Lincolnshire Community Health Services NHS Trust

Lincolnshire community Health Trust
United Lincolnshire Hospital Trust
St Barnabas Hospice
Marie Curie

Lincolnshire wide policy for the assessment and provision of Mouth Care (Adult Palliative Care)

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Policy Statement

Background The purpose of this policy is to ensure a consistent approach to the Mouth care of patients Countywide in Lincolnshire with Hospital ,Hospice and community services**.**

Statement This is a new policy developed across services and will be implemented for staff within LCHS, ULHT AND St Barnabas Hospice services.
The aim is to create a united approach to mouth care to ensure all patients are receiving evidence based mouth care.

Responsibilities All staff are required to ensure that the policy is adhered to, ULHT,LCHS and St Barnabas.

Training Training on this policy is available through ESR. Training is provided by Clinical Educator initially to enable cascade training within departments.

Dissemination Via Team Brief and LCHS and ULHT Websites and available on the J-Drive

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AIM

The aim of this document is to create a united approach to Mouth care and ensure all patients within Lincolnshire are receiving evidence based mouth care.

INTRODUCTION

Oral hygiene is important for patients' health and well-being for a variety of reasons. The mouth is intricately linked with appearance, nutrition, speech and general health (Steel 2017 a). Poor oral health causes discomfort. Pain and interferes with eating, speaking, swallowing and communication, adversely affecting peoples heath related quality of life (Public Health England PHE 2015). Oral health is relatively neglected in healthcare despite recent increasing recognition of its importance (Steel 2017a)

DEFINITIONS

- **Mouth care (Oral Hygiene)** – the condition or practice of maintaining the tissues and structures of the mouth in a healthy state.
- **Aspiration** – food or fluid go below the level of the vocal cords which can lead to chest infections and aspiration pneumonia.
- **Cheilitis** – reddened, crusting or bleeding area, often around the lips.
- **Debris** – dead, diseased or damaged tissue and any foreign material that is to be removed from a wound or other area being treated.
- **Dental caries** – a plaque-induced disease caused by the complex interaction of food, especially starches and sugars, with bacteria that form dental plaque.
- **Dental plaque** – a biofilm composed of microorganisms that attaches to the teeth and causes dental caries and infections of the gingival tissue.
- **Dysphagia** – difficulties with eating, drinking and swallowing
- **Dysphagia Trained Nurse (DTN)** – a nurse who has been trained by Speech and Language Therapists to conduct a basic screen of someone's swallowing
- **Gingivitis** – a condition in which the gingival margin around the teeth can be red, inflamed, swollen and may bleed.
- **Halitosis** – offensive breath commonly caused by poor oral hygiene, dental or oral infections.
- **Leukoplakia (white) –** a lesion that cannot be scraped off or attributed to any other cause.
- **Mucositis** – inflammation of the lining of the mouth
- **Oral candidiasis** – also known as oral thrush, this common fungus can become prevalent when the natural fauna and flora of the body are unbalanced.
- **Stomatitis** – inflammation of the oral cavity with or without ulceration.
- **Tartar** – hardened plaque adhered to teeth.
- **Ulceration** – ulcers which are white, small, punched out lesions of epithelial surfaces of the mouth, probably of viral origin.
- **Xerostomia** - dryness of the mouth caused by reduced saliva secretion (Malkin 2009).

EVIDENCE BASED PRACTICE

The Essence of Care (Department of Health, 2010) highlighted oral hygiene as a priority, acknowledging it as an indicator of the standard of patient care. The importance of oral care for good communication and nutrition should not be

underestimated. Good oral care is integral to general health and essential for an individual's well-being and is a determinant factor for quality of life (Public Health England 2017). Oral problems can lead to reduced dietary intake and increase the possibility of malnutrition (World Health Organization, 2007).

Inadequate oral care can be detrimental to social and emotional well-being and adversely affect interaction with others (Rawlins and Trueman, 2001). Poor oral hygiene also increases the risk of infection (British Society for Disability and Oral Health, 2000). This risk is often significantly underestimated, resulting in lower priority for oral care compared with other nursing activities (Furr et al, 2004). Patients with dysphagia and poor oral hygiene can be at high risk of aspirating debris and bacteria from the oral cavity resulting in aspiration pneumonia.

The purpose of this policy is to provide guidelines to avoid mouth care practices which are often historical rather than research or evidence based. A mouth care assessment tool is essential in order to make an initial assessment and to promote high quality and standardised oral care through a coordinated team approach. Failure to conduct an adequate oral assessment and documentation of oral care management may be interpreted as a poor standard of holistic care (NICE guidelines oral health for adults 2017). As nurses/practitioners we should be mindful of our legal responsibilities to not only ensure high standards of care for patient/clients but also accurate documentation (Public Health England Delivering Better Oral Health 2017, NMC 2018).

MOUTH CARE

In a healthy mouth, oral mucosa and the tongue should be pink and moist, with smooth and moist lips and clean teeth or well-fitted dentures. Difficulties with swallowing or eating may make it hard to maintain the mouth's healthy condition, as build-up of debris can alter its pH and inadequate dietary intake can reduce salivary flow.

The principal objective of oral care is to maintain the mouth in a good condition. It specifically aims to:

