Clinical

Food, Fluid and Nutritional Care Policy

SECTION 5: PROTOCOL FOR THE MANAGEMENT OF ORAL HYGIENE FOR ADULTS

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This policy does / ~~does not~~ apply to Medical / Dental Staff
(delete as appropriate)

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5. PROTOCOL FOR THE MANAGEMENT OF ORAL HYGIENE FOR ADULTS

1. PURPOSE AND SCOPE

This aim of this protocol is to provide guidance for assessment and management of oral hygiene for patients within hospital and community care settings for all health care staff to ensure best practise and maintain good oral hygiene. Using the term 'oral' indicates all areas of the mouth.

The overall aims of the protocol are as follows:

1. For each individual patient to move towards an optimal state of oral hygiene
2. To minimise the risk of oral deterioration
3. To offer symptom control and promote comfort and promote oral intake

Whenever possible the patient should be encouraged and supported to carry out their own oral care, however when they are unable to do so it is an essential nursing duty to do this for them and is considered a fundamental aspect of care (Department of Health, 2010 and White, 2004).

Exclusions: paediatrics, haematology/oncology, patients that have had head and neck radiotherapy or oral carcinoma. (See NOSCAN oral care guidance/ palliative care guidance at (www.knowledge.scot.nhs.uk/taysidenutrition).

2. RESPONSIBILITIES AND ORGANISATIONAL ARRANGEMENTS

General Managers/Assistant Directors (or equivalent) have responsibility for distribution of this protocol to staff within their area/directorate/business unit, ensuring that staff has the opportunity to access the Food, Fluid and Nutritional Care Policy (FFNC) Policy.

Clinical Directors & Senior Clinical Nurses have responsibility to ensure that this protocol is implemented within their area and to monitor compliance.

3. BACKGROUND

Oral health can be affected as part of systemic disease, and by many common drug treatments, (Adams, 1996). The literature consistently supports that various conditions can increase an individual's risk of oral complications such as:

- Diabetes
- Limited/restricted fluids and / or poor nutritional intake
- Oral disease/trauma
- Cognitive impairment
- Dysphagia
- Terminal illness
- Acute/chronic breathing difficulties/ oxygen therapy
- Debility, depression or physical inability to undertake oral hygiene

Wilson, (2011) and Thurgood, (1994).

Assessing a patient's mouth and delivering appropriate oral care can prevent potential infections, distress and discomfort to the patient as well as reducing the risk of both dental and systemic disease (Xavier 2000, Royal Marsden 2011).

3.1 Dehydration and Malnutrition

Lack of nutrition and hydration can lead to the worsening of oral problems. Nurses working with the multidisciplinary team need to:

- support the patient to adapt their diet to compensate for oral changes including the presence of mouth ulcers and taste changes
- give advice on supplementary foods
- consider the use of supportive measures including nasogastric, nasojejunal, percutaneous feeding and total parenteral nutrition

Special attention should be given to patients who are Nil by Mouth or have restricted oral intake.

3.2 Dysphagia

Dysphagia is a common occurrence in a variety of acute and chronic illnesses such as Parkinson's disease, stroke, and end stage dementia. Swallowing impairment can result in significantly delayed recovery from acute illness; contribute to malnutrition and dehydration and as a result increased risk of poor oral health (Appendix 4).

Oral hygiene is an important part of patient care and it should not be assumed that patients who cannot swallow and are being fed parenterally do not require mouth care. Good oral hygiene needs to be maintained in all patients to ensure that dental plaque is removed and pathogenic organisms are not allowed to proliferate in the mouth, preventing oral and dental disease and reducing the risk of aspiration pneumonia (SIGN 119 Guidance, 2010).

3.3 Drugs and Treatments

Many drugs and treatments can adversely affect the mouth, and the ability to swallow (Appendix 5).

Where inhalers are used, the patients' mouth/dentures should be rinsed after use to prevent candida infections.

4. ROLES AND RESPONSIBILITIES

4.1 Registered Nurse

Oral hygiene should be part of a holistic assessment of the patient on admission. It is the responsibility of the Registered Nurse (RN) to undertake a full assessment of the patient's oral cavity on admission, including the appropriate frequency of care and the use of oral care equipment and agents, (see Appendix 3). Medical staff must be informed if the patient requires a full clinical assessment and/or referral for emergency dental care. The result of the assessment and a plan of care should be documented in the nursing notes and mouth care delivered according to the patient's level of risk i.e. 2 hourly, 4 hourly, 8 hourly or 12 hourly. An evaluation of care planned should be undertaken at least daily.

4.2 Student Nurse

Student nurses may undertake an oral assessment under the supervision of a RN.

4.3 Non-registered Staff

Delivery of oral hygiene can be delegated to a Healthcare Support Worker by a RN. Any concerns should be reported to the nurse responsible for the patient care immediately.

4.4 Medical Staff

Medical staff are responsible for developing a plan of care/prescribing a course of treatment if concerns are raised as a result of an oral assessment.

