Rational Dental Care for the Elderly

- The four key areas of dental need to be considered when treating frail elderly are function, symptoms, pathology and esthetics. (Berkey et al. 1996) These areas will require pragmatic modification based on fundamental issues such as illness and degree of functional and cognitive impairment.

- The concept of "rational care" for medically compromised elderly patients, **which can be more appropriate than "technically idealized care"**, was introduced in 1984. (Ettinger 1984) A key issue in rational dental care is the understanding of what is an acceptable oral status for a particular patient, as opposed to a subjective estimate of need based on the dentist's own experience.

- "Oral impairment and disability are inevitable features of old age, but they do not necessarily have a negative impact on one's quality of life." (MacEntee 2007)

- Rational dental care involves "individualized care with all modifying factors evaluated and considered" (Ettinger 2006). Factors include the patient's ability to tolerate the stress of treatment, the possibility of reasonable and less extensive treatment alternatives, how the patient's dental problems affect his or her quality of life, as well as the patient's ability to maintain oral health independently. The idea that "nothing less than idealized dentistry is secondhand, compromised care offered by bad dentists" has been strongly refuted.

- Treatment for the "biologically compromised" older dental patient should ideally take place in shorter appointments in a comfortable, supportive and positive environment with capable practitioners. Treatment plans may need to evolve over time as treatment progresses and the patient's situation changes. (Lindquist and Ettinger 2003)

- Caries in frail older patients or patients with early dementia may often need to be managed by conventional hand instruments and a slow-speed handpiece. For anterior esthetic

restorations where moisture control is possible, a composite resin, glass ionomer or glass ionomer/composite sandwich technique is appropriate. Where moisture control is less than optimal, the material of choice will be glass ionomer — or even a temporary zinc oxide and eugenol material. For posterior restorations where moisture control is less than optimal, the material of choice will be amalgam or glass ionomer, especially for subgingival locations. (Chalmers 2006b) Long-term temporary restorations using hard-setting zinc oxide and eugenol can also be extremely useful in difficult management situations. Fractured teeth can be maintained simply by smoothing any sharp edges to ensure patient comfort.

- For deep caries there is increasing evidence that the deepest layers of carious dentin in a vital tooth may not require removal, or may be treated successfully through two-stage (stepwise) restorative management. (Van Thompson et al. 2008) Although management of a deep carious lesion would normally involve two-stage treatment using a temporary restorative material, an expedient, safe and pragmatic technique for the biologically compromised older patient is to place a permanent restorative material at the first visit, leaving deeper caries in appropriate situations (Chalmers 2006b) Avoiding exposure of the carious pulp will reduce the need for more invasive treatment such as endodontic therapy or extraction.

- The rate of total edentulism has steadily decreased over the past 50 years due to a combination of improved access to dental care, diet and prevention. However, the rate of partial edentulism has increased, especially in the elderly. The demand for dental prostheses to replace missing teeth is significant. For healthy older adults, fixed or removable partial dentures or implant-supported crowns may be considered. For patients missing a limited number of posterior teeth, especially a single posterior unit, the best option is often no treatment. A shortened dental arch limited to a combination of two opposing bicuspids and/or molars per side provides adequate function at any age. When considering tooth replacement for frail older adults, the least intrusive and most cost-effective means should be considered. A well-designed and constructed acrylic removable partial denture is often the best solution. This prosthesis will require relining over time to compensate for residual ridge resorption, but has the advantage of easy conversion to a complete denture if the remaining teeth are lost. All dental prostheses require reassessment and maintenance over time; the removable partial denture in particular tends to collect plaque on surfaces in contact with teeth, making these teeth more susceptible to caries and gingivitis.

4. Medical Issues

Systemic diseases are more common in older adults, even among those who are functionally independent. Dental professionals need to be aware of the medical status of older patients, the medications they are taking and the possible effects of these drugs on treatment. Before the first

appointment, and every recall appointment thereafter, it is advisable to ask older patients or their caregiver to bring a **printed list of medications** and dosages. A standardized referral form or patient information form received before the first visit to the dental office may be helpful. Two examples of patient information forms are available for use in Appendices A and B. These documents can also be found in Word and PDF format on the CDA website at http://www.cda-adc.ca/en/dental_profession/practising/best_practices_seniors/default.asp. The first appointment for an elderly patient should be of sufficient length to allow for an unhurried medical history and oral examination.