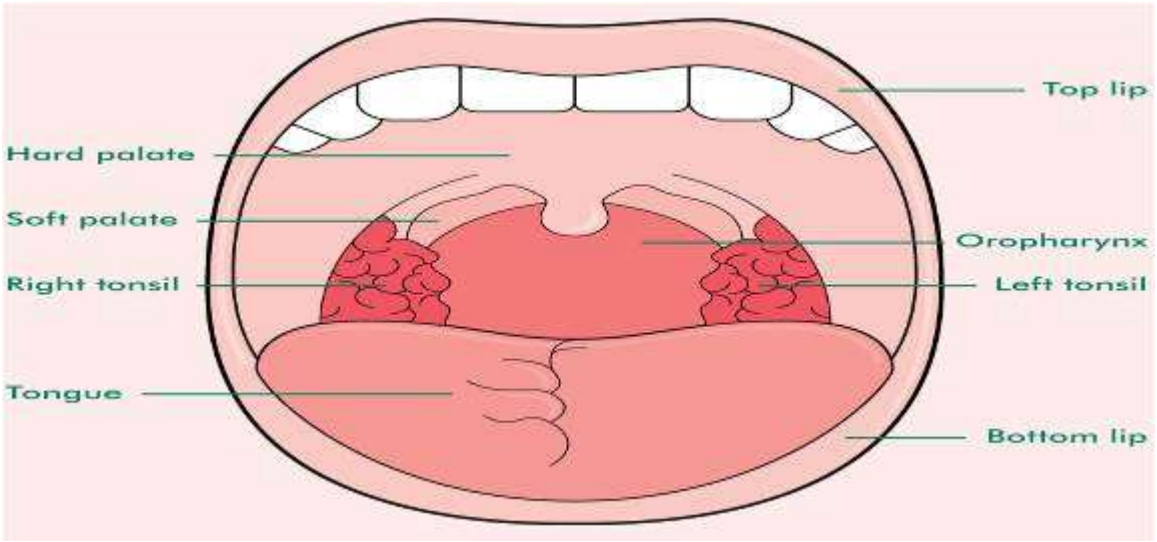
- Keep the oral mucosa clean, soft, moist and intact, thus preventing infection
- Keep the lips clean, soft, moist and intact
- Remove food debris / dental plaque without damaging the gingiva
- Alleviate pain / discomfort, thus enhancing oral intake (appendix 4)
- Prevent halitosis and freshen the mouth
- Decrease the risk of oral and systemic infection
- Increase general well-being.
- Regular mouth care will prevent or reduce the risk of many oral problems such as infections or mucositis (Palliative care oral NICE CKS 2018)

IMPACT OF ORAL DISEASES

- Pain and discomfort
- Poor Behaviour
- Functional Limitation
- Self Esteem
- Aesthetics
- Social isolation
- Deterioration
- Unnecessary Distress
- Fear and Anxiety
- Communication Difficulties
- Cancer
- (Steel 2017 a)
-

ORAL PHYSIOLOGY

The oral cavity is the first part of the alimentary tract. The structures visible on examination are:



RISK FACTORS

Certain medications and predisposing conditions can put patients at increased risk of poor oral hygiene. Dependent, dysphagic, critically or terminally ill people are particularly vulnerable (British Society for Disability and Oral Health, BSDOH, 2000).

Age

Older people and very young children may have difficulty managing their own oral care due to problems with dexterity, fragility of the oral mucosa as well as being unable to tell their carer when they are in pain. Advanced dental restoration can cause complications in older people if it fails. Additionally, denture wearers are at increased risk of chronic atrophic candidosis (denture stomatitis) as the acrylics within the dentures provide favorable conditions for *Candida albicans* (Arkell and Shinnick, 2003). With increasing age, the risk of gum disease and bone loss increases.

Dysphagia

Dysphagia describes eating and drinking disorders in children and adults which may occur in the oral, pharyngeal and oesophageal stages of deglutition.

If oro-pharyngeal dysphagia is suspected then an assessment of the person's swallowing should be carried out by a suitably trained practitioner (e.g. Speech and Language Therapist, SLT or Dysphagia Trained Nurse, DTN). If the patient has diagnosed dysphagia or is being managed by a SLT, please consult the SLT for patient specific advice.

Subsumed in this definition are problems positioning food in the mouth and in oral movements, including sucking, mastication and the process of swallowing. The 'normal' swallow needs the respiratory, oral, pharyngeal, laryngeal and oesophageal anatomical structures to function in synchrony, which is dependent upon the motor and sensory nervous system being intact.
(Royal College of Speech and Language Therapists, 2016).

Mental health

Those with mental health problems may not have an awareness of the need or importance of oral care and may also be unable to express to health professionals when they have problems. Oral symptoms may be the first manifestation of mental health problems (BHSDOH 2000)

Learning and physical disabilities

Some patients may be unable to carry out oral care or express their problems with it (Bollard, 2002). Medications given in syrup form, in addition to a tendency to mouth breathe; can result in dental caries and xerostomia. Those with severe and profound learning disabilities may have behavioral problems with biting that make their oral hygiene difficult to maintain (Bernal, 2005).

Dementia

Decline in cognitive function associated with dementia frequently causes behavioural changes that directly affect oral health. People with mild to late stage dementia may develop reflexes that make tooth brushing difficult such as closing their lips, clenching their mouth, biting ad moving their head (Mouth Care Matters 2017). There is also an increased risk of a dry mouth due to mouth breathing and medication,

which can lead to difficulty eating and drinking and increased dental pain (Brennan and Strauss 2014).

Poor diet
Inadequate dietary intake reduces the secretion of saliva, while a lack of sufficient vitamins and minerals can predispose patients to infection (BSDOH, 2000) and malnutrition. A high intake of refined carbohydrates and sugar can affect oral health and increase the risk of dental carries (Delivering better oral health PHE 2107)

Tobacco smoking
Smoking increases the risk of periodontal disease, increases the risk of losing teeth and reduces benefits of treatment (NHS England 2017)

Medical conditions
Immunosuppression related to conditions such as HIV, leukemia, diabetes and cancer can have oral manifestations and their associated treatments such as radiotherapy, can impact on hydration and the natural flora of the oral cavity, putting patients at risk of infection or malnutrition. Diabetes and poor sugar control can increase the risk of gum disease and make treatment less effective. The mouth will also be affected by conditions which render a patient unconscious, including for those patients at the end of their lives. Dehydration or the absence of oral intake will reduce the protective production and function of saliva (xerostomia) (Malkin 2009).

Medications
Medicines that can alter the fauna and flora of the oral cavity by reducing protective salivary secretion include:

- Anticholinergics
- Antiemetics
- Antibiotics
- Diuretics
- Antihypertensives
- Anticonvulsants – can also cause gingival hypertrophy (Bharti & Bansal 2013)
- Antidepressants
- Antispasmodics
- Analgesics – particularly opioid based

Medicines that suppress the immune system include:

- Steroid therapy
- Chemotherapy

Oxygen has been noted to have a drying effect on the mucosa. (Malkin 2009)

ASSESSMENT

Patients under care of ULHT and LCHS may have an assessment of their oral hygiene using the Oral Assessment Tool (Appendix 2). This guidance applies to all healthcare professionals and healthcare assistants involved in patients' care.

Capacity to consent to treatment:
Prior to any assessment consent needs to be gained from the patient. All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. If a patient declines mouth care, it does not mean they have a lack of capacity, as long as they understand the consequences of their decision. If an adult lacks the capacity to give consent, a decision on whether to go ahead with oral hygiene will need to be made by the health professionals treating them. In order to make a decision, the person's "best interests" must be considered (Mental Capacity Act 2005).

