B S D H

UNLOCKING BARRIERS TO CARE

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

Report of BSDH Working Group
J. Fiske
J. Griffiths
R. Jamieson
D. Manger

Revised January, 2000

BRITISH SOCIETY FOR DISABILITY AND ORAL HEALTH
Registered Charity No: 1044867

ORAL CARE FOR LONG STAY PATIENTS AND RESIDENTS

INTRODUCTION

The dental disease pattern and oral status of the UK is changing[1]. The general trend is for a reduction in edentulism and an increase in the retention of natural teeth until later life[2]. Attitudes towards dental health are changing too, in such a way that tooth loss is considered less acceptable.

The impact of oral conditions on individuals' quality of life can be profound[3,4]. Long stay patients and residents experience the same oro-dental problems as the general population, however poor oral health may add an additional burden, whereas good oral health has real health gains in that it can improve general health, social acceptability, self-esteem and quality of life.

Care is provided by the statutory, voluntary and private sectors for a variety of client groups in a wide range of accommodation which include: **residential homes** **nursing homes** **hospitals** **hostels** **group homes** **schools** **secure units.**
They are varied in structure, function and organisation, and in the dependence and needs of residents. Admission whether temporary or permanent should not mitigate against the maintenance of residents' health.

However it is recognised that within long term care facilities, numerous problems mitigate against routine provision of oral health care and encourage neglect. Some of the reasons for neglect include:
Lack of personal perception of oral health problems by residents[5-7]
Inability of residents to articulate a need[8]
Family members placing dental care as a low priority[9]
Long term care staff placing patients' dental care as a low priority[9]
Long term care staff limitations[10]. With heavy workloads, staff often argue that they have more pressing tasks to perform
Chronic inadequate oral hygiene practices[11]
Local dental personnel unable or unwilling to provide adequate dental care[12]
Difficulty in obtaining dental care[7].

In the light of these difficulties it is pertinent to highlight certain groups in residential care where there is evidence of poor oral health and inadequate or restricted access to dental services (Appendix 1). These include: **older people** **people with a learning disability** **physically compromised people** **medically compromised people** **people with mental health problems** **people in secure units**.

The principles which underpin residential care stress the need for an enhanced quality of life through positive choice, continuity of care by establishing links with former services, and the retention of dignity and self-care whenever possible. Good quality residential care begins with assessment on admission, health inputs based on multi-disciplinary assessment, and the development of individual care plans in co-operation with staff[13]. The same principles apply to continuing care facilities. Dentistry and dietetics are identified as specialist support services rather than mainstream services.

There are many issues that need to be addressed in improving standards of oral health and quality of life for residents in continuing care. These include:
Oral and dental needs and demands of residents, functional dependence and access to personal oral care[14--22]
Attitudes to oral care and knowledge of health professionals and health care workers[23-27]
Oral hygiene practices which are scientifically inadequate, or based on personal oral habits[20]
Access to oral hygiene equipment appropriate to individual needs
Environmental factors which mitigate against the preservation of self-care
Access to accessible and appropriate general and specialist dental services[21,30].
Guidelines that address these issues must focus on the needs and demands of residents, be non-discriminatory in practice and based on the principles of equal access to oral care, information and services regardless of financial or other constraints.

SCREENING

There is a wealth of information on the oral health needs of older people however information on younger client groups and those who are totally dependent for all personal needs is scarce. Screening provides base line data for planning dental services and oral health promotion strategies appropriate to residents' needs. Data can be utilised to evaluate the outcome and the results should be routinely reported to responsible clinicians and managers.

Screening is recommended as a means of making an initial assessment of a population's oral health needs and identifying individuals requiring further assessment. Long term screening programmes may be inappropriate if the oral health needs of residents are being addressed and there is access to appropriate general and specialist dental services.

ASSESSMENT

Screening does not provide an holistic assessment of individual need. Functional assessment by health care teams is well recognised, particularly for people aged 75 and over. RCN guidelines for assessment of older people do not include oral assessment criteria however the importance of basic oral assessment and oral care by nursing staff is reported[31]. Health gain targets that specify an annual oral examination need wider publicity within the health professions[32].

Oral assessment is recommended on admission to residential care using criteria which are client centred and which can be used by all grades of staff[20,33]. A simple questionnaire that provides the basis for an assessment tool which alerts staff to problems can be adapted to different client groups and assist in the development of an oral care plan[34-37]. More complex assessments involving oral examination require training to recognise signs and symptoms of pathology[38] (See Appendix 2[35]).