- Older people tend to be more sensitive to drugs and to invasive dental treatments. Dentists should use local anesthesia whenever possible as the risks of general anesthesia are greater in older patients than in younger patients. Local anesthetic used with recommended dosages of epinephrine has no significant effect on cardiac arrhythmias in functionally independent older patients. (Scully and Ettinger 2007)

- The 10 most common systemic diseases found in the aging population that influence oral health care have been described by Scully and Ettinger (2007):

    - **Arthritis** (reduced dexterity for oral hygiene, joint discomfort in the dental chair, tendency to bleed, possible need for corticosteroid supplementation and antibiotic coverage for joint prostheses).

    - **Head and neck cancer** (need for oral health before cancer therapy, reduced salivary flow after radiotherapy, management of oral ulceration, mucositis and candidiasis).

    - **Chronic obstructive pulmonary disease** (management depends on extent of dyspnea, medications include bronchodilators and/or corticosteroids, patient best treated upright).

    - **Diabetes** (risk of hypoglycemia is main concern during dental treatment, well-controlled diabetics tolerate procedures well, poorly controlled will require referral for invasive procedures; diabetics may be immunocompromised, more susceptible to infections and may require more aggressive infection management).

    - **Ischemic heart disease** (training in CPR and emergency procedures necessary, level of stability of disease important, stress-reduction protocols, limiting of epinephrine, knowledge of INR).

    - **Hypertension** (control before treatment, avoidance of anxiety and pain).

- **Mental health, cognitive impairment, Alzheimer disease** (behavioural problems, adverse drug reactions, increased oral disease, reduced cooperation as disease advances).

- **Osteoporosis** (fractures, bisphosphonates).

- **Parkinson disease** (involuntary movements, COMT inhibitors may interact with epinephrine, restorative care increasingly difficult).

- **Stroke** (confusion, mobility and/or communication problems, deterioration of oral hygiene, defer elective care for 3 months, short sessions, treat patient upright).

The authors conclude that the dentist's focus should always be on **prevention of dental disease, especially in people who have progressive debilitating systemic diseases.**

- Saliva flow rate may be reduced in elderly people due to medications and various associated medical conditions. Xerostomia (dry mouth) is the most common adverse drug-related effect in the oral cavity and has been associated with over 500 medications. It is common in patients being treated for hypertension or mental illness. Because of the synergistic effects of multiple medications, dry mouth is a particularly common and significant problem for elderly patients. (Porter et al. 2004) Lack of saliva often causes soreness, dryness of the mucosa and lips, caries, candidiasis and intolerance to removable dentures. An increase in the severity of xerostomia can lead to a greater risk of dysphagia, choking and nutritional problems. (Madinier et al. 2009) Management includes general and local hydration, saliva substitutes and lubricants, local agents to stimulate secretion (e.g. sugarless gum), antifungal treatment, modification of the diet and nutritional supplementation. (Madinier et al. 2009) Intense caries prevention is essential. Dialogue with the patient's physician is recommended.

5. Palliative Dental Care

- For the frail, elderly, dependent adult still in the community and attending private dental offices with a caregiver, the concept of palliative dental care is appropriate — particularly if the patient has dementia. In such cases, care involves "regular hygiene to reduce bacterial invasion of the lungs, relief of pain and 'maintenance of dignity'." (MacEntee, private correspondence)

- Focusing on idealized dental care for the frail older patient with a failing dentition, without recognizing the stress and expense involved and without taking into account the limited therapeutic benefits, can exaggerate the need for treatment (MacEntee 2007) and lead to pointless and unnecessary over-treatment.