Assessment is needed to identify and initiate interventions and evaluate progress and establish the patient's ability to self-oral care. This requires an understanding of related anatomy and physiology yet there appears to be a lack of nursing knowledge about oral care (Evans, 2001). Assessment can also be hindered by reluctance and nurses' perceptions about oral care (Clay, 2000).

An initial assessment should include clarifying with patients or carers:-

- History of previous dental care
- Previous and current oral problems
- Patient age and other risk factors such as dentures and advanced dental restorations
- Current nutritional status
- Identify potential dysphagia. Patients with oro-pharyngeal dysphagia should refer to local Speech and Language Therapist guidance
- Current treatment and any proposed regimen, including medications, radiotherapy and surgery
- Usual oral hygiene practices

Gloves and aprons must be worn during physical assessment and oral hygiene procedures, in accordance with infection-control policies (Malkin 2009).

Visual examination
A visual examination of the oral cavity should be done with patient's consent. A pen torch and tongue depressor are needed to clearly identify the structures and any abnormalities. Familiarity with the oral cavity's structures will enable assessors to identify any abnormalities. Loose teeth should be identified, and advice sought from a dentist regarding advice on their removal.

Voice
The voice changes in response to infection (viral, bacterial or fungal) and dryness. (Stemple et al 2000, Casper and Leonard 2006). Changes in voice should be investigated and treated as appropriate, e.g. if infection is suspected refer to medical practitioner for appropriate treatment.

Swallow reflex
If oro-pharyngeal dysphagia is suspected then an assessment of the person's swallowing should be carried out by a suitably trained practitioner (e.g. Speech and Language Therapist, SLT or Dysphagia Trained Nurse, DTN). If the patient has diagnosed dysphagia then please refer to local SLT for guidance with oral care.

Dry mouth care of patients in last days of life
If the patient has a dry mouth ensure regular mouthcare as per guidance provided. Factors such as dehydration, mouth breathing and oxygen therapy should increase the frequency of oral care to maintain patients' comfort and reduce further risk (Cooley, 2002).

Best practice
- Daily assessment – identify all risk factors and status of all oral structures, including voice and swallowing
- Plan oral hygiene with patients if possible
- Twice daily brushing with toothbrush and fluoride toothpaste, spit, don't rinse
- Floss if assessment indicates it is safe to do so, or use interdental brushes
- Use antiseptic mouthwashes twice daily between brushing, if prescribed
- Use mouthwashes after oral intake if prescribed
- Ensure frequent oral fluid intake if condition allows
- Consider using saliva replacement products for dry mouths
- Keep lips supple and moist with paraffin or lip salve. (*Contraindicated in oxygen therapy use water based products only i.e. KY Jelly*
- Ensure denture care includes brushing with denture cream and the use of proprietary dental cleaners
- Document oral care for evaluation (Malkin 2009)

STAFF WHO MAY CARRY OUT THE PROCEDURE
The mouth care needs of patients are identified on an individual basis**.**
In line with guidelines laid down by the Nursing and Midwifery Code (NMC) (2018) for records and record keeping there must be a current and appropriate plan of care for all patients. The plan must incorporate on-going evaluation and reassessment of care and evidence that relevant interventions and observations have been communicated to appropriate members of the multidisciplinary teams.

Patient/Carer advice points
- Refer to a dentist if pain or ulceration in the mouth
- Regular tooth brushing and dental hygiene are essential
- Visit a dentist regularly who can recommend frequency of check ups needed even if no teeth are present and advise on plaque removal to prevent gum disease and tooth loss. People with dry mouths, predisposing factors or those

with extra needs may need a fluoride varnish to their teeth.(NHS Choices provides information on free dental care and finding an NHS Dentist)
- Avoid frequent sugary drinks and snacks during the day (frequent consumption of sugary drinks and foods is an important cause of dental caries (Maynihan & Kelly 2014)

Oral care for patients in the last days of life

- Carry out mouth care as often as necessary to maintain a clean mouth. See Self-care in the Scenario: Prevention (Appendix 1)
- In people who are conscious, the mouth can be moistened every 30 minutes with water from a water spray or dropper, or ice chips can be placed in the mouth.
- In unconscious people, moisten the mouth at least once an hour with water from a water spray, dropper, or moutheze oral care stick.
- To prevent cracking of the lips, smear petroleum jelly (for example Vaseline®) on the lips. However, if a person is on oxygen apply a water-soluble lubricant (for example K-Y Jelly®).
- When the weather is dry and hot, if possible, use a room humidifier or air conditioning.
- Manage pain symptomatically, using analgesics via a suitable route. Stop treatment of the underlying cause of pain when the burden of treatment outweighs the benefits. See Appendix 3: Oral pain.
- Dry mouth and thirst are very common in people who are dying, regardless of whether they are dehydrated. Reversing dehydration improves symptoms in only a small number of people.

Basis for recommendation

The basis for these recommendations is expert opinion:-

- People in the last 24–48 hours of life often have difficulty taking food, fluid, or oral medication. Good symptom control may allow the dying person to eat, drink, and talk comfortably. Mouth care can easily be carried out by the family, giving them greater involvement in the care of their dying relative.

(NICE Palliative Care–Oral, 2018, NICE Guidance on care of the dying adult in the last days of life 2015)

EQUIPMENT FOR PROCEDURE

Mouthwash

Mouthwashes are an adjunct to brushing, not a replacement (Steel 2017b) For those with active caries, dry mouth or risk factors 0.05% (225ppm) fluoride mouthwash is recommended (PHE 2107) Fluoride mouthwashes should be used once a day and at different times to brushing (Steel 2017 b). Some mouthwashes interact with toothpaste, use with precaution and consult local pharmacy advice. Antiseptic mouthwashes are effective antibacterial agents but prolonged use may cause reversible staining of the teeth and adversely affect the natural microorganisms in the oral cavity (Rawlins and Trueman, 2001). Chlorhexidine gluconate 0.2% mouthwash is the most effective antibacterial mouthwash, producing a significant reduction in dental plaque when combined with brushing (Richards 2017) It is useful as a short term agent when brushing is more difficult. It should not be used within 30 minutes of tooth brushing because ingredients in the products inactivate each other (Steel 2017b) Patients with oro-pharyngeal dysphagia may not be able to use mouthwashes as they are at risk of reduced oral control resulting in aspiration of the mouthwash.