No routine dental care can be offered to in-patients within NHS Tayside unless there is a serious risk of compromise to an individuals' health (see Appendix 1 Emergency Dental Care Pathway). However, where a problem is identified the medical staff should refer as appropriate.

5. ORAL ASSESSMENT

Assessment of the oral cavity is required to:

(i) provide baseline data
(ii) monitor and evaluate response to care and treatment and
(iii) identify new problems as they arise (Royal Marsden, 2011)

A baseline assessment should include appropriate questioning to ensure individualised care, including:

- Usual routine of oral hygiene
- Frequency of teeth cleaning/ or Denture care
- Current or past oral health problems

The assessment is completed with an examination of the patient's mouth (Huckinson & Lloyd, 2009). A RN should make an assessment by inspection of the patient's lips, mouth and teeth using a hand held pen torch, as part of the initial and on-going assessment.

An effective plan of care should include documented evidence of:

- The condition of the patients mouth
- The frequency of mouth care required
- The most appropriate care tools and agents
- The patients response to oral therapy provided
- Identify any new problems as they arise (Doughty & Lister, 2008)

Consider the use of the safety brief to identify patients requiring regular mouth care.

The Lloyd Goss Oral Health Assessment Scale and Record (THB 216) may be used to formally assess patients in Haematology/ Oncology and Palliative Care

specialties (Appendix 7). For all other patients no formal assessment is required, however the Mouth Care flowchart can be followed or oral care guidance/care planning (Appendix 3)

6. EQUIPMENT

6.1 Toothbrush

A toothbrush is the most effective tool to ensure good oral hygiene is achieved (Royal Marsden, 2011). It is recommended that adults use a small to medium sized tooth brush with soft to medium bristles. Toothbrushes should be replaced every 3 months.

Sponge sticks are not recommended (see Medical Device Alert, Appendix 2) and may present a serious choking hazard to patients. A sponge stick is not as effective as a toothbrush and is not intended as a substitute. It is an option for those patients who cannot tolerate a toothbrush (Huckinson & Lloyd, 2009) and vigilance should be taken.

A small ward stock of toothbrushes should be kept for patients who are admitted and do not have their own toothbrush. These are for single use only.

6.2 Toothpaste

Fluoride toothpaste is recommended to prevent dental decay. Non- foaming toothpaste such as "Sensodyne" is recommended for patients with swallowing problems.

A small ward stock of toothpaste should be kept for patients who are admitted and do not have their own.

6.3 Mouthwash

Mouthwash helps freshen breath and dislodge debris and, if antibacterial, can help to reduce gum disease and control plaque.

- Mouthwash should be rinsed around the mouth for 1 minute and then spat out
- Mouthwash should not be swallowed

Mouthwash must not be used for patients with swallowing problems or reduced gag reflex and Chlorhexidene spray may be a useful alternative.

Types of mouthwash:

- Water is as effective in the absence of mouthwash
- Commercially available mouthwash may be used
- Many mouthwashes contain alcohol and therefore may not be suitable those that avoid alcohol e.g. Muslim faith
- Corsodyl or Chlorhexidine mouthwash reacts against toothpaste, so an interval of 30 minutes should be left between using toothpaste and mouthwash
- Corsodyl is a chemical plaque remover and therefore not indicated in people without teeth (excluding radiotherapy)

6.4 Saliva Replacement

Subjective Dry mouth
The feeling of a dry mouth (xerostomia) can arise as a result of loss of the mucous layer without clinical evidence of dryness. There is usually little relief with artificial saliva preparations or mucosal gel preparations in these patients; therefore the use of artificial saliva preparations is discouraged. Advise the patient to take frequent sips of cool drinks, suck pieces of ice or sugar-free fruit pastilles, or use sugar-free chewing gum to provide symptomatic relief.

Actual Dry Mouth
Dry mouth can also be caused by drugs that have antimuscarinic effects (tricyclic antidepressants, antipsychotics), diuretic drugs and irradiation of the head and neck region or by damage or disease of the salivary glands (e.g. Sjörgen's syndrome). In these cases artificial saliva preparations can provide useful relief.

6.5 Lubricants/Lip Moisturisers

Petroleum jelly (also called petrolatum) lip balms (Vaseline) can ignite in the presence of oxygen and therefore should be avoided. Additionally it is harmful if ingested therefore not suitable for patients with swallowing problems. Water-based surgical lubricating jelly, which is non-flammable such as KY Jelly may be used (Lowry et al, 2001).

7. MOUTH CARE TECHNIQUE

7.1 Method for tooth brushing

Using a soft toothbrush and no more than a pea size amount of toothpaste (Mooney 2007). Brush in slow short horizontal motion on the front, crown and rear of the tooth holding brush at 45 degree angle to the tooth and the gingiva (gum). This should take between 2-3 minutes each time. A circular motion for brushing teeth is recommended.

Gentle brushing of the tongue is also recommended, in a forward motion.