An oral health assessment should be incorporated into routine assessment by care staff. For residents who are not intellectually or mentally compromised, a self reporting assessment is recommended. An advocacy system may provide the key to empowerment in identifying needs and choices. Assessment need not be confined to professional carers and can be incorporated into wider assessment by members of the multi-disciplinary team.

ORAL HEALTH EDUCATION AND PROMOTION

All health personnel should receive additional training to support the concept of primary oral health care[39]. Lack of formal training for professional carers is reported[17,21,26]. Recent research continues to highlight the inadequacy of professional nurse training[40]. Training programmes based on scientific principles which stress that poor standards of oral hygiene can be a serious health threat[27-29], need to address the needs of all grades of staff and shift patterns of practice[20,41]. Providing training alone is not sufficient to promote behaviour change and the attitudes and value systems of carers also need to be addressed[42].

It is recommended that oral assessment techniques, explicit standards for routine mouth care, oral hygiene materials, equipment and adaptations, denture care and denture marking, specific guidance on oral care for compromised patients and access to dental services be included in a ward based health promotion strategy[20]. The recommendations have been incorporated into a comprehensive approach to oral health education in Project 2000 which can be adapted for continuing education, post-basic nurse training, and health care workers[43]. Training also needs to be provided through National Vocational Qualifications.

Improvements in oral hygiene have been demonstrated through training of direct care staff[44]. Successful programmes in continuing care and nursing homes are reported [17,45]. An oral health input to induction programmes for care staff can overcome some of the difficulties of releasing staff for training[46]. There is a need for structured modular training and finding the time is a perennial difficulty[13] however it is essential to gain the support of staff[47] and demonstrate the potential benefits to managers

and care staff. Particular attention needs to be drawn to the potential dental implications of long-term and sucrose-based medication[48]. Residents should not be denied the opportunity to participate in programmes to promote healthy life-styles that contribute to oral health.

DIET and NUTRITION

The influence of diet and nutrition on oral and general health are issues which must be addressed[49]. Davies[50] suggested that good nutrition can have a marked effect on the health, happiness and independence of older people whereas the poor oral status of institutionalised older people may contribute to eating problems, weight loss, dehydration and debility[22,51]. Also mentally ill people as a group are vulnerable to malnutrition. Dental health is linked to health, happiness and good general health. Locker[3] indicates that people often avoid having food in company because of problems eating and associated embarrassment. He emphasised the importance of aesthetically acceptable and functionally adequate dentitions so people can feel confident about eating at home or in company. Fiske et al[52] explored the emotional reactions to tooth loss and found that tooth loss affected self-esteem, confidence, enjoyment of food, selection of food, socialisation and forming close relationships even when teeth were replaced by dentures.

Sugars are not only detrimental to dental health, they can also have a negative impact on general health[53]. Thus the reduction of sugar intake for dental health can also benefit general health e.g. reduced incidence of obesity, diabetes, coronary artery disease. Dietary advice for dental health should be made within the context of policies for healthy eating[54]. It is recommended that in line with good health promotion, healthy eating choices are made available. The Nutrition Task Force points out that it is also important to provide consumers with simple, practical and realistic guidance for selecting a balanced diet[55]. In turn staff will require appropriate training and resources to promote healthy eating policies. Oral food supplements prescribed to maintain nutritional status pose challenges to oral health in dentate persons[56]. Direct care staff need to be aware of the risk factors for oral health and appropriate techniques to prevent caries.

STANDARDS and PROCEDURES

Many institutions do not support a philosophy for change in oral health care. Negotiated and agreed standards and procedures for oral care promote a structure and process for putting theory into practice and supporting staff in what may be viewed as an unrewarding task.

Locally negotiated standards should include:

Oral health assessment on admission
Training programmes for care staff
Access to emergency dental services
Facilitation of contact with appropriate dental services.

Basic principles of good infection control should be practised by all health care workers involved in oral care[57,58]. The routine wearing of gloves for mouth care and handling dentures may help to overcome aversion reported by carers[21,27]. It is important that managers are made aware of the health risks to residents and staff from poor standards of infection control in mouth care. This will go some way towards justifying the cost implications.