- Water-based mouthwashes may be better tolerated and these are effective for debris removal from teeth and the oral cavity, and some studies support their use as antiseptic agents (Knox et al, 2000). However, earlier studies identified their ineffectiveness in plaque removal (Kite and Pearson, 1995).
- Many mouthwashes contain alcohol and therefore may not be suitable for those who abstain through principal e.g. Muslim faith.

Corsodyl is a chemical plaque remover and therefore not indicated in people without teeth (excluding radiotherapy)
(Worthington et al, 2007)

Toothbrush

A small headed, soft bristle toothbrush with a long handle is preferable and will remove plaque and debris from the surfaces and crevices of teeth with minimal gingival trauma, even when a person is unable to brush their own teeth (Pearson and Hutton, 2002) Various methods exist to facilitate self-care in those with reduced manual dexterity such as grips and chunky tooth brush handles. Electric toothbrushes could be an alternative as they tend to be chunkier and require less pressure and manual dexterity. A systematic review showed better plaque control with an electric versus a manual brush (Yaacob et al 2014).Twice daily brushing is ideal with a pea-sized amount of fluoride tooth paste (4350ppm) spitting after brushing (Steel 2017 b) High risk patients will benefit from a higher concentration of fluoride which is available on prescription.

Moutheze oral cleansers
Moutheze oral cleansers are a replacement for the mouth sponge swab. .They can be used to provide dry mouth care, including the application of dry mouth gels; the soft, rubbery head can hold water to help hydrate and cleanse the mouth and by applying a rotating action Moutheze can collect food debris and tenacious dried saliva. They are gentle enough to use on patients with sore mouths and yet strong enough, with a hard plastic handle, to reduce the choking hazard. The integrity of the Moutheze should be checked by tugging the end before use, and should be used with care for patients who have strong biting reflexes, for example those with profound brain injury . (HEE 2017 Mouth Care Matters) Moutheze is for those people who are dependent or require assistance for mouth care and for people where conventional methods i.e. toothbrushes are not suitable; they should not be used to brush teeth (Appendix 3).

Toothpaste
Fluoride prevents dental cavities by protecting gums and teeth and toothpastes containing this should be used. A high concentration fluoride toothpaste can be prescribed for those with predisposing factors. A pea-sized amount of toothpaste should be used on a toothbrush and a smear for people with dysphagia (HEE Mouthcare matters 2017)

Patients who have a hypersensitivity to toothpaste or unable to tolerate using toothpaste could use a foamless (non SLS, sodium lauryl sulphate) option.

Oral cavity moisturisers
Sucking ice chips or natural pineapple juice is advocated for alleviating the dry mouth that patients frequently experience with a variety of treatments (Clay, 2000) although pineapple juice can be detrimental to dental health if used frequently. Replacement saliva substitutes are advocated for dry mouth xerostomia, but not in excessive volume (Bowsher et al, 1999). Although this replaces moisture it does not provide the antibacterial properties of natural saliva.

Paraffin
NB contraindicated if used with oxygen therapy. (Replace with water based products such as KY Jelly.

Cracked, dry lips are a risk for infection and affect speech ability. Moisturising them maintains integrity and function. The use of soft paraffin or lip salve is effective for this in the absence of oxygen (Cooley, 2002).

Sponge swabs
These are ineffective for removing plaque (Pearson and Hutton, 2002) but may be used for cleaning gums.

MDA/2012/020 whilst identifying that foam heads of oral swabs may detach and thus present a choking problem, it does not advise against using them. Sponge swabs may be used providing certain actions are carried out 1. Check that the foam head is firmly attached to the stick before use in line with infection control procedures. 2. Do not leave the oral swab in liquid before use as this may affect the strength of the foam head attachment. 3. Ensure all users including patients and carers who are not

supervised are aware of this advice and follow manufacturer's instructions for use where available.4.For single use and immediate disposal per episode of mouth care.

Finger/forcep and gauze
Finger/forcep and gauze cleansing is not effective (Holmes, 1996) and the scrubbing action is likely to be traumatic to oral tissues. This method also puts nurses at risk of being bitten by patients.

Denture care
Well-fitted dentures are essential for speech and oral intake. There is significant increased risk of infection from poorly fitted dentures, which can chafe the gums and harbour debris and cause ulceration (Fitzpatrick, 2000).

Once-daily cleansing by toothbrush is effective for cleaning dentures using denture cream. Toothpaste is very abrasive on a plastic denture. Soak in water overnight or when not worn. When using commercial denture cleaners (adhere to manufacturer's instructions whenever possible to help prevent infection risks). If the denture is metal or has a soft lining then commercial cleaners are contra-indicated. Daily replacement of cleansing fluids is necessary to prevent contamination by bacteria such as *Pseudomonas*. Dentures can be rinsed after meal times to aid cleanliness. Always wet a denture before inserting to aid comfort on seating and to assist with retention. Dentures should be placed in a labelled denture pot with a lid, when not in the mouth. Health Education England in their document Mouth Care Matters (2017) have introduced The denture sunflower which prompts extra vigilance to prevent the loss of dentures, which can be distressing for a patient as it affects their dignity and ability to eat and drink (Appendix 5) Always wet a denture before inserting to aid comfort on seating and to assist with retention.
Dental implants should be cared for as a natural tooth.

PROCEDURE GUIDELINES

Equipment for standard mouth care

1.Small bowl	7.Disposable bag
2.Plastic cup	8. Pen torch / good lighting
3.Water	9.Denture pot (label if required)
4.Small headed toothbrush/ moutheze oral cleanser	10.Gauze if dentures are present
5.Toothpaste /SLS free toothpaste	11.Mouthwash if prescribed
6.Disposable gloves & apron (refer to local infection control policy)	12. Artificial Saliva product if indicated

Procedure for delivering mouth care

Action	**Rationale**
1. Explain and discuss the procedure with the patient.	To ensure that the patient understands the procedure and gives his/her valid consent.