- The average length of stay in a long-term care residence depends on the gender and age of the resident, as well as the level of care required. Eighty-five percent of nursing home residents are 75 years of age or older. The average expected length of stay for this age group (for all levels of care) averages 3.9 to 4.5 years across regions of Manitoba. (DeCoster et al. 1995) Individuals needing lower levels of care stay, on average, much longer than individuals needing higher levels. The average length of stay for Veterans Affairs Canada's in-patients in long-term care facilities (average age over 80 years) was less than 1.9 years for 2005-06. (Veterans Affairs Canada data, Dec 2006)

- The goal of palliative care for seniors who are either terminally ill or approaching the end stage of life is not to focus on disease, but rather on quality of life and the relief of discomfort and pain. Early identification and rational management of potential dental problems play an important role in relieving suffering at this stage of life.

6. Educational Resources

As part of its Oral Longevity initiative, the American Dental Association has developed educational resources to assist dentists in educating patients, consumers and health professionals about oral care for the elderly.

7. References

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BEST PRACTICES FOR DENTAL CARE FOR THE HOMEBOUND

Dentists may want to visit patients in their own home, or may be called to do so. The British Society for Disability and Oral Health has developed guidelines for the provision of at-home oral health services for homebound patients. This resource offers practical advice about offering care in the home setting environment, including infection control and other safety issues, and the planning and provision of treatment.

BEST PRACTICES FOR ORAL CARE IN LONG-TERM CARE (LTC) FACILITIES

1. **Organizational Support**

   For an oral health care program to be successful, there needs to be support at all levels within the facility and a culture that values and promotes oral health as a basic right of residents that is integral to their overall health and well-being. Champions within the facility should be identified to oversee the program and liaise with all members of the team. As part of the organization's quality assurance program, the facility should monitor and evaluate its oral care program and ensure its sustainability.

2. **Multidisciplinary Approach**

   An interprofessional approach should be used for the design, implementation and evaluation of the oral health care program. LTC administrators and champions should contact local dental organizations to develop partnerships and for assistance in identifying dental professionals who can work as part of the program team. Provincial associations and/or local dental societies should identify facilities and health networks within their area to develop partnerships and promote interprofessional capacity to support oral care programs in LTC facilities.

3. **Facility Policy for Oral Care**

   All LTC facilities should develop policies regarding oral health best practices. New or existing policies and procedures should be evaluated, so that gaps between current and best practices can be identified and corrected. Ontario's Regional Geriatric Program central (RGPc) has developed a resource that facilitates the comparison of an LTC facility's practices, policies and procedures to those in the Registered Nurses Association of Ontario (RNAO) Oral Health Best Practice Guideline (see Appendix C). A sample oral care policy for LTC facilities is included with this document (see Appendix D).

4. Assessment

Entry into an LTC facility provides an opportunity for a thorough oral assessment of the patient, identification of oral problems that require attention, and ongoing nursing assessment and oral care. A dental examination or an oral assessment by a qualified dental health professional should be completed or arranged shortly after admission and periodically thereafter. These examinations should be supplemented by oral health assessments and screenings by nurses and caregivers, as outlined below.

4.1. Oral History on Admission

Within 24 hours of admission, an oral health history should be taken in addition to the Minimum Data Set (MDS), as part of the new resident's admission history. The oral health history should include information about oral health beliefs, oral care practices and current state of oral health, as perceived by the resident or his or her caregiver. A sample oral hygiene history questionnaire has been developed by the RNAO and is included with this document (see Appendix E).

4.2. Regular Oral Assessment

Nursing assessment of oral health should be done within 24 hours of admission, at least quarterly thereafter, and whenever the resident, a family member or caregiver identifies a change in oral health status. Ontario's Halton Region Health Department has developed an oral health assessment tool for this purpose.

Oral Health Assessment Tool

Using the Oral Health Assessment Tool

5. Oral Care Plan

All residents, including those who do not have natural teeth (with or without dentures), should have an individualized oral care plan. The oral care plan should be reviewed and modified as needed after each oral assessment. An example of an oral hygiene care plan and a guide to interventions for residents in LTC are available from Ontario's Halton Region Health Department.

