HSE National Oral Care Guideline - Supporting Smiles

for Health and Social Care Teams supporting daily oral care for adults who require assistance

National Oral Health Office 2025

Disclaimer

This guideline was developed by a multidisciplinary Guideline Development Group and is based upon the best evidence available together with the clinical expertise of the Group members.

A **guideline** is defined as a principal or criterion that guides or directs action. Guideline development emphasises using clean evidence from the existing literature, rather than expert opinion alone. A guideline provides general recommendations on how to perform a task, or advice on how to proceed in a situation. (HSE, 2011)

The guideline supersedes all previous Health Service Executive (HSE) guidelines for daily oral care for populations included in the scope of the guideline. The National Oral Health Office (NOHO) is part of the HSE and any reference in this disclaimer to the NOHO is intended to include the HSE. Please note the guideline is for guidance purposes only. The appropriate application and correct use of the guideline is the responsibility of each health and social care team member. The guideline Development Group's expectation is that health and social care teams will use clinical judgment in applying the principles and recommendations contained in this guideline. These recommendations may not be appropriate in all circumstances and it may be necessary to deviate from this guideline. Clinical judgment in such a decision must be clearly documented. Care options should be discussed with the person and where necessary, with family or other persons in a relationship of trust and with the multidisciplinary team as required. The NOHO accepts no liability nor shall it be liable, whether arising directly or indirectly, to the user or any other third party for any claims, loss or damage resulting from any use of the guideline.

HSE National Oral Care Guideline (Supporting Smiles) for Health and Social Care Teams supporting daily oral care for adults who require assistance
National Policy ☐ National Procedure ☐ National Protocol ☐ National Guideline ☑ National Clinical Guideline ☐

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Short summary:
The purpose of the HSE National Oral Care Guideline (Supporting Smiles) is to set out an evidence-informed HSE national guideline for the assessment of oral health and delivery of daily oral care by health and social care teams for all adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided.
Description: The HSE National Oral Care Guideline (Supporting Smiles) facilitates a standardised and consistent approach to the assessment of oral health and delivery of daily oral care by setting out the processes that: • Ensure consistency in the standard of daily oral care delivered by health and social care teams. • Assign responsibility, authority, and accountability for daily oral care at all stages. • Agree appropriate key performance indicators. • Ensure ongoing monitoring, audit and evaluation necessary to underpin delivery of a quality service across Health Regions

Executive Summary

The HSE National Oral Care Guideline – Supporting Smiles for Health and Social Care teams was developed in response to Actions 6 and 16 of the National Oral Health Policy 'Smile Agus Sláinte'.

A clean, healthy mouth is fundamental to everybody's quality of life and general health. Helping people with oral care is an essential part of personal care, which allows people to eat, communicate and is important for overall dignity and wellbeing.

The guideline aims to promote and improve oral and general health for adults in healthcare settings by enabling a consistent, standardised approach to oral care.

Key recommendations are:

- Carrying out an Oral Health Assessment using the oral health assessment tool (OHAT).
- Developing an oral care plan
- Delivering oral care at least twice per day

The Guideline is for health and social care teams who support or provide oral care as part of daily personal care for adults who require assistance in acute, older persons, mental health, disability, palliative and social inclusion healthcare settings.

Management have a key role in the implementation of the guideline ensuring the procurement of oral care products and ongoing monitoring, audit and evaluation of the programme.

The key feature of the Supporting Smiles programme is the integration of oral care into daily practice and collaborative working across multidisciplinary teams in health and social care settings. Implementation of the Guideline is supported by an evidence-based toolkit and accompanying education programme.

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1.0 Background and Context:

1.1 Purpose

The HSE National Oral Care Guideline (Supporting Smile)'s purpose is;

- To set out evidence-informed recommendations on daily oral care for all adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided by health and social care teams. Examples of healthcare settings include but not limited to:
  - Older Person Residential/Day Care Facility
  - Disability Residential/Day Care Facility
  - Approved Mental Health Centres/Mental Health Residential/Day Care Facility including Addiction and Homeless Services
  - Acute inpatients (Intensive Care Unit, Surgical and Medical wards)
  - Palliative Care/Haematology/Oncology settings
- To facilitate a standardised and consistent approach to carrying out an oral health assessment using an oral health assessment tool (OHAT).
- To facilitate a standardised and consistent approach to the delivery of daily oral care including clear guidance on the following;
  - How to deliver daily oral care as detailed in guidance sheets on mouth care, brushing of teeth and gums and denture care using appropriate oral care equipment, products and adjuncts.
  - How to deliver daily oral care for persons with specific oral care considerations related to their medical condition including; cancer, neurological diseases, frailty, dysphagia, Critical Care and End of Life care.
- To replace/align any previously existing local policies, procedures, protocols, guidelines (PPPGs) with this HSE national guideline.