The development of standards which can be audited promote improved quality of care and facilitate the identification of problem areas. Participation by dental staff within the multi-disciplinary team in setting standards helps to promote the acceptance of oral health care and facilitates as well as encourages communication between disciplines. These are issues that should be addressed to the Social Services Inspectorate that has responsibility for the registration of accommodation and monitoring the quality of care provided. (Examples of locally negotiated standards in residential and continuing care that can be audited are given in Appendices 3 and 4).

ORAL HYGIENE EQUIPMENT

There is little data on the availability of oral hygiene equipment however there is a wealth of professional anecdotal evidence about the difficulty in obtaining toothbrushes in hospitals. Despite the fact that a toothbrush is the cheapest and most effective tool for oral hygiene and is more effective than a foam stick[59,60], mouth care packs and foam sticks are still in general use[61,62]. Screening, assessment and oral care plans identify basic and individual oral hygiene equipment needs. This information is useful to support staff in obtaining equipment appropriate to the needs of clients.

It is recommended that managers of long stay and residential accommodation take on the responsibility of ensuring that appropriate oral hygiene equipment is readily available and that staff are made aware of procedures for obtaining it.

ENVIRONMENT

Many older institutions do not have facilities for privacy and dignity in personal oral care. Dormitories and communal bathroom facilities, poor illumination, and fixtures that are not adapted or placed to meet the needs of people with a physical impairment do not promote the preservation of self-care. Furthermore, institutional patterns of care pose barriers to preservation of self-care and independence.

These are issues which should be raised in the development of an oral health strategy in order to promote independence and self-care in a dignified manner. Similarly the need for suitable accommodation for on site dental screening, assessment and treatment to be conducted in privacy and comfort has to be addressed.

DENTAL SERVICES

Residents and people in continuing care are entitled to equal access to general and specialist dental services appropriate to their needs. Many residents rely upon carers' perception of need for access to dental services[26] and treatment is generally only provided when there is a perceived oral problem[63]. Assessment on admission serves to identify individual oral health care needs and previous access to dental services[33].

In accordance with the principles of good quality residential care, people should be encouraged to retain continuity of dental care where appropriate and be supported in their choice. Emergency dental care should be available within twenty-four hours with clear referral mechanisms for routine advice and treatment. Continuing dental care should be available for anyone in long-stay and residential accommodation, and this includes people in secure units. Access and referral to dental services should be included in admission, transfer and discharge procedures.

Residents, managers and health care workers should have access to information on General Dental Services (GDS), Community Dental Services (CDS) and specialist Hospital Dental Services[64]. Health Authorities have a responsibility to provide regularly updated information on the availability of NHS and CDS care, physical access to surgeries, mobile dental clinics and the range of clinical domiciliary care provided. Purchasers have a responsibility to ensure that the CDS has a contract and resources to provide a safety net service, and that adequate facilities are provided for client groups requiring restorative dental care under general anaesthesia.

BSDH[64] makes clear recommendations for organisation, staffing and clinical facilities in hospitals with 200 or more residents in continuing care, and the use of mobile surgeries and/or domiciliary service for smaller units[65]. Follow up procedures for continuity of dental care on discharge are particularly important as institutions discharge patients for care in the community. Communication between the dental team and other disciplines is most effective when the dental team provides an input to multi-disciplinary care and assessment. Collaborative care planning which provides an opportunity to demonstrate the contribution of oral health care to general health and well-being should be endorsed.

SUMMARY

People in residential or continuing care have an equal right to good oral health as people residing in the community. Entry to residential or continuing care provides an opportunity to assess need, identify problems, improve oral and dental health thereby contributing to improved general health and quality of life. This document provides guidance to establish standards for oral health care which are appropriate to the needs, demands and choices of individuals whether they live in continuing or residential care (Appendix 5).

REFERENCES:

1. Downer MC. The improving dental health of United Kingdom adults and prospects for the future. Br Dent J. 1991; 170 (4): 154-158.
2. Adult Dental Health Survey: Oral Health in the United Kingdom 1998. Office for National Statistics (99) 302.
3. Locker D. The burden of oral disorders in populations of older adults. Comm Dent Health. 1992; 9: 109-124.
4. McGrath C, Bedi R. A study of the impact of oral health on the quality of life of older people in the UK - findings from a national survey. Gerodontology. 1998; 15 (2): 93-98.
5. Smith J, Sheiham A. Dental treatment needs and demands of an elderly population in England. Comm Dent Oral Epiemiol. 1980; 8: 360-364.
6. McEntee MI, Silver JG, Gibson G et al. Oral health in a long term care institution equipped with a dental service. Comm Dent Oral Epidemiol. 1985; 13: 260-263.
7. Lester V, Ashley FP, Gibbons DE. Reported dental attendance and perceived barriers to care in frail and functionally dependent older adults. Br Dent J. 1998; 184: 285-289.
8. Fiske J, Gelbier S, Watson RM. Barriers to dental care in an elderly population resident in an inner city area. Journal of Dentistry. 1990; 18 (5): 236-242.
9. Quinn MJ. Establishing a preventive programme in a long-term care institution. Gerodontics. 1988; 4: 165-167.
10. Weeks J. Oral care of people with a disability: a qualitative exploration of the views of nursing staff. 1991. MSc dissertation, University of London.
11. O'Donnell D. Dental health care programme for physically handicapped adults in Hong Kong. J Roy Soc Health. 1987; 3: 104-106.
12. Stiefel DJ, Truelove EL, Jolly DE. The preparedness of dental professionals to treat persons with disabling conditions in long term care facilities and community settings. Special Care in Dentistry. 1987; 7: 108-113.
13. Department of Health. 1989. Community Services Branch - Social Services Inspectorate. Delivery of health care in residential homes for elderly people.
14. Giles DL, Murphy WW. Dental treatment of the elderly inpatients. Journal of Dentistry. 1980; 8 (4): 341-348.
15. Brauer L. et al. Oral health status and needs for dental treatment in geriatric patients in a Danish hospital. Comm Dent Oral Epidemiol. 1986; 14: 132-135.
16. Holland TJ, O'Mullane DM. Dental treatment needs in three institutions for the handicapped. Community Dent Oral Epidemiol. 1986; 14: 73-75.
17. Hoyen-Chung DJ. Oral hygiene training programmes in long-stay hospitals. Br Dent J. 1989; 167 (5): 178-179.
18. Tobias B, Smith DMH. Dental screening of long stay patients in West Essex and recommendations for their care. Comm Dent Health. 1990; 7: 93-98.
19. Aldred MJ et al. Oral health in the terminally ill: a cross-sectional pilot study. Special Care in Dentistry. 1991; 11 (2): 59-62.
20. Boyle S. Assessing mouth care. Nursing Times. 1992; 88 (15): 44-46.
21. Fiske, J., Lloyd, H.A. Dental needs of residents and carers in elderly peoples' homes and carers' attitudes to oral health. European Journal of Prosthodontics & Restorative Dentistry. 1992; 1 (2): 91-95.
22. Simons D, Kidd EAM, Beighton D. Oral health of elderly occupants in residential homes. Lancet. 1999; 353: 1761.
23. Diu S, Gelbier S. Dental awareness and attitudes of general medical practitioners. Comm Dent Health. 1987; 4: 437-444.
24. Rak OS, Warren K. An assessment of the level of dental and mouthcare knowledge amongst nurses working with elderly patients. Comm Dent Health. 1990; 7 (3): 295-301.
25. Logan HL. et al. Common misconceptions about oral health in the older adult: nursing practices. Special Care in Dentistry. 1991; 11 (6): 243-247.
26. Merelie DL., Heyman B. Dental needs of the elderly in residential care in Newcastle-upon-Tyne and the role of formal carers. Comm Dent Oral Epidemiol. 1992; 20 (2): 106-111.
27. Eadie DR, Schou L. An exploratory study of barriers to promoting oral hygiene through carers of elderly people. Comm Dent Health. 1992; 9: 343-348.
28. Lewis, I.A. Developing a research based curriculum; an exercise in relation to oral care. Nursing Education Today. 1984; 3: 143-144.