2. Wash hands with soap and water/ antibacterial alcohol hand rub and dry with paper towel. Apply apron and disposable gloves.(refer to local infection control policy)	To reduce the risk of cross-infection.
3. Prepare solutions required.(refer to equipment for standard mouthcare)	Solutions must always be prepared immediately before use to maximize their efficacy and minimize the risk of microbial contamination.
4. If the patient cannot remove their own dentures, using a tissue or piece of gauze, grasp the upper plate at the front teeth with the thumb and second finger and move the denture up and down slightly (Kozier et al, 1998). Lower the upper plate, remove and place in denture pot.	Removal of dentures is necessary for cleaning of underlying tissues. A tissue or topical swab provides a firmer grip of the dentures and prevents contact with the patient's saliva. The slight movement breaks the suction that secures the plate.
5. Lift the lower plate, turning it so that one side is lower than the other, remove and place in denture pot once cleansed (Kozier et al. 1998).	Lifting the lower plate at an angle helps removal of the denture without stretching the lips.
6. Remove a partial denture by exerting equal pressure on the border of each side of the denture.	Holding the clasps could result in damage or breakage.
7. Inspect the patient's mouth with the aid of a pen torch and document oral assessment.	The mouth is examined for changes in condition with respect to moisture, cleanliness, infected or bleeding areas, ulcers, etc.
8. Using a soft, small toothbrush and pea sized amount of toothpaste brush the patient's natural teeth, gums and tongue.	To remove adherent materials from the teeth, tongue and gum surfaces. Brushing stimulates gingival tissues to maintain tone and prevent circulatory stasis.

9. Hold the brush against the teeth with bristles at a 45˚ 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 10. Repeat until all teeth surfaces have been cleaned. Clean the biting surfaces by moving the toothbrush back and forth over them in short strokes (Kozier et al. 1998). Interdental brushes enable cleaning between the teeth.	Brushing loosens and removes debris trapped on and between the teeth and gums. This reduces the growth medium for pathogenic organisms and minimizes the risk of plaque formation and dental caries.
11. Encourage spitting not rinsing. Paper tissues should be to hand. If the patient is immunosuppressed do not allow them to rinse directly into a sink.	Reservoirs of stagnant water may harbor Pseudomonas bacteria.
12. Apply artificial saliva product to the mouth if appropriate and/or suitable lubricant to dry lips.	To increase the patient's feeling of comfort and well- being and prevent further tissue damage.
13. Clean the patient's dentures on all surfaces with a denture brush or toothbrush. Hold dentures over a sink of water in case they are dropped (Clay 2000; Curzio & McCowan 2000). Check the dentures for cracks, sharp edges and missing teeth (Curzio & McCowan 2000). Rinse them well and return them to the patient.	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.
14. Dentures should be soaked in diluted antifungal if prescribed as per instructions if oral Candida species are present.	Soaking in diluted antifungal reduces the risk of reinfecting the mouth with infected dentures.
15. Discard remaining mouthwash solutions.	To prevent the risk of contamination.
16. Rinse the tooth brush thoroughly and allow to dry (where possible stand toothbrush in upright position in small pot to air dry)	
17. Wash hands with soap and water or alcohol hand-rub and dry with paper towel.	To reduce the risk of cross-infection.

(See Appendix 2)