7.2 Dentate person (with teeth)

- The teeth should be cleaned with a tooth brush a **MINIMUM** of twice a day (The British Dental Association (2008a))
- Mouthwash may be used especially after meals to remove debris
- Ensure tongue is also brushed
- Ensure patient rinses well with water to ensure all toothpaste is removed as it dries the mouth
- Use moisturiser or a similar product to keep lips moist and so avoid drying and cracking
- Use denture fixative (patient's own regular brand)
- Reassess each shift and take appropriate action if any problems are identified

7.3 Edentate person (no teeth)

- **MINIMUM** twice daily brushing of gums with toothbrush and toothpaste (The British Dental Association (2008a))
- Soaked gauze may be used to clean gums for patients with sore mouth
- The mouth should be rinsed well with water to ensure all toothpaste is removed as it dries the mouth
- Offer mouthwash in between brushing
- Use moisturiser or a similar product to keep lips moist and so avoid drying and cracking
- Use denture fixative as per patients' preference/usual brand if available; if not ward stock may be used
- Reassess each shift and take appropriate action if any problems identified

N.B. Saline soaked gauze must not be used in place of a tooth brush.

7.4 Denture or oral appliance care

Remove dentures/appliance and clean a minimum of 12 hourly (see Appendix 6).

When rinsing dentures the preferred area would be to use the sinks in the patient washrooms in the core central block on the wards. For wards that do not have wash rooms, then patient bathrooms could be used. If none of these are suitable/ practical then the bay wash handbasin could be used as long as it is thoroughly cleaned & flushed afterwards to prevent bacterial contamination. Under no circumstances should Disposal Rooms/Treatment Rooms be used.

Denture cleaning:

- Dentures should be removed at night and left to soak in either water or a Milton solution (2 teaspoons to one cup of water)
- Soak dentures for 20 minutes in Milton solution (1% Sodium Hypochlorite solution); add ½ a capful (15ml) to 1L of water
- Store in a labelled pot
- Prepare a new solution every 24 hours
- After soaking in the Milton solution, rinse dentures in water before replacing back in the mouth

STEREDENT ® is NOT recommended due to the serious harm if swallowed.

If ill fitting, then dentures should be avoided where possible and diet amended accordingly until dentures can be replaced/repaired.

The patients/ carers are responsible for repair/replacement unless dentures have been lost by the hospital (see Appendix 1).

8. CRITICAL CARE/ DYSPHAGIA

A suction toothbrush should be used to prevent aspiration pneumonia for any patient who is unconscious, intubated or has difficulty swallowing (Schieder et al 2002, Schieder 2003, Cutler and Davis 2005).

A pea-sized amount of fluoride toothpaste should be used, and oral care performed a minimum of twice a day.

Additionally:

- Ensure patient is positioned in the recovery position to ensure all fluids can drain easily from mouth to avoid a choking hazard
- If using suction no more than 120mm/Hg or 20 kPa
- Follow mouth care guidelines as above
- Consider the use of artificial saliva
- Moisturise lips to keep moist and avoid drying and cracking

9. CONSENT

The administration of mouth care requires patient (or carers) consent.
Where the patient is unable to give consent care may be given under the Adults with Incapacity Scotland Act, (2000), firstly ensuring that an Adult with Incapacity Form is in place.

10. AUTHORISED PROFESSIONALS

A RN or midwife MUST carry out the oral assessment whilst Health Care Support Workers may carry out oral care, if deemed competent or under supervision of a RN.

Student Nurses who have had formal training pre- registration may undertake oral care, but it is the responsibility of the RN to carry out an oral assessment, plan and evaluate care, using relevant documentation.

11. EDUCATION AND TRAINING

In order to ensure safe practice and minimise risk, staff must be appropriately skilled and competent in the above technique. The Standard Operating Procedure can be used to assess skills and competence.

Additionally, whist no formal training is required for practitioners to undertake this procedure all staff are encouraged to attend the NHS Tayside Oral Health and Dysphagia Study Day and reflect upon their own competence, skills and knowledge.

12. LEGAL LIABILITY

NHS Tayside as an employer will assume vicarious liability for the actions of all staff, including those on honorary contracts, providing that:

- Staff have undergone any training identified as necessary for the procedure
- The member of staff is authorised by NHS Tayside to undertake the procedure
- The provision of this protocol and the supporting procedure has been followed by the member of staff at all times

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5.1.1 STANDARD OPERATING PROCEDURE – Oral Care Assessment and Technique

Policy Food, Fluid and Nutritional Care	**Policy Reference:** 5.1.1	**Originator:** Victoria Hampson

Operation	Oral Care Assessment and Technique
Part Number/ Name	This procedure is recommended for all staff performing mouth care for adult patients
Safety Tools/ Clothing	Universal precautions
Tools/ Equipment	Clean tray Disposable plastic cups/clean tooth mugs (for rinsing) Mouthwash Disposable vomit bowls Paper tissues Small headed, soft toothbrush Toothpaste Disposable gloves Denture pot, denture brush and toothpaste/liquid soap/Milton solution (if edentate) Small torch Contiwipes for holding mouth open or tongue down (wooden spatula's are not recommended as they have been known to cause trauma) Plastic tweezers Lip lubricant – water based e.g. KY Jelly **Sponge sticks are not recommended (see Medical Device Alert, Appendix 2) and may present a serious choking hazard to patients.**