29. Trenter Roth P, Creason NS. Nurse-administered oral hygiene: is there a scientific basis? Journal of Advanced Nursing. 1986; 11: 323-331.
30. Wilson KI. Treatment accessibility for physically and mentally handicapped people - a review of the literature. Comm Dent Health. 1992; 9: 187-192.
31. Samson P, Page C, Shepherd G. Oral hygiene: the mouth trap. Nursing Times. 1987; 83: 19.
32. Welsh Health Planning Forum. 1992. Protocol for Investment in Health Gain: Oral Health.
33. Hoad-Reddick G. Assessment of elderly people on entry to residential homes and continuing care arrangements. Journal of Dentistry. 1992; 20 (4): 199-201.
34. Hoad-Reddick G. A study to determine the oral health needs of institutionalised elderly patients by non dental health care workers. Comm Dent Oral Epidemiol. 1991; 19: 233-236.
35. Griffiths JE. An oral health assessment carried out by nurses to identify older people needing advice and support in accessing dental services. Ageing in a Changing Europe. III European Congress of Gerontology. Abstracts. 1995. National Institute of Gerontology, Utrecht. Abstract No 026.0807.
36. Griffiths JE. Working with nurses who care for clients with cognitive impairment. International Dental Journal. 1996; 46 (4): Supplement 2: 440.
37. Griffiths JE, Williams J. Risk factors for oral health in neuro-psychiatric patients in a rehabilitation unit. Japanese Society of Dentistry for the Handicapped. Abstracts / Proceedings - Supplement. 1998; 19; 347.
38. Griffiths J, Boyle S. Chapter 6: Oral assessment in Colour Guide to Holistic Oral Care: a practical approach. 1993. Pub Mosby-Year Book Europe. p87-98.
39. Sheiham A. The Berlin Declaration on Oral Health and Oral Health Services: Berlin Declaration Summary Report. Comm Dent Health. 1993; 10 (3): 289-292.
40. Longhurst R. A cross-sectional study of the oral healthcare instruction given to nurses during their basic training. Br Dent J. 1998; 184: 453-457.
41. Nelson J. Continuing education at night. Geriatric Nursing and Home Care. 1988; 8(1): 9-10.
42. Frenkel H. Behind the screens: care staff observations on delivery of oral health care in nursing homes. Gerodontology. In press.
43. Boyle S. Holistic Oral Care in Project 2000. Oral Health Education Research Group Newsletter. 1994.
44. Nicolai AB. Tesini DA. Improvements in the oral hygiene of institutionalised mentally retarded individuals through training of direct care staff. Special Care in Dentistry. 1982; 2: 217-221.
45. O'Laughlin JM. A dental program for nursing home residents. Geriatric Nursing. 1986; 7 (5): 248-250.
46. Davies KW, Whittle JG. Dental health education: training of home carers of mentally handicapped adults. Comm Dent Health. 1990; 7: 193-197.
47. Hogan JI, White T. Dental health education in an adult handicapped centre. Dental Update. 1982; June: 283-289.
48. Thomson WM, Slade GD, Spencer AJ. Dental caries experience and use of prescription medications among people aged 60 in South Australia. Gerodontology. 1995; 12 (12): 104-110.
49. Steele LP. A Participative Approach to Oral Health. A Review of Oral health, related Nutritional Health and Health Education for Older People. Occasional paper No.7. 1989. Health Education Authority.
50. Davies L. Three score years - and then: a study on nutrition and well being of elderly people at home. London: 1981. William Heinemann.
51. Steele JG, Sheiham A, Marcenes W, Walls AWG. National Diet and Nutrition Survey: people aged 65 years and over. Volume 2: Report of the Oral Health Survey. 1998. London: The Stationary Office.
52. Fiske J, Davis DM, Frances C, Gelbiers S. The emotional effects of tooth loss in edentulous people. Br Dent J. 1998; 184: 90-93.
53. C.O.M.A. Dietary sugars and human disease. Report of Committee on Medical Aspects of Food Policy. Panel on Dietary Sugars. 1989. London, HMSO.
54. C.O.M.A. The nutrition of elderly people. Report of the Working Group of the Committee on Medical Aspects of Food Policy. 1992. London, HMSO.

55. Nutritional Task Force. 1994.
56. Fiske J, Hyland K, Matthews N. Parkinson's disease – nutrition, diet and oral care. J Community Nursing. In press.
57. Staat RH, Van Stewart A, Stewart JF. MRSA: an important consideration for geriatric dentistry practitioners. Special Care in Dentistry. 1991; 11 (5): 197-199.