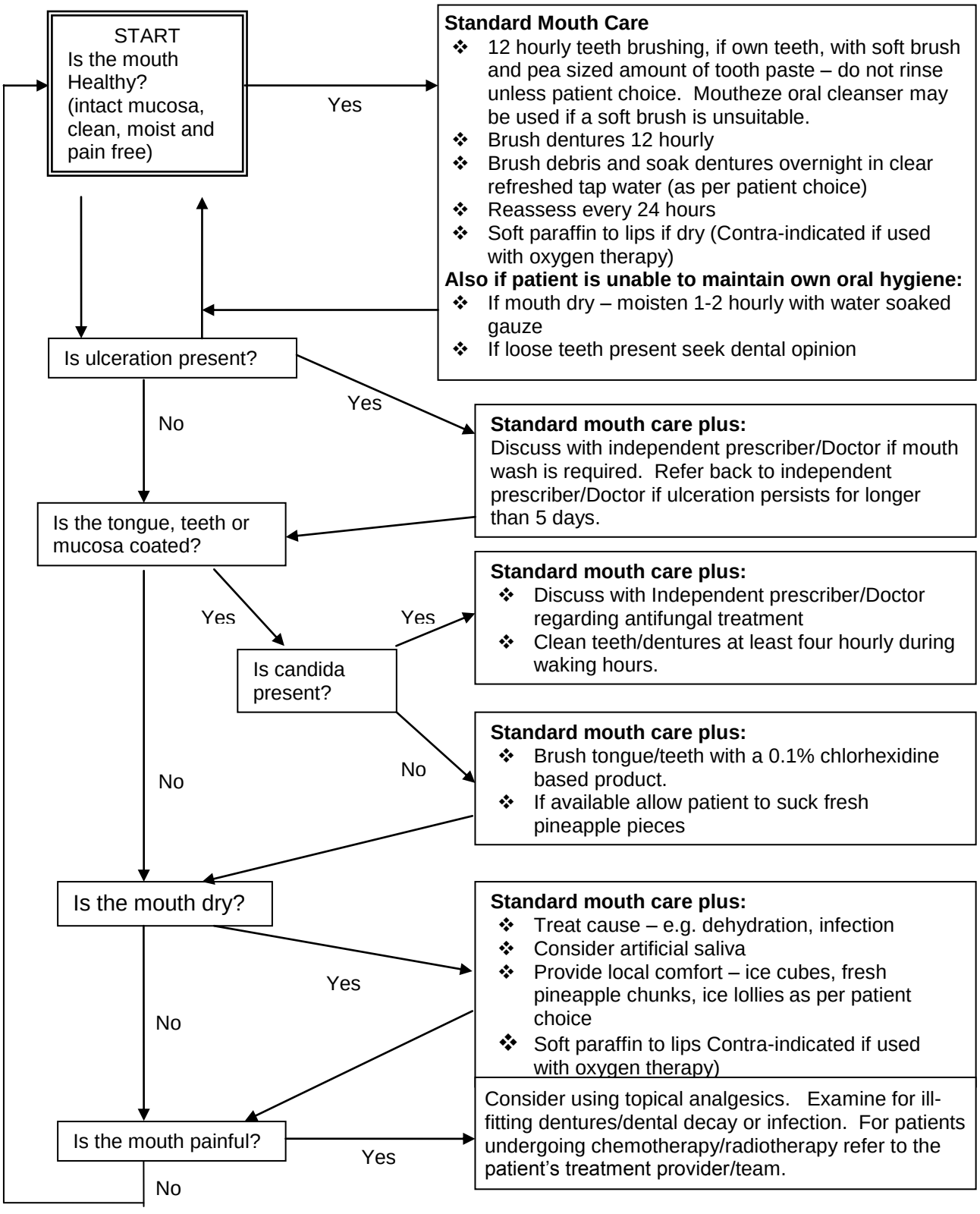
Problem solving

Problem	Cause	Suggested Action
Dry Mouth	Inadequate hydration, oral medication.	Monitor fluid balance and increase fluid intake where necessary
	Impaired production of saliva e.g. as a consequence of radiotherapy or chemotherapy. Consider medications e.g. anticholinergic drugs	Apply artificial saliva to the oral cavity as required. Give the patient ice cubes to suck.
	Presence of specific stressors, e.g. mouth breathing, oxygen therapy, no oral intake, intermittent oral suction	Inspect the mouth frequently, e.g. half-hourly. Swab mucosa with water.
Dry lips	As above	Smear a thin layer of appropriate water based lubricant e.g. KY jelly, (soft paraffin contra-indicated if used with oxygen therapy).
Thick mucus	Postoperative closure of a tracheostomy. Radiotherapy. Poor swallowing mechanism (please ensure that patient is able to rinse mouth without swallowing the solution. If the patient has poor oral control please refer for SLT assessment as appropriate)	Use sodium bicarbonate solution in the mouth care procedure. Rinse the mouth afterwards with water or 0.9% sodium chloride. Every 3–4 hours, rinse it around your mouth and spit it out. Make the mouthwash by adding one teaspoon of sodium bicarbonate to 550ml (one pint) of cooled, boiled water. Make a fresh mouthwash each day.
Patient unable to tolerate toothbrush	Pain, e.g. postoperatively; stomatitis, ulcers, caries, trauma to gums etc.	Use small soft toothbrush, or moutheze oral care cleanser to clean the patient's gums and mucosa. For severe pain use an anaesthetic mouth spray or mouthwash before giving mouth care.

Toothbrush inappropriate or ineffective	Infected stomatitis. Accumulation of dried mucus, new lesions, blood or debris.	As above and take a swab of any infected areas for culture before giving mouth care.

(Scottish Palliative Care Guidelines for Mouth Care 2019,
Royal Marsden Hospital Manual of Clinical Nursing Procedures, 6th Edition.
A practical guide to living with and after cancer managing the late effects of head & neck cancer treatment. Macmillan, 2012 Leaflet MAC14270.)

FLOW CHART TO GUIDE ORAL ASSESSMENT AND CARE



N.B. All medication must be prescribed
(Adapted from Doncaster & Bassetlaw NHS Foundation Trust 2007)

Document all care provided and assessments undertaken

ORAL ASSESSMENT TOOL
Please insert appropriate number in relevant box based on you clinical examination of the patient.
Contact the Medical Team for further advice on the management of patients with scores of 3.

PATIENT NAME:			**PLEASE DATE AND SIGN**						
ASSESSMENT	**METHOD OF ASSESSMENT**	**DATE**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
VOICE 3 = difficult/painful speech 2 = deeper/raspy 1 = normal	**Converse with the patient**								
SWALLOW 3 = unable to swallow 2 = painful 1 = normal	**Ask patient to swallow**								
LIPS AND ANGLE OF MOUTH 3 = ulcerated/with or without bleeding 2 = dry/cracked 1 = normal	**Observe and palpate the tissues**								
TONGUE 3 = blistered/cracked 2 = coated or loss of papillae 1 = smooth, pink, moist	**Observe the appearances of the tissues**								
SALIVA 3 = absent 2 = thick/ropy 1 = watery	**Insert tongue depressor and observe tongue and floor of mouth**								

MUCOUS MEMBRANES/GINGIVA 3 = ulceration/bleeding – gentle pressure 2 = candida infection suspected - reddened/coated or white patches 1= pink and moist	**Observe the appearance of the tissues**								
ORAL CLEANSING COMPLIANCE 3 = unable to clean 2 = cleans but needs help 1 = no difficulties – self care	**Observe tooth brushing/denture cleaning**								

Adapted from Eilers J. Berger A. Peterson M. Development, testing and application of the Oral Assessment Guide. Oncology Nursing Forum 15 (3): pp 325-330a: 1988) Copyright Host Defence Unit Great Ormond Street Hospital Trust

Evaluation of Assessment Tool

Score 7-8
Clean mouth 12 hourly at the patient's own discretion
Score 9-11
Clean mouth 3 times a day especially after meals
Score 11-14
4 hourly mouth care especially after meals
Score 14-21
Hourly mouth care. Consider seeking advice.

Document the score following assessment after each occasion.

Encourage the use of a small toothbrush as the main mouth care aid.

Ensure the patient/carers fully understand the importance of regular mouth care.

Appendix 1: Oral Care self-care – Advice for carers

What self-care is recommended?

Brush the teeth twice a day with soft toothbrush and fluoride toothpaste, spit do not rinse. Note: a 'sore mouth' toothpaste (SLS) may be better tolerated.
Rinse the mouth after each meal and at night with warm water or 0.9% sodium chloride solution (readymade or made up if patient wishes).

- Irrigation with warm water or 0.9% sodium chloride solution helps to remove oral debris and is soothing and no traumatic. Sodium chloride solution can be made for each rinse by dissolving half a 5 mL teaspoon of salt in 225 mL water.

If the tongue is heavily furred (especially if causing distress), brush with a soft toothbrush twice a day and use an antiseptic mouthwash, such as chlorhexidine.

Use chlorhexidine mouthwash if gum disease is diagnosed. For more information on mouthwashes, see Choice of Mouthwash.

Take adequate fluids.

Dry mouth Regular sips of water, sugar free sweets or artificial saliva may help. Artificial saliva with a neutral ph should be used with dentures.

Clean debris from the teeth. Dental floss, or chewing pineapple (contains ananase, which is a cleansing enzyme), fresh or unsweetened, may help to remove debris.

The frequency of mouth care should be increased to:

- Every 2 hours if there is a high risk of oral problems (any persons with advanced disease or neurological impairment, and/or those undergoing advanced treatment).
- Every hour in people at high risk or who have severe problems (for example oral infections, coma, severe mucositis, dehydration, immunosuppressed, diabetes, or needing oxygen therapy).

Dentures should be removed at night and cleaned with a soft toothbrush and unperfumed soap or denture toothpaste. Seek the advice of a dentist regarding how to soak dentures overnight.