Oral Hygiene Care Plan for LTC

Dementia Reference Tool

6. Education of Staff

LTC facilities, in collaboration with dental health professionals, should implement continuing education opportunities for nurses and personal support workers that include appropriate oral health knowledge and skills training. Samples of training materials are provided in the resources section.

RESOURCES

1. Oral Care Best Practices Sources

Oral Health: Nursing Assessment and Interventions Best Practice Guideline

This guideline, developed by the RNAO as part of its evidence-based Nursing Best Practice Guidelines Program, focuses on specific vulnerable populations (those who need assistance to meet their oral hygiene needs).

Oral Health: Nursing Assessment and Interventions Recommendations

This is a summary of the recommendations from the RNAO Oral Health Best Practice Guideline.

Best Practices Approach to Oral Care in Long-Term Care Homes

These materials were developed by the Ontario's Regional Geriatric Program central, one of five geriatric regional programs in Ontario.

2. Training Resources

The following resources were developed by the Halton Oral Health Outreach Program of the Halton Ontario Region Health Department. They are designed to assist in the education of staff in LTC facilities.

- Basic Oral Care - K.I.S.S
- Dysphagia: Oral Health Care Tips for Individuals That Have Difficulty Swallowing
- Palliative End Stage Care
- Dementia Care
- Dry Mouth: Managing Xerostomia (Hypo-salivation)

- Diabetes: Managing Oral Care for the Elderly Diabetic
- Oral Pathology Basics: Common Mouth Sores in the Elderly
- Tooth Abscess: Recognizing a Tooth Abscess
- Cancer Care: Mucositis
- Denture Care
- Oral Health Products and Tips

3. Oral Care for Patients With Dementia – DVD

Oral Hygiene: Managing Oral Care for Residents with Responsive Behaviours – This instructional 16-minute video/DVD was developed by the RNAO as part of the evidence-based best practice guideline Oral Health: Nursing Assessments and Interventions. It is designed to assist caregivers in providing proper oral care for patients with dementia and is available from www.rnao.org. (Cost is $15. The material may be replicated in its entirety for educational purposes only, with appropriate credit or citation.)

4. Oral Health Promotion Fact Sheets for LTC

These Oral Health Promotion Fact Sheets for Long-term Care were developed by the Health Promotion Unit, Centre for Community Oral Health - Faculty of Dentistry, University of Manitoba.

University of Manitoba's Centre for Community Oral Health

5. Oral Health Educational Material for LTC

These Oral Health Educational Materials for Long-term Care were developed by the University of British Columbia ELDERS (Elders Link with Dental Education, Research and Service) group.

University of British Columbia ELDERS Group

Appendix A

Community Form PATIENT INFORMATION RECORD
Please bring to dental appointment

NAME: _____□ Dr. □ Ms □ Mrs. □ Miss □ Mr.

Male_____ Female_____

BIRTH DATE ____ / ____ / ____
YEAR MONTH DAY

ADDRESS: _____

TELEPHONE. No. _____ PHYSICIAN: _____

CONTACT _____ Relationship_____

HOME: (____)_____ BUSINESS: (____)_____

MEDICATION LIST (Please list ALL medications, including non prescription drugs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9.

ALLERGIES:_____

For patients on Warfarin (Coumadin): Most recent INR Date:_____ Reading:_____

ADDITIONAL INFORMATION FOR PATIENTS WITH CAREGIVERS:
MOBILITY:
Does patient use: Wheelchair_____ Walker_____

Able to transfer to dental chair:

☐ NO ☐ YES ☐ with minimal assistance ☐ with 2 persons assisting

COGNITIVE/SENSORY STATUS:

Alert ___ Mildly confused _____ Moderately confused ____ Advanced cognitive impairment ____

Hard of hearing ☐ NO ☐ YES mild ___ moderate ___ profound ___

Please answer the following questions:

REASON FOR VISIT_____

Last dental visit_____
Radiographs available_____

Appendix B

Hospital Facility PATIENT INFORMATION RECORD

Please fax to _____ prior to appointment date

NAME: _____□ Dr. □ Ms □ Mrs. □ Miss □ Mr.