58. Griffiths J, Boyle S. Chapter 14: Oral infections and related conditions in Colour Guide to Holistic Oral Care: a practical approach. 1993. Pub Mosby-Year Book Europe. p202 -203.
59. Addems A, et al. The lack of efficiency of a foam brush in maintaining gingival health: a controlled study. Special Care in Dentistry. 1992; 12 (3): 103-106.
60. Bowsher J, Boyle S, Griffiths J. A clinical effectiveness-based systematic review of oral care. Nursing Standard. 1999; 13 (37): 31.
61. Harris M. Tools for mouth care. Nursing Times. 1980; 76 (8): 340-3342.
62. Howarth H. Mouth care procedures for the very ill. Nursing Times. 1997; 73 (10): 354-355.
63. de Baat C, Bruins H, van Rossum G, Kalk W. Oral health care for nursing home residents in the Netherlands - a national survey. Comm Dent Oral Epidemiol. 1993; 21 (4): 240 -242.
64. British Society of Dentistry for the Handicapped. 1987. Recommendations for dental services for residents in long stay hospitals and other institutions: Report of a seminar.
65. British Society for Disability and Oral Health. The Development of Standards for Domiciliary Dental Care Services: Guidelines and Recommendations. 2000.
66. Awath-Behari S, Harper RS. Retrospective study of dental treatment for elderly hospital in-patients in Wolverhampton. Comm Dent Health. 1990; 7: 437-442.
67. Jones D, Lester C. Dental health of a random community based elderly population. 1992. Research Team, Department of Geriatric Medicine, University of Wales College of Medicine, Cardiff.
68. British Society for Disability and Oral Health. Guidelines for Oral Health Care for People with a Physical Disability. 2000.
69. Phillips PL, Brunner A. "But sometimes you do say help!", Report on a survey of people with long-term health problems or physical disabilities in NE Essex between June and November, 1990. 1990. Colchester, North East Essex Health Authority.
70. Creek D, Moore M, Oliver M, et al. Personal and social implications of spinal cord injury: A retrospective study. 1987. Eltham Thames Polytechnic; 303-304.
71. British Society for Disability and Oral Health. Oral Health Care for People with Mental Health Problems: Guidelines and recommendations. 2000
72. Stiefel DJ, Truelove EL, Menard TW et al. A comparison of the oral health of persons with and without chronic mental illness in community settings. Special Care in Dentistry. 1990; 10 (1): 6-12.
73. Hede B. Oral health in Danish hospitalized psychiatric patients. Community Dent Oral Epidemiol. 1995; 23: 44-48.
74. Hede B. Dental health behavior and self-reported dental health problems among hospitalized psychiatric patients in Denmark. Acta Odontol Scand. 1995; 53: 35-40.
75. Barnes GP, Allen EA, Parker WA. et al. Dental health needs among hospitalised adult mental patients. Special Care in Dentistry. 1988; 8: 173-177.
76. Whittle JG, Sarll DW, Grant AA et al. 1987. The dental health of the elderly mentally ill: a preliminary report. Br Dent J. 1987; 162: 381-384.
77. Thornton JB, Al-Zahid S, Campbell VA et al. Oral hygiene levels and periodontal disease prevalence among residents with mental retardation at various residential settings. Spec Care Dent. 1989; 9 (6): 186-190.
78. Whyman RA, Treasure ET, Brown RH et al. The oral health of long-term residents of a hospital for the intellectually handicapped and psychiatrically ill. New Zealand Dent J. 1995; 91: 49-56:
79. Scully, C. and Cawson, R.A. 1998. Medical Problems in Dentistry. Pub Wright.
80. Home Office. 1991. Report of Her Majesty's Chief Inspector of Prisons. January 1990 - March 1991. HMSO, London; 4.43- 4.45.
81. Murphy M, Gaffney K, Carey O et al. The impact of HIV disease on an Irish prison population. International Journal of STD and AIDS. 1992; 3: 426-429.
82. Morse DL, Truman BI, Hanrahan JP. Et al. AIDS behind bars. Epidemiology of New York State prison inmate cases 1980-1988. New York State Journal of Medicine. 1990; 90: 133-138.

APPENDIX 1

OLDER PEOPLE

A higher incidence of periodontal disease and lower standards of oral hygiene are reported amongst institutionalised elderly people[8]. Tobias and Smith[18] reported a considerably higher treatment need in hospitalised geriatric patients than elderly people living at home. A high prosthetic treatment need was identified in a population of in-patients with ill-fitting or lost dentures[66]. A more recent study reports a significant association between severity of disability and tooth loss in this group[67].

PHYSICALLY COMPROMISED PEOPLE

People who fall into this category may have reduced ability for self care and mobility problems which affect their ability to reach dental services and consequently their uptake of dental care[67,68]. Problems of physical access to health service premises including dental surgeries are reported[30,69,70].