Different strategies are used to soak dentures overnight. Some experts recommend the following options:

- Plastic dentures should be soaked overnight in a denture solution containing sodium hypochlorite 0.5% sodium hypochlorite to 80 parts water. (1 part Milton® 1 per cent to 80 parts of water).
- Dentures with metal parts should be soaked overnight in chlorhexidine solution (as sodium hypochlorite causes metal discolouration).
- Dentures should be rinsed well under running water before being returned to the mouth.

Basis for recommendation
These recommendations are pragmatic and are based on expert opinion (NICE Palliative Care–Oral, 2018)

A healthy mouth is clean, moist, and pain free. Regular mouth care will prevent or reduce the risk of many oral problems, such as infections and mucositis. Maintaining oral hygiene is very important [Regnard and Dean, 2010]. The incidence of ulceration or infection of the oral mucosa also increases with dry mouth.

Regular mouth care to prevent oral problems is standard nursing practice [Xavier, 2000] and is based on expert opinion [Milligan et al, 2001; Regnard and Dean, 2010]

Chlorhexidine gluconate 0.2% mouthwash is the most effective antibacterial mouthwash, producing a significant reduction in dental plaque when combined with brushing (Richards 2017). It is useful as a short-term agent when brushing is more difficult, such as after oral surgery or injury. It should not be used within thirty minutes of tooth brushing as products in the two ingredients inactivate each other (Steel 2017b)

The strategies for soaking dentures are based on expert opinion [Davies and Finlay, 2005 Steel 2017b)].

Appendix 2: Mouth Care Products

Oral ulceration and inflammation
Benzydamine (Difflam oral rinse)
Benzydamine (Difflam spray)
Carmellose (Orabase paste)
Lidocaine ointment 5%
Choline salicylate (Bonjela gel)

Radiotherapy/chemotherapy induced painful oral lesions
Polyvinylpyrrolidone and Sodium Hyaluronate (Gelclair gel)

For Severe Mucositis associated with Chemotherapy/Radiotherapy
Seek Oncology recommendation

Oropharyngeal anti-infectives
Daktarin (Miconazole oral gel) contraindicated with warfarin, enhances anticoagulant effect of warfarin (MHRA safety alert 2016)
Nystan (Nystatin oral suspension)

Lozenges and Sprays
There is no convincing evidence that antiseptic lozenges and sprays have a beneficial action and they sometimes irritate and cause sore tongue and sore lips. Some of these preparations also contain local anaesthetics which relieve pain but may cause sensitisation.

Mouthwashes and gargles
Chlorhexidine mouthwash
Chlorhexidine (Corsodyl dental gel)
Chlorhexidine (Corsodyl oral spray)

Choice of mouthwash
Water or 0.9% sodium chloride solution are recommended.

Water and sodium chloride solution are soothing, non-traumatic, and safe to use as frequently as required. Water can be given warm or cool, depending on individual preference.

Chlorhexidine can be used in people who have, or are at risk of, secondary bacterial infection, including people that do not have their own teeth.

Chlorhexidine should not be used more than twice a day. It contains alcohol, which may cause stinging, particularly in people with inflamed mucosa (for example people with mucositis). It also commonly alters taste initially, which may not be desirable.

Note: chlorhexidine is the most commonly used mouthwash. Other mouthwashes are available, and selection is often based on personal preference.

(NICE Palliative Care –Oral, 2018)

Dry Mouth
Artificial Saliva – Saliva Orthana/Glandosane spray
lactoperoxidase*: enzyme in cow's milk* - Biotene Oral balance gel, Bio Xtra, Oralieve gel
Salivix pastilles (acidic – avoid in dentate patients)

Also available from RDC
Toothpaste
Small headed, soft bristle toothbrush
Optilube gel mini tube (instead of using soft paraffin, for those on oxygen)
Gelclair – see above under chemotherapy/radiotherapy

Appendix 3: Moutheze labelling and instructions for use

MOUTHEZE

Oral Care with comfort and confidence

8.0 Labelling and Instructions for use

CE **Patent Pending**

MouthEze is a safe replacement for the mouth sponge swab. The cone-shaped head and soft, rounded filaments soothe the soft tissues when cleansing the oral mucosa. The extended handle is easy to grip and allows good access to the back of the mouth. The primary patient group are those in intensive care (ICU) who are susceptible to chest infections – clinically known as Ventilator Associated Pneumonia (VAP).

Other patient groups include stroke and head & neck oncology patients, or those dependent on mouth care by other people, who are particularly vulnerable to contaminated secretions.

USES: The MouthEze is used to help prevent VAP and other conditions related to accumulated debris in the oral cavity; suction can also be used to help remove any excess fluids or saliva. Moutheze should be included as part of the Trust protocol and individual ward oral care plan.

MouthEze can be used to:

- hydrate (moisten) the lips, tongue and soft tissues inside the mouth with water, water based gels and mouth rinses
- clean coated tongues
- remove retained food and debris from the mouth
- remove sticky tenacious secretions, crusty plugs on the palate and stringy saliva following cancer therapy treatment
- aid oral desensitisation for patients with special requirements and learning difficulties

Instructions for use:

- MouthEze can be used wet or dry.
- Rinse before use.
- Do not use if the filaments or handle appear damaged in any way.
- Remove MouthEze from sleeve and gently sweep around the soft tissues inside the mouth.
- Remove food and debris - use a rotation action
- For coated tongues – moisten with water or water based gel and gently sweep across the tongue from the base to the tip.
- For lubricating the mouth - dip MouthEze in water, mouthrinse or water based gel and gently sweep around the mouth.
- Oral desensitisation – follow care plan procedure

After use, clean and rinse MouthEze thoroughly under running water and immerse in disinfectant. Allow to air dry. For Critical Care/Intensive Care Units follow local procedure for rinsing with sterile water or discard after single use.

To Clean MouthEze after use:

- **MouthEze can be re-used with the same patient. Place the MouthEze under running water and then immerse in disinfectant and allow to air dry**
  OR
- **If not disinfecting, please dispose of MouthEze after each use**

Storage: There are no special storage requirements for the unopened pack

Appendix 4: Oral pain (for 16 years and onwards)

Topical pain relief

When should topical pain relief be used?

Treat the underlying cause of oral pain where possible. If this is not possible or not fully effective, treat pain symptomatically.