No	Main Operating Steps	Rationale	Evidence/support
1	Ensure all the correct equipment is available and assembled and perform the following checks: • sealed packaging • expiry dates	To assure equipment is sterile and expiry dates still current	NHS Tayside Infection Prevention and Control Policy (2015)
2	Explain the procedure and gain the patient (or carers) consent to the procedure	To advocate for the patient and promote empowerment	NHS Tayside Informed Consent Policy(2014)
3	Position patient comfortably and safely	Patient safety/person centeredness	
4	Wash hands using hygienic hand wash procedure and apply gloves	Reduce the risk of cross infection Adherence to infection control policy	NHS Tayside Infection Prevention and Control Policy (2015)
5	Prepare solutions as required	Solutions must always be prepared immediately before use to maximise efficacy and minimise contamination	NHS Tayside Infection Prevention and Control Policy (2015) NHS Tayside Safe and Secure Handling of Medication Guidance (2008)

6	If the patient has dentures and is unable to remove them, grasp the upper plate of the front teeth with the thumb and second finger and move the denture up and down slightly. Lower the upper plate, remove and place in a denture pot. The slight movement breaks the suction that secures the plate	Removal of dentures is essential to clean underlying tissues If the tongue, teeth or mucosa are coated and candida is present, anti-fungal preparations must be used along with standard care and Difflam mouthwash. Nystatin or amphoterecin act on the candida. These must also be prescribed by medical staff. When candida is present it may also be harboured in the patient's dentures.	Buglass 1989 Sweeney (1998) Thurgood (1994) Turner (1996) Ryles (2007) Royal Marsden (2011)
7	Lift the lower plate, turning in order that one side is lower than the other, remove and place in a labelled denture pot	By angling the lower plate removal is aided without stretching the lips	Ryles (2007)
8	If the patient has a partial denture, this may be removed by exerting equal pressure on the border of each side of the denture	Holding the clasps may result in damage/breakage	Ryles (2007)
9	Inspect the patient's mouth with a small torch	The mouth is examined for changes in condition with respect to moisture, cleanliness, infected or bleeding areas, ulcers etc.	Sweeney (1998) Thurgood (1994) Turner (1996) Ryles (2007) Royal Marsden (2011)
10	Using a small soft toothbrush and toothpaste/Brush patient's natural teeth, gums and tongue *Studies suggests nurses, are fearful of using tooth brushes preferring to the use of sponge sticks. However, this is not effective in the removal of plaque and debris. There is also the danger of the sponge becoming separated from the stick.*	To remove adherent materials from, teeth tongue and gum surfaces. Brushing stimulates gingival tissues to maintain tone and prevents circulatory stasis.	Ransier et al (1995) Sweeney (1998) Thurgood (1994) Turner (1996) Ryles (2007) Somerville (1999) Royal Marsden (2011)
11	Hold the brush against the teeth with the bristles at a 45 degree angle. The tips of the outer bristles should rest against and penetrate under the gingival sulcus. Then move the bristles back and forth using a vibrating motion, from the sulcus to the crowns of the teeth.	Brushing loosens and removes debris trapped on and between the teeth and gums. This reduces the growth medium for pathogenic organisms and minimises the risk of plaque formation and dental caries.	Ransier, A. et al (1995) Sweeney (1998) Thurgood (1994) Turner (1996) Ryles (2007) Royal Marsden (2011)

	Clean the biting surfaces by moving the toothbrush back and forth over them in short strokes Repeat until all teeth surfaces have been cleaned		
12	Encourage patient to rinse the mouth with water as vigorously as possible then void contents into a receiver. Paper tissues should be readily available. If the patient is immuno-suppressed do not allow to rinse directly into a sink If the patient is unable to rinse and void, use a rinsed soft toothbrush to clean the teeth, gums and oral mucosa. If use of a saline soaked swab is appropriate, the swab should be used in a rotational action to wipe the gums and oral mucosa Use a moistened Contiwipes to remove excess toothpaste for patients who are unable to rinse	Rinsing removes loosened debris and toothpaste and makes the mouth taste fresher. The glycerine content of toothpaste will have a drying effect if left in the mouth. Reservoirs of stagnant water may harbour Pseudomonas bacteria To remove debris as effectively as possible By removing toothpaste residue reduce side effect of dryness from toothpaste and irritation to lips by peppermint oil/flavourings	Sweeney (1998) Thurgood, (1994) Turner (1996) Ryles (2007) Royal Marsden (2011)
13	Apply artificial saliva to the tongue if appropriate and/or suitable lubricant to dry lips (water-based e.g. KY Jelly)	To increase the patient's feeling of comfort and well-being and prevent further tissue damage	Ryles (2007)
14	If the patient has dentures - clean the patient's dentures on all surfaces with a toothbrush (see Appendix 6) Hold dentures over a sink of water in case they are dropped Liquid soap (from a dispenser) and cold running water should be used to clean dentures Prior to placement in the patient's mouth, dentures must be checked for cracks, sharp edges and missing teeth Rinse them well and return them to the patient Use dentures fixative as per	Cleaning dentures removes accumulated food debris which could be broken down by salivary enzymes to products which irritate and cause inflammation of the adjacent mucosal tissue Some commercial denture cleaners may have an abrasive effect on the denture surface. This then attracts plaque and encourages bacterial growth	Ryles (2007)