Male_____ Female_____ BIRTH DATE ____ / ____ / ____
YEAR MONTH DAY

ADDRESS: _____

UNIT/FLOOR: _____ TELEPHONE. No. _____

PHYSICIAN: _____ PRIMARY CARE NURSE: _____

SDM: _____

HOME: (____)_____ BUS: (____)_____ CELL: (____)_____

ALTERNATE CONTACT _____

HOME: (____)_____ BUSINESS: (____)_____

INSURANCE: ☐ NO ☐ YES _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: _____

ADDRESS: _____

REASON FOR REFERRAL/VISIT:

MEDICATION LIST (Please list ALL medications, including non prescription drugs OR attach MARS)

For patients on Warfarin (Coumadin): Most recent INR Date:_____ Reading:_____

ALLERGIES:

MOBILITY:
Does patient use: Wheelchair_____ Walker_____

Able to transfer to dental chair:

☐ NO ☐ YES ☐ with minimal assistance ☐ with 2 persons assisting

COGNITIVE/SENSORY STATUS:

Alert ___ Mildly confused _____ Moderately confused ____ Advanced cognitive impairment ____

Hard of hearing ☐ NO ☐ YES mild ___ moderate ___ profound ___

Please answer the following questions:
1. Is patient in pain? Yes ___ No ____
2. Does patient have an acute infection? Yes ___ No ___If yes, describe location of pain/infection and if pain is intermittent or constant, and duration of pain.
3. What treatment for pain relief/infection has been used?

Appendix C

Oral Care Gap Analysis

Oral Care Gap Analysis

Based on the RNAO Oral Health BPG Recommendations (2007).

Compare your LTC home's practices, policies and procedures to those in the RNAO's Oral Health Best Practice Guideline.

Gap Analysis - Oral Health: Nursing Assessment and Interventions

RNAO Oral Health BPG Practice Recommendations	Resources / Tools	Yes - No - N/A	Current Practice
1. Nurses should be aware of their personal oral hygiene beliefs and practices, as these may influence the care they provide to residents.			
2. As part of their admission assessment, nurse will obtain an oral health history that includes oral hygiene beliefs, practices and current state of oral health.	Oral Care Resource Kit Oral Health Assessment Tool for Nursing LTC RNAO BPG Appendix D: Oral Hygiene History – Sample Questions University of Iowa BPG Appendix A: Oral Health Assessment Tools		
3. Nurses use a standardized valid and reliable oral assessment tool to perform their initial and ongoing oral assessment.	RNAO BPG Appendix E: Oral Health Assessment Tools Oral Health Assessment Tool for Nursing LTC (adapted OHAT) RAI-MDS: including E, G1j, J1k, J2,K1-6, L1, P1a		
4. Oral health status information is regularly reviewed with all members of the health care team to monitor resident progress and facilitate the development of an individualized plan of care.	Oral Care Resource Kit Oral Hygiene Care Plan for LTC RNAO BPG Appendix F: Sample Care Plans University of Iowa BPG Appendix A.4: oral Hygiene Care Plan RAI-MDS: Dental Care RAP		

Appendix C

Oral Care Gap Analysis

RNAO Oral Health BPG Practice Recommendations	Resources / Tools	Yes - No - N/A	Current Practice
5. Nurse provide, supervise, remind or cue oral care for residents at least twice daily, on a routine basis. This includes residents who: • Have diminished health status; • Have a decreased level of consciousness; and • Who have teeth (dentate) or do not have teeth (edentate).	RNAO BPG Appendix I: Denture Care and Appendix J: Tooth Brushing Techniques Oral Care Resource Kit – includes University of Manitoba Oral Care Information Sheets		
6. Nurse provide or supervise the provision of oral care for residents at risk for aspiration.	RNAO Oral Care DVD II: Xerstomia, Mucositis and Dysphagia		
7. Nurses provide ongoing education to the resident and/or family members regarding oral care.	University of Manitoba, Faculty of Denistry Centre for Community Health – LTC Fact Sheets		
8. Nurse are knowledgeable of oral hygiene products and their applications as they pertain to their specific client populations.	RNAO BPG Appendix G: Oral Hygiene products Review Supplier's list for oral care supplies		
9. Nurses are aware of treatments and medications that impact on the oral health of residents.	Oral Care Resource Kit Medications that Impact Oral Care Reference Tool RNAO BPG Appendix H : Medication Chart University of Iowa BPG Appendix B – Medication Chart		