PEOPLE WITH MENTAL HEALTH PROBLEMS

People with mental illness are considered to have a significant increase in risk factors for oral disease[71-73]. These factors include poor oral hygiene, not initiating dental care, not using dental services and the xerostomic effects of medication[74]. Extensive unmet treatment needs in hospitalised adults with mental illness are also reported[73,75]. Amongst elderly mentally ill people, poor levels of oral and denture hygiene, older dentures, more dental problems and less use of dental services have been reported compared with a control group[76].

PEOPLE WITH LEARNING DISABILITIES

Surveys of institutionalised adults with a learning disability report poor oral hygiene and gingival health, more extractions, less restorative care and a high level of treatment need[16,77,78].

MEDICALLY COMPROMISED PEOPLE

Oral status in this group of people is affected by the individual's level of oral care, oral factors relating to the condition and treatment including the side effects of medication. Oral disease and dental management may pose a serious risk to general health in a range of conditions[79]. Risk factors include danger of excessive haemorrhage, susceptibility to bacteraemia and/or reduced resistance to infection, and the dangers associated with the administration of a general anaesthetic for dental treatment.

PEOPLE IN SECURE UNITS

Literature on the dental needs of and dental services for this group of people is scant. What little there is paints a bleak picture. Whilst some prisons have been accused of seemingly performing over-elaborate crown and bridge work, other prisons have been criticised for long waiting lists for treatment. Of greater concern were the dirty, unhygienic conditions in some prisons[80]. In the light of the relatively high incidence of HIV infection in prison populations compared with the general population, these findings are particularly worrying[81,82].

Appendix 2: ORAL HEALTH ASSESSMENT

Oral health assessment by health professionals provides a mechanism for opportunistic identification of clients who have oral and/or dental problems, are not receiving regular dental care and/or are at risk of poor oral health. Subjective indicators include the ability to speak, smile or eat without pain or discomfort. This example of an Oral Health Assessment may be adapted to suit any client groups or used for self assessment. It should be used in collaboration with local dental services in order to facilitate access to an appropriate dental service. The Community Dental Service is best placed to fulfil the role of facilitator. **A response in a highlighted box may signify a need for action.**

Name: _____ **Date of birth**: _____
Mr / Mrs / Miss / Ms
Address: _____

Telephone:

1. Does the client have natural teeth? No ☐ Yes ☐

2. Does the client have dentures? No ☐ Yes ☐ Specify Upper ☐ Lower ☐
   a) If Yes, are dentures labelled? Yes ☐ No ☐ Don't Know ☐
   b) If Yes, how old are dentures? Less than 5 yrs ☐ More than 5 yrs ☐ Don't Know ☐

3. Does the client have any problems? No ☐ Yes ☐ Don't Know ☐
   e.g pain, difficulty eating, decayed teeth, denture problems, dry mouth, ulcers, halitosis, other etc. If Yes, describe problem Teeth ☐ Gums ☐ Denture ☐ Other ☐

4. Has the client ever smoked? No ☐ Yes ☐ Current smoker ☐ Don't know ☐

5. Is the client on medication with oral side effects? No ☐ Yes ☐ Don't Know ☐

6. Does the client need urgent dental treatment? No ☐ Yes ☐ Don't Know ☐

7. When did the client last see a dentist? Less than 1 year ☐ More than 1 year ☐ Don't know ☐

8. Is the client registered with a dentist? Yes ☐ No ☐ Don't Know ☐
   If Yes, record name and address of dentist: _____

Signature:..... **(Job title)**.....

Date.....

Adapted from Griffiths[35]

APPENDIX 3

NURSING STANDARDS FOR ORAL HEALTH IN CONTINUING CARE

Standards for oral health must address: Needs of residents / clients
Knowledge
Environment
Equipment
Oral hygiene practices
Resources

STANDARD

Residents will have equal opportunity for good oral health as the self-caring individual.

STRUCTURE

All qualified nurses will have a basic knowledge and understanding of the importance of oral health and disease.
Oral assessment will be used to identify oral status and oral hygiene needs.
There will be a clear referral procedure for routine and emergency dental advice and treatment.
Oral hygiene equipment appropriate to a resident's needs will be available.
Standard equipment will include:
- Tooth brushes
- Toothpaste
- Denture brush
- Denture bowl

Specific oral hygiene aids recommended by the dental team will be available.
Residents will have access to privacy for oral hygiene.
Information will be available for residents / staff.