	patients' preference		
15	Dentures should be removed at night and placed in a suitable cleaning solution for 20 minutes (Milton) prior to being left to soak in cold water This solution should be replaced every 24 hours.	The use of Steredent is prohibited for hospital use A Milton solution may be used If oral candida species are present, dentures should be soaked in diluted antifungal for 4-6 hours daily or few drops of added Chlorhexidine mouthwash but never both at once Soaking in diluted antifungal reduces the risk of reinfecting the mouth with infected dentures but Chlorhexidene mouthwash antagonises antifungal such as Nystatin as affects Ph	Sweeney (1998) Thurgood (1994) Turner (1996)
16	Discard remaining mouthwash solutions Clean and thoroughly dry the toothbrush	To prevent the risk of contamination	NHS Tayside Infection Prevention and Control Policy(2015) Royal Marsden (2011)
17	Remove gloves and wash hands with soap and water or alcohol hand rub and dry with paper towel	To reduce the risk of cross infection	NHS Tayside Infection Prevention and Control Policy (2015)
18	Document all care in the patients notes and review patients oral care needs using the traffic lights per shift		NHS Tayside Policy for Records and Record Keeping (2016

APPENDIX 1: Emergency Dental Care Pathway for Secondary Care Adult In-Patients

For the purpose of referral, urgent dental care is defined as the patient presenting with an **acute disorder** of oral health such as: traumatically broken, loose, or avulsed teeth, infections and inflammations of the oral soft tissues, facial or neck swelling and persistent bleeding.

For suspicion of oral carcinoma - please send an urgent referral to the Department of Oral and Maxillofacial Surgery, Ninewells.

PERTH AND KINROSS	**NINEWELLS**	**ANGUS**	**DUNDEE**
Community Dental Services Broxden Dental Centre, Perth	Oral and Maxillofacial Surgery/ Oral Medicine Ninewells Hospital	Community Dental Services Springfield Medical Centre, Arbroath	Community Dental Services King's Cross HCCC Dundee
9am-5pm Monday-Friday Tel: 01738 450550 Fax: 01738 450578 Out of Hours: contact NHS 24	9am-5pm Monday-Friday Tel: 35593 Fax: 425703 Out of Hours: advice only given – will be seen by DF2 next working day Max Fax On-Call (trauma only)	9am-5pm Monday-Friday Tel: 01241 432481 Fax: 01241 432480 Out of Hours: contact NHS 24	9am-5pm Monday-Friday Tel: 01382 596990 Fax: 01382 596995 Out of Hours: contact NHS 24

DENTURES

Denture repair/replacement is NOT undertaken by Hospital or Community Emergency Dental Services for in-patients

Ill-fitting dentures: **remove** and give to relative/carer for safe keeping. It may be necessary to arrange for a suitable diet to be given until the patient /carer is able to arrange an appointment to have new dentures made

Broken dentures: remove and give to relative/carer for safe keeping or **to send for repair.** It may be necessary to arrange for a suitable diet to be given

Lost dentures: if patient is in long term hospital care and the dentures are lost whilst in hospital then these may be replaced at the discretion of dental services (contact Heather MacRitchie at King's Cross

APPENDIX 2: Medical Device Alert – Oral Swabs with a Foam Head

Medical Device Alert

Ref: MDA/2012/020 Issued: 13 April 2012 at 12:00

Device

Oral swabs with a foam head.

All manufacturers.

Problem

Foam heads of oral swabs may detach from the stick during use. This may present a choking hazard for patients.

Action by

All those involved in the use and supply of these devices including those who advise patients and carers.

CAS deadlines

Action underway: 27 April 2012

Action complete: 14 May 2012

Action

Follow the manufacturer's instructions for use (where available).

Check that the foam head is firmly attached to the stick before use.

Do not leave the swabs soaking in liquid prior to use as this may affect the strength of the foam head attachment.

If required moisten the swab immediately before use.