RNAO Oral Health BPG Practice Recommendations	Resources / Tools	Yes - No - N/A	Current Practice
10. Nurse use appropriate techniques when providing oral care to residents.	RNAO DVD I: Oral Care for Residents with Dementia RNAO DVD II: Oral Care: Xerostomia, Mucositis and Dysphagia Approaches to Oral Care Quick Reference Tool		
11. Nurse advocate for referral for those residents who require consultation with an oral health professional (eg. dental hygientist, denturist, dentist).	Referral Notes		
12. Nurse ensure that all oral health related history, assessment and care is documented.	Oral Hygiene Care Plan Oral Health Assessment Tool for Nursing LTC RAI-MDS: including E, G1j, J1k, J2,K1-6, L1, P1a		

Appendix C

Oral Care Gap Analysis

RNAO Oral Health BPG Organization & Policy Recommendations	Tools/Resources	Yes – No – N/A	Current Practice
15. Health care organizations develop oral health care policies and programs which recognize that the components of oral health assessment, oral hygiene care and treatment are integral to quality resident care.	Draft policy included in Oral Care Resource Kit RNAO BPG Appendix C: Algorithm to Guide Oral Health Assessment and Interventions –		
16. Health care organizations develop partnerships and increase capacity among providers to deliver collaborative practice models that improve the oral health care they provide to residents.	Current dental contract arrangements		

RNAO Oral Health BPG Organization & Policy Recommendations	Tools/Resources	Yes – No – N/A	Current Practice
17. Health care organizations implement continuing education opportunities for nurses, and support them to complete oral hygiene education and training that is applicable to their health setting	Refer to #14		
18. Oral hygiene care standards that are based on the best available evidence are developed, implemented and monitored as part of the organization's commitment to providing quality oral health care and services.	Implementation of evidence-based oral care practices and tools within the organizations		
19. Organizations encourage and offer support, including time and resources, for nurses to participate in oral hygiene research that assists in a better understanding of the issues related to oral hygiene care provision in various health care settings.			
20. Oral hygiene care is monitored and evaluated as part of the organization's quality management program, utilizing a variety of quantitative and qualitative approaches.	Oral hygiene indicators included in quality management program Oral hygiene quality reports		
21. Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: • An assessment of organizational readiness and barriers to education. • Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. • Ongoing opportunities for discussion and education to reinforce the importance of best practices. • Dedication of a qualified individual to provide the support needed for the education and implementation process. • Opportunities for reflection on personal and organizational experience in implementing guidelines.	RNAO Toolkit: Implementation of clinical practice guidelines – available at www.rnao.org		

References:

- Registered Nurses Association of Ontario. (2007). *Oral Health: Nursing Assessment and Interventions. Toronto, ON: Author.* www.rnao.org
  Oral Care DVD I: Oral Care for Residents with Dementia (2007)
  Oral Care DVDII: Xerostomia, Mucositis and Dysphagia (2008)
- The University of Iowa College of Nursing (2002). Oral hygiene care for functionally dependent and cognitively impaired older adults. Evidence-based practice guideline. Iowa City, Iowa: Author / Gerontological Nursing Interventions Research Centre. www.nursing.uiowa.edu

Resource websites:

- www.rnao.org, www.nursing.uiowa.edu, www.umanitoba.ca/faculties/dentistry/ccoh/ccoh_longTermCare.html
- www.rqpc.ca (LTC Best Practices Resource Centre >> Oral Care)

Available for download on www.rqpc.ca >> Long-Term Care Best Practices Resource Centre

Appendix D

Sample LTC Oral Care Policy

Oral Care

Policy

This is a SAMPLE LTC Oral Care policy and it can be used as a template.