- **For mild to moderate oral pain,** use topical non-opioid analgesia.
    - For localized pain:
        - Choline salicylate gel — short-lived effect. Excessive use should be avoided because it can lead to ulceration, particularly if the gel is trapped under dentures.
        - Benzydamine spray — relatively short duration of action, and numbness and stinging are sometimes a problem.
        - Lidocaine 5% ointment or 10% spray — duration of action of topical local anaesthetics, such as lidocaine, is relatively short, and these agents will not provide continuous pain relief throughout the day. Care should also be taken not to anaesthetize the pharynx before meals, as this might lead to aspiration or choking. Ideally, use of topical local anaesthetics should be reserved for severe pain (for example chemotherapy- or radiotherapy-induced mucosal pain/mucositis).
        - Carmellose paste — can be difficult to apply effectively to some parts of the mouth. If used to manage ulcer pain, it hardens on contact with saliva to form a protective cover over the ulcer.

    - For diffuse oral pain:
        - Benzydamine mouthwash — diluting the mouthwash in an equal volume of water before use reduces stinging.
        - For moderate to severe pain relief consider combining use of topical and systemic analgesia.

- **For severe oral pain,** consider the combined use of topical and systemic preparations. Topical opioids, for example morphine, may help and are recommended by some specialists, but usually systemic opioids are required for severe pain.
    - Seek specialist advice if pain is difficult to manage.

For more information see the CKS topic on oral pain (NICE Palliative Care Oral 2018)

Basis for recommendation

These recommendations for pain relief are based on expert opinion [O'Neill and Fallon, 1997; Davies and Finlay, 2005; Twycross et al, 2009, Regnard and Dean, 2010; Twycross and Wilcock, 2011].

Systemic pain relief

When should systemic pain relief be used?

Treat the underlying cause of oral pain where possible. If this is not possible or not fully effective, treat pain symptomatically.

- **Use systemic analgesia** if the person prefers this option or as an alternative/addition to topical analgesia in cases where oral pain is extensive and not controlled by topical analgesia.
    - Topical treatment is preferred to systemic treatment because of the lower incidence of significant adverse effects. Some drugs have both topical and systemic actions (for example dispersible diclofenac).
- **The choice of systemic analgesia** depends on the severity of pain and the benefits compared with risks for the individual person.
    - Mild pain: nonsteroidal anti-inflammatory drug (NSAID) or paracetamol.
    - Mild to moderate pain: full-dose weak opioid *plus* paracetamol or NSAID.
    - Moderate to severe pain: strong opioid (for example morphine) *plus* paracetamol or NSAID.
- **Oral analgesia is preferred where possible,** but if the person cannot eat or drink (for example mucositis), consider using a 24-hour continuous subcutaneous infusion of an opioid (for example diamorphine).
    - See the CKS topic on Palliative cancer care - pain for further information on starting and titrating oral morphine.
    - See the CKS topic on Analgesia - mild-to-moderate pain for prescribing information on NSAIDs, paracetamol and weak opioids.
- **Seek specialist advice if pain is difficult to manage.**

Basis for recommendation
The basis of these recommendations is the World Health Organization (WHO) Cancer pain ladder (2019)

For more information on pain management see CKS topic on palliative cancer pain (NICE 2016)

Appendix 5: The Denture Sunflower

Mouth Care Matters

NHS
Health Education England

1. If you see the denture sunflower at a patients bedside, please try to be extra vigilant when clearing up after meals.

2. Patients occasionally wrap their dentures in tissue and leave them on the bedside / dinner tray. These can be accidentally swept away as rubbish.

3. Losing a denture is highly distressing for a patient and it affects their dignity and ability to eat and drink.

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Equality Analysis: Initial Assessment Form

Title: Lincolnshire wide policy for the assessment and provision of Mouth Care (Adult Palliative Care

Describe the function to which the Equality Analysis Initial Assessment applies:		
☐ Service delivery	☐ Service improvement	☐ Service change
✠ Policy	☐ Strategy	✠ Procedure/Guidance
☐ Board paper	☐ Committee / Forum paper	☐ Business care
☐ Other (please specify) ……		

Is this assessment for a new or existing function?	**Existing need for oral care guidance**
Name and designation of function Lead professional:	**Kathryn O'Brien Macmillan Palliative Care CNS ULHT**
Business Unit / Clinical Directorate:	**Palliative Care**

What are the intended outcomes of this function? (*Please include outline of function objectives and aims):* To be guidance for staff to recommend best practice for mouth care in predominantly palliative patients who are unable to manage their own oral care and need support.		
Who will be affected? Please describe in what manner they will be affected?		
Patients / Service Users:	**Staff:**	**Wider Community:**

To support patients with improved and recommended best practice for oral care	**To provide guidance to health care staff for the provision of oral care for palliative patients (however this may apply to wider care groups also)**	**County wide policy to support recommended best practice Lincolnshire wide**

What impact is the function expected to have on people identifying with any of the protected characteristics (below), as articulated in the Equality Act 2010? (Please tick as appropriate)

	Positive	Neutral	Negative	**Please state the reason for your response and the evidence used in your assessment.**
Disability		x		
Sex		x		
Race		x		
Age		x		
Gender Reassignment		x		
Sexual Orientation		x		
Religion or Belief		x		
Pregnancy & Maternity		x		
Marriage & Civil Partnership		x		

Carers	x			To give a recommended guidance and support
Other groups identified (please specify)				

If the answer to the above question is a predicted negative impact for one or more of the protected characteristic groups, a full Equality Analysis must be completed. (The template is located on the Intranet)

Name of person/s who carried out the Equality Analysis Initial Assessment:	**Kathryn O'Brien Macmillan Palliative Care CNS ULHT**
Date assessment completed:	**06/06/2019**
Name of function owner:	**Kathryn O'Brien Macmillan Palliative Care CNS ULHT**
Date assessment signed off by function owner:	**June 2019**
Proposed review date (please place in your diary)	**March 2021**

As we have a duty to publicise the results of all Equality Analyses, please forward a copy of this completed document to tim.couchman@ulh.nhs.uk.

Signature Sheet

Policy title: Guidelines for the assessment and provision of Mouth Care

Names of people consulted about the document:

Name	**Job title**	**Department**
Kathryn O'Brien	Macmillan Palliative CNS	ULHT Palliative Care
Michelle Dale	Macmillan CNS	LCHS
Abi Alexander	Macmillan CNS	LCHS

Names of committees required to approve the document:	**Approved on**
Clinical Effectiveness Steering Committee ULHT	
Effective Practice Assurance Group LCHS	September 2019
St Barnabas Clinical Governance	
Drugs and Therapeutic Committee	