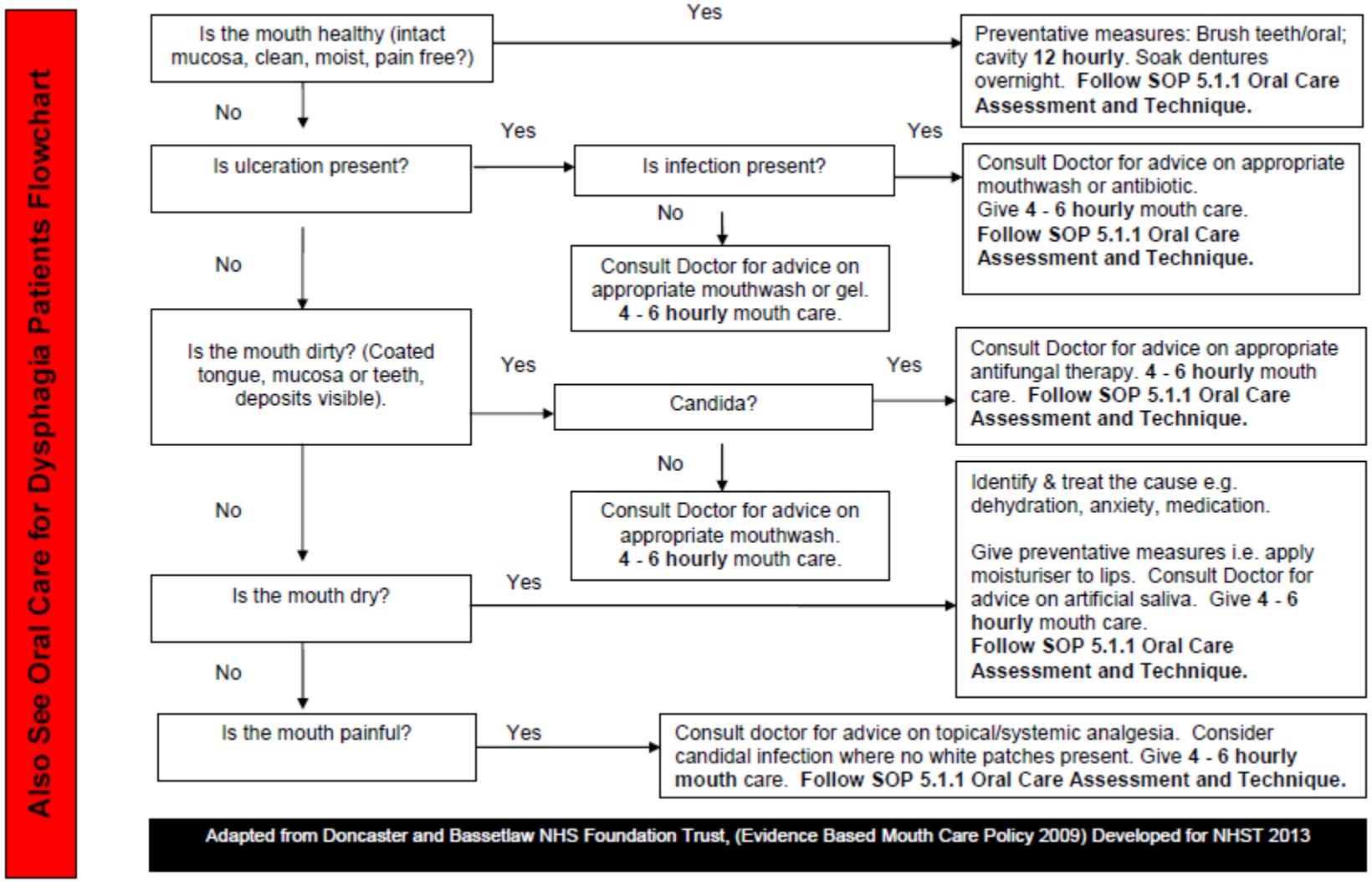
If the patient is likely to bite down on the swab consider using an alternative such as a small headed toothbrush with soft bristles.

Ensure that all users, including unsupervised patients and carers, are aware of this advice and the manufacturer's instructions for use.

Discard oral swabs after use.