LTC Home	***SAMPLE ONLY- feel free to adapt to your LTC home***
Nursing	
Subject	Oral Care

POLICY:

1. An oral health history will be completed as part of the resident admission assessment and will include oral hygiene beliefs, practices and current state of oral health.

2. Assessment of oral health will be included in all resident health assessments:
   - Within 24 hours of admission
   - At least quarterly and annually
   - As oral health status changes

3. Residents' oral health status will be assessed using the Oral Health Assessment Tool (OHAT) for Long-Term Care.
   - For LTC homes using MDS-RAI 2.0: complete Sections K and L , as necessary, complete the OHAT to supplement the RAI with additional oral status information.

4. An individualized Oral Hygiene Care Plan (plan of care) will be determined and implemented based on the completed oral assessment (OHAT), MDS Dental Care RAP, resident's preferences, functional ability, cognition and ability to cooperate and follow instructions.

5. Staff will provide, remind or cue oral care for residents at least twice daily. If possible, oral care should be completed in the resident's bathroom (i.e., due to the physical cues available).

6. Prior to initiating oral care, staff should review the oral hygiene care plan and be aware of the resident's cognitive status, their responsive behaviours, communication, sensory and functional impairments, and dysphagia.

7. Encourage residents to be independent with oral care. Staff will complete any oral care that the resident was not able to complete. Staff will provide or supervise the provision of oral care for those residents at risk of aspiration.

8. Communicate with the resident at all times during oral care ensuring that the resident is aware of the steps of the procedure and independent tasks required.

9. The "Approaches to Oral Care" tool can be used as a resource for staff in completing resident's oral care. Recommended interventions:

Appendix D

Sample LTC Oral Care Policy

- Never use toothpaste or mouth rinses with residents who have swallowing difficulties. Only use water.
- Never use lemon glycerine swabs with oral care.
- The resident should be properly positioned to receive oral care.
- For residents who are unable to keep their mouth open, use mouth propping devices (ie. two toothbrush technique, wedges, etc.)
- Use a toothbrush with a small head, soft bristles and a larger handle with a rubberized grip.
- Use pea size amounts of toothpaste.

10. Interventions for care of dentures:

    - Never use denture tablets for soaking dentures of residents with dementia. The ingestion of tablets/solution is serious. Vinegar/water solution can be used as an alternate (mix ½ water and ½ vinegar).
    - Remove dentures daily for at least three hours, for gums to rest.
    - Clean dentures with denture paste, denture brush and soak in cool water.
    - Brush the mouth tissues and tongue with soft bristle brush prior to applying the dentures. Dentures should be thoroughly rinsed

11. Denture cups and toothbrushes will be labelled and replaced every 3 months and as required. Replace toothbrushes after every oral infection.

12. The effectiveness of the oral care interventions will be evaluated at least quarterly. Additional or alternate interventions will be added as necessary.

13. At the time of admission and throughout their stay, residents will have access to oral health professionals including dentist, denturist and dental hygienist.

14. Based on the nursing assessment and in consultation with the resident and /or SDM, referrals to an oral health professional (dentist, denturist, dental hygienist) will be made.

EDUCATION:

1. Orientation: New staff, Registered Nursing staff and Personal Support Workers / Health care Aides (full and part-time) will receive oral hygiene care education and information during their orientation.

2. Continuing Education: Staff education sessions regarding oral care hygiene will be provided annually and additionally, as required.

QUALITY/ AUDITING MONITORING:

The LTCH Satisfaction Surveying process will include an annual evaluation of:
1. Residents' satisfaction with oral hygiene care received
2. Family / SDM's satisfaction with oral hygiene care provided.