PROCESS

A baseline oral assessment will be carried out to identify the resident's oral status and risk factors.
After assessment, the resident will be provided with equipment appropriate to their oral needs.
Oral assessment will be repeated at specified intervals to monitor the effectiveness of oral care.
Oral hygiene will be carried out as specified and according to resident's needs.
Staff will support, motivate and assist residents to carry out oral hygiene as necessary.

OUTCOME

Identified oral care plan for resident's needs.
Provision of appropriate oral hygiene equipment and regular oral assessment will seek to maintain and prevent deterioration in the resident's oral status.
To maintain oral health, enhance oral comfort, prevent oral disease and handicap.

APPENDIX 4

STANDARDS FOR ORAL HEALTH IN RESIDENTIAL HOMES FOR OLDER PEOPLE

These standards are in accord with the statement of principles of residential care which stress positive choice, enhanced quality of life, and continuity of care by establishing links with former services, retention of dignity and self-care whenever possible.

Assessment on admission

Residents will be encouraged and assisted if necessary to register with a dentist for regular dental care and an annual check-up.

1. The name of the dentist with whom the resident is registered (if known) will be recorded.
2. The length of time since the last dental check-up will be recorded. If more than a year, staff will offer to assist with arranging a dental check-up.
3. The resident's oral status will be noted, i.e. presence of natural teeth, dentures etc, and whether dentures are labelled with the owner's name.
4. Residents with dentures more than 5 years old will be encouraged to have a check-up.
5. Denture labelling will be provided with the owner's consent.

Environment

1. Residents should have access to privacy for oral hygiene.
2. Sanitary fittings should be fully accessible to disabled residents, and adequately illuminated.
3. Taps should be suitably adapted for the individual resident's needs.
4. Suitable facilities will be provided for on site dental treatment.

Oral Hygiene Equipment

1. Residents should have easy access to oral hygiene equipment that is appropriate to their needs.
2. Oral hygiene equipment will be reviewed every 3 months.

Staff will:

1. Receive training in basic skills for oral and denture hygiene.
2. Motivate, encourage, and if necessary, assist residents with oral and denture hygiene.
3. Encourage oral hygiene after meals and before retiring.
4. Encourage the removal and thorough cleaning and storage of dentures overnight.
5. Arrange a dental appointment for a resident if an oral or dental problem is identified.

APPENDIX 5

RECOMMENDATIONS to DEVELOP LOCAL STANDARDS for ORAL HEALTH in RESIDENTIAL and CONTINUING CARE

1. Liaison between health, social and voluntary agencies to identify residential and continuing care establishments without a dental service or with inadequate access to dental services.

2. Screening programmes to identify base line data for dental service planning and oral health promotion strategies appropriate to residents' needs.

3. Oral assessment criteria on admission to identify:
   a) risk factors for oral health
   b) individual oral care needs and develop an oral care plan
   c) appropriate oral hygiene equipment
   d) preventive and palliative measures
   e) need for and access to dental services

4. A policy on the care and safe-keeping of a resident's dentures to include:
   a) denture labelling on admission with the resident's consent
   b) responsibility for the cost of replacement dentures if lost or mislaid.

5. Dental input to multi/inter-disciplinary assessment where appropriate including
   a) procedures for access to pain relief, appropriate general and specialist dental services, oral hygiene advice and support
   b) support for health professionals and carers in oral care
   c) procedures for ensuring continuity of dental care on discharge.

6. Training for health care professionals in:
   a) the scientific basis of oral health and disease
   b) oral assessment criteria and tools for oral assessment
   c) identification of risk factors and stressors for oral health
   d) current oral care practices appropriate to individual needs
   e) practical oral care to motivate, encourage, support and assist residents to carry out oral, dental and denture hygiene
   f) eligibility for free or partial exemption for the cost of NHS dental care
   g) accessing local dental services.

7. Oral health advice and support for residents, family and carers, appropriate to their needs.

8. Oral health education and promotion for residents, carers and health professionals which address:
   a) the oral health needs of residents
   b) dietary issues in the context of healthy eating for oral and general health.

9. Facilities for privacy, dignity and comfort for personal oral hygiene and on site dental screening, assessment and treatment.

10. Negotiated standards and procedures for oral health which promote a structure and process for putting theory into practice and which can be monitored / audited.