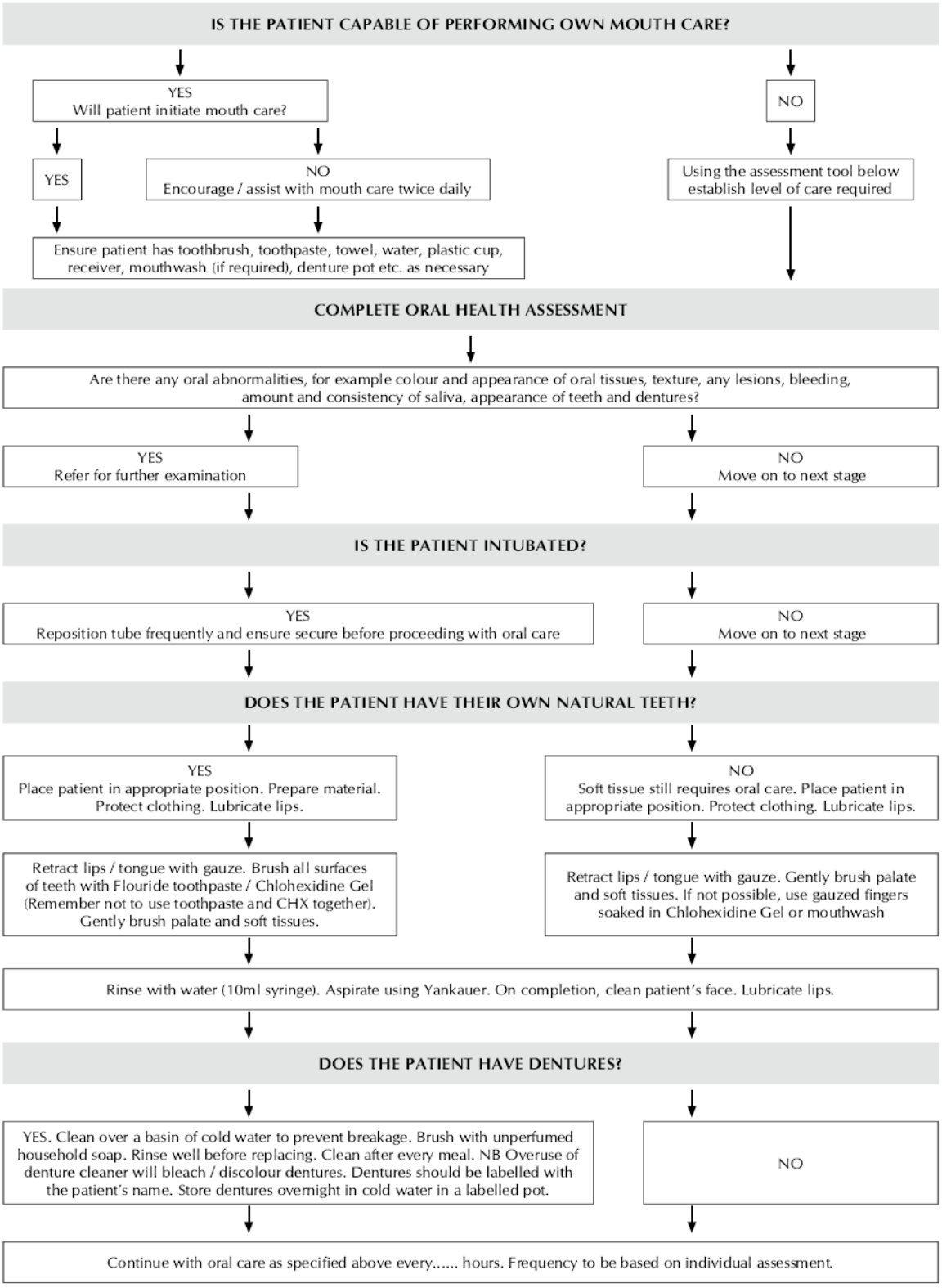
This advice supersedes the advice given in MDA/2008/017.