Appendex D

Sample LTC Oral Care Policy

Procedure

Denture Care

a) Introduction

- Plaque & tartar form on dentures just the same as they form on natural teeth
- **Brush dentures** (as you would natural teeth) at least **twice daily**
- **Remove dentures daily** for at least 3 hours for gums to rest, overnight is easiest
- Use a separate brush for any natural teeth
- Ask the resident to remove their dentures. Assist, if they can't
    - For upper dentures
        - slide your index finger along the denture's side then push gently against the back of the denture to break the seal. Grasp it and remove by rotating it. Grasp lower dentures at the front and rotate.
    - For partial dentures
        - place thumbnails over or under the clasps, apply pressure, being careful to not bend the clasps and catch them on lips or gums.

b) Cleaning dentures:

- Wear gloves
- Line the sink with a towel. Fill it with some cool water just in case the dentures slip and fall. Hot water can warp dentures.
- Rinse with cold water to remove food
- Scrub dentures using a denture brush and denture paste. Never use abrasive cleansers or scouring powders
    - Thoroughly brush all surfaces especially those that touch the gums. Rinse well.
- At bedtime, place dentures in denture cup with cool water and vinegar (½ water and ½ vinegar)
- Only soaking them overnight with a cleansing table is not sufficient – it doesn't clean off the plaque
    - NEVER use denture tablets for soaking dentures of residents with dementia - ingestion of tablets/solution is serious
    - Never use vinegar on dentures with any metal on them as this will cause the metal to turn black.

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Sample LTC Oral Care Policy

Toothpastes

- Use pea-sized amounts of toothpaste, squeezing out a long strip of toothpaste is too much
- Most toothpastes have a strong taste, many residents don't like this, not appealing to residents with Alzheimer's Disease
- Foaming action of toothpaste increases saliva flow & will result in the resident wanting to spit >> choke, gag
- DO NOT use toothpaste for residents who have dysphagia, who cannot swallow or spit/rinse properly, have high level of dementia - there are oral cleansing gels available

Toothbrushes

- The best type of toothbrush to use for residents
  - is one with a small head, soft bristles, larger handle with rubberized grip
  - 2-Toothbrush Technique:
  - For residents who bite down during care, consider using 2 toothbrushes – one to prop the mouth open and one for cleansing
- Replace toothbrush:
  - every 3 months or after an infection

Available for download on www.rgpc.ca >> Long-Term Care Best Practices Resource Centre

Appendix E

Sample Oral Hygiene History

Oral Health: Nursing Assessment and Interventions

Appendix D: Oral Hygiene History – Sample Questions

Please Note: These are suggested questions to assist in taking an oral hygiene history. It is not a validated tool for the assessment of the person's oral health history.

Admission Oral Hygiene History Sample Questions

Hygiene Beliefs:

Which statement best describes your beliefs regarding your teeth:

a) I expect that with proper care my teeth will last me a lifetime.
b) No big deal if I lose my teeth, most people do when they get older.
c) If I lose my teeth I can always get dentures.

Where on a scale would you place your oral health?

1	3	5
Not Important	Somewhat Important	Very Important

Personal Practices:

1. Are your teeth your natural teeth? Do you have dentures? Do you have crowns?
   If the client has dentures: Do you have partial or full dentures? Do they fit properly? How long have you had the ones you are currently using?
2. Are you having any difficulty doing your oral care?
3. How often do you brush your teeth in a day?
4. What type of toothbrush do you use?
5. What type of toothpaste do you use?
6. How often do you replace your toothbrush?
7. Do you use mouthwash?
8. Do you floss regularly?
9. Have you used tobacco products within the last six months? If so, how many cigarettes/cigars/pipes do you currently smoke a day or how much chewing tobacco do you use?
10. Do you drink caffeinated beverages?
11. How often do you visit the dentist?
12. When was the last visit to the dentist?
13. Does going to the dentist upset you?
14. Do you have difficulty chewing or swallowing?
15. Is there anything else that you do to keep your mouth healthy?

Current State of Oral Health:

1. Are you currently experiencing any problems in your mouth?
2. Are your teeth sensitive to hot or cold?
3. When was your last visit to a dentist?
4. Are you currently taking any medications?