APPENDIX 3: Mouth Care Flow Chart



APPENDIX 4: NHS Tayside Oral Care for Dysphagic Patients

ORAL CARE FOR DYSPHAGIC PATIENTS

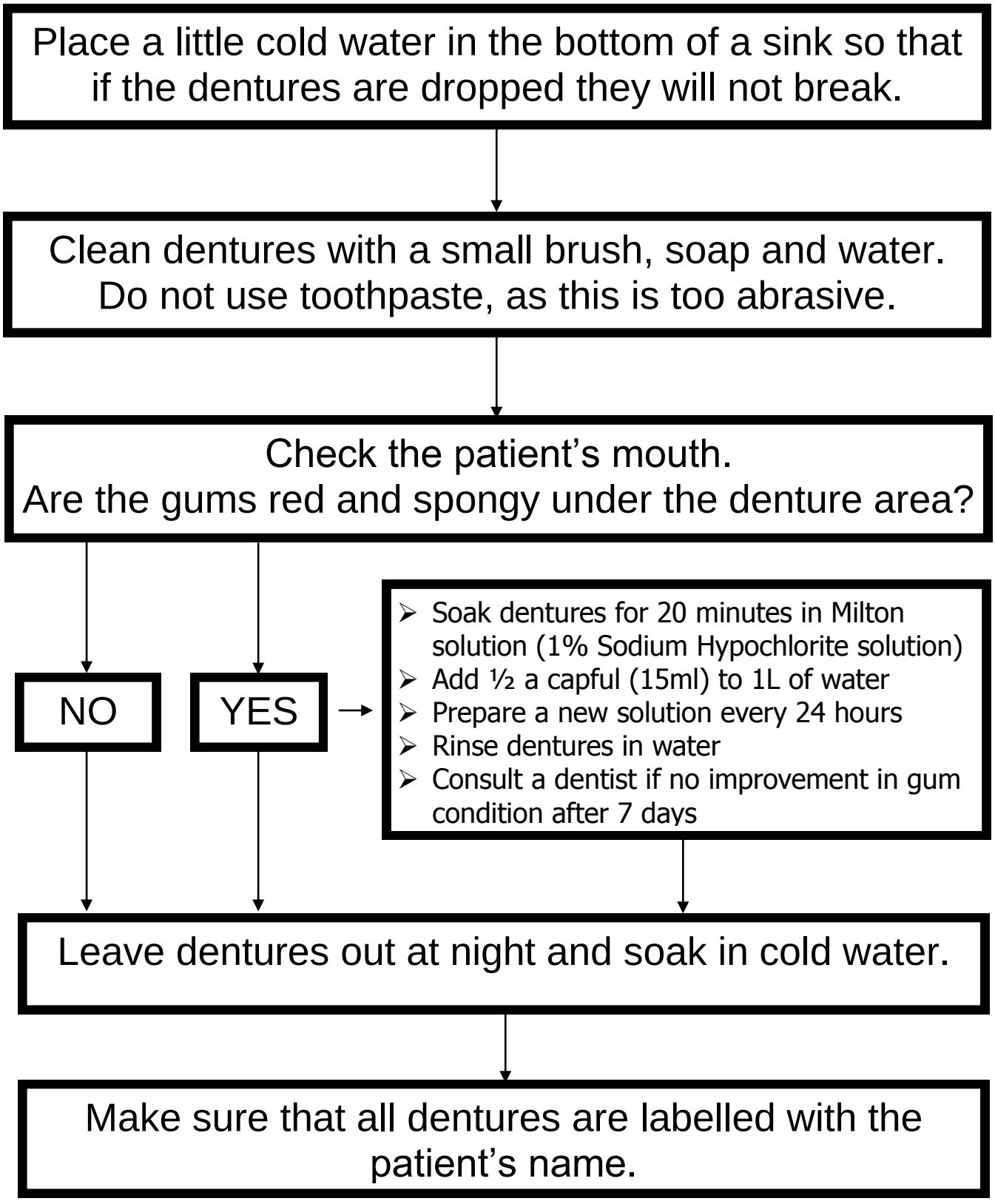


Source: Scottish Intercollegiate Guidelines Network (SIGN 119) (2010)
This flowchart is from SIGN Management of Patients with Stroke: Identification and Management of Dysphagia, A national clinical guidelines (Annexe 6)

APPENDIX 5: Drugs that can affect Oral Care

Drugs	**Affect**
Cytotoxic/Chemotherapeutic Drugs	Reduce the auto-immune response
Corticosteroids	Affect the healing properties of tissues
Antibiotics	Alter the bacterial balance of commensal organisms in the mouth and allow candidal invasions
Antispasmodics	Alters gut mobility and reduces salivary production
Antihistamines Anticholinergics Psychotropic's Antidepressants and tranquillisers	These groups of drugs reduce salivary production
Diuretics	Potential dry mouth due to increased fluid loss
Morphine	Strong association with dryness of the mouth/nausea
Radiotherapy to the Head and Neck	Reduced ability to eat/drink normally Localised inflammation
Oxygen Therapy	Unhumidified Oxygen administered by mask can dry the mouth
Intermittent suction	Potential risk of damage to oral tissues
General Anaesthesia	Reduces oral secretions/ nausea and vomiting

Denture Care



APPENDIX 7: The Lloyd Goss Oral Health Assessment

WRITE OR ATTACH LABEL
Surname……..Sex……..
Forename……..
DOB and CHI……

For barcode

Hospital _____ Ward _____

THE LLOYD-GOSS ORAL HEALTH ASSESSMENT SCALE AND RECORD

A	LIPS	Score
	Smooth & Moist	0
	Dry/Cracked	1
	Bleeding	2
	Ulcerated	3

B	TONGUE	Score
	Pink & moist	0
	Coated	1
	Shiny/Red	2
	Blistered/Cracked	3

C	MUCOUS MEMBRANE	Score
	Pink & moist	0
	Reddened/Coated	1
	White patches	2
	Ulcerated/Bleeding	3

D	SALIVA	Score
	Watery	0
	Thick	1
	Insufficient	2
	Absent	3

E	TEETH/DENTURES	Score
	Clean/No Debris	0
	Localised plaque/debris	1
	Generalised plaque/debris	2
	Caries/Ill-fitting denture	3

F	PAIN	Score
	Pain-free	0
	Fear of pain	1
	Pain on Movement	2
	Uncontrolled Pain	3

G	MENTAL STATUS	Score
	Alert/Motivated	0
	Sedated/apathetic	1
	Uncooperative	2
	Unconscious	3

H	NUTRITION	Score
	Good	0
	Anorexic	1
	Fluids only	2
	No intake	3

I	OTHER FACTORS: *if present score additional:-*			
Oral thrush		5	O_2 therapy/dyspnoea	5
Recent Chemo/Radiotherapy		5	Steroid Therapy	5

Scoring Risk: 6 or less = *no risk*, 7-10 = *low risk*, 11-19 = *medium risk*, 20+ = *high risk*

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