1.1.1 Why is oral health important?

"Oral health is multi-faceted and includes ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions without pain, discomfort and disease of the craniofacial complex" (1)

Oral health is essential to overall health, well-being, and quality of life across the life course. In their Lancet publication highlighting the global public health challenge of oral diseases, Peres *et al.* (2) stated:

"**Oral health matters. The teeth and the mouth are an integral part of the body, supporting and enabling essential human functions, and the mouth is a fundamental feature of personal identity".**

In addition to enabling pain-free and comfortable oral function, a healthy mouth helps to maintain the person`s dignity and should be valued.

1.1.2 Evidence of poor oral health

Oral diseases are among the most prevalent diseases globally and have serious health and economic burdens, greatly reducing quality of life for those affected. The most prevalent and consequential oral diseases globally are tooth decay, gum disease, tooth loss, and cancers of the lips and oral cavity (2). However, the burden of oral diseases is not uniformly distributed across populations. Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes, people living with disabilities, older people living alone or in care homes, people who are refugees, in prison or living in remote and rural communities, and people from minority and/or other socially marginalised groups (3). Research confirms that the oral health of adults with intellectual disabilities (ID), older adults living in residential care, people living with dementia, people with severe mental illness (SMI) or neuromuscular disabilities is poor compared to the general population, with high levels of tooth decay, gum disease and tooth loss (2,4-12) Poor access to dental care can result in greater deterioration in oral health, resulting in higher rates of extraction for people with disabilities. Additionally, for those who require general anaesthetic (GA) for their dental care, dental decision making may be heavily influenced by dentists' efforts to minimise uncertainty with extraction being more commonly used to treat teeth of uncertain prognosis in a bid to reduce the need for future GA (13).

Lesions of the lining of the mouth (oral mucosa), oral discomfort due to dry mouth and denture wearing problems are also frequently reported for older adults living in residential care (7,8,14).

Poor oral hygiene is a risk factor for tooth decay and gum disease (15). Research has also shown that hospitalisation is associated with deterioration in oral health, particularly for vulnerable patients, with increased accumulation of dental plaque and inflammation of the gums and lining of the mouth being reported (12).

1.1.3 Impact of poor oral health

The World Health Organisation (WHO) recognises oral health as an integral part of general health (3). Addressing oral diseases among other non-communicable diseases is a global health priority (2). Oral diseases share common risk factors with many chronic diseases, primarily unhealthy dietary habits, tobacco usage and higher alcohol intake and poor oral health may impact negatively on general health and vice versa (16). Evidence consistently shows a two-way association between gum disease and diabetes and there is also some evidence of an association with cardiovascular disease, stroke and respiratory disease. Gum disease, tooth decay and tooth loss may also be associated with other conditions such as cognitive decline, certain cancers and pneumonia (3).

Poor oral hygiene and high plaque levels are a risk factor for aspiration pneumonia especially for people with dysphagia (swallowing difficulty) (17). Several studies have revealed that the oral hygiene status of intensive care unit (ICU) patients is linked to the occurrence of Ventilator Associated Pneumonia (VAP). VAP is a serious medical condition with a risk of mortality and is highly associated with oral pathogenic bacteria (17-24). Whenever an endotracheal (ET) tube is in place, most defences against pneumonia are impaired (18). Daily oral hygiene is needed to minimise biofilm formation and to prevent aspiration of microorganisms into the lower respiratory tract and subsequent VAP. An effective daily oral care programme reduces the incidence of Ventilator Associated Pneumonia (VAP) and Hospital Acquired Pneumonia (20). Poor oral health in hospitalised patients, particularly among older adults, can result in inadequate nutritional intake due to oral discomfort and malnutrition and has been shown to delay discharge and result in higher hospital mortality rates (25). Malnutrition due to oral health problems can also be an issue for older adults living in residential care, resulting in a wider deterioration in a person's health (26).

It was noted during the COVID-19 pandemic that people with advanced gum disease had poorer health outcomes with COVID-19. A high viral load in saliva was the best predictor of death from COVID-19. The hypothesis was that the virus entered the bloodstream through the damaged gums and then into the lungs (27).

Poor oral health can also impact negatively on quality of life causing infection, pain or discomfort that some vulnerable people may be unable to communicate. 'Dry mouth' as a side effect of polypharmacy is common in older people living in residential care and requires particular daily oral care from carers to improve their comfort (7,8).

Older adults want to eat and speak comfortably, to feel happy with their appearance, to remain pain free, to maintain self-esteem, and to maintain habits/standards of hygiene and care that they have had throughout their lives (28).

The social impact of poor oral health for people with disabilities should also not be underestimated. MacGiolla Phadraig *et al.* reported that people with ID who were aware of their dental problems "want their teeth to look nice and do not want to be embarrassed to smile" (29). Older people with ID who have no teeth were reported to be 12 times less likely to wear a denture than their age-matched peers in the general population. This has negative impacts on their eating ability, food choices and digestive health, as well as appearance (6).

1.1.4 Why develop a HSE National Guideline on daily oral care for adults who require assistance?

Census 2022, (CSO) documented that 1,109,557 people (22% of the population) reported having a long-lasting condition/difficulty or disability to any extent (30). Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (31), which was ratified by Ireland in 2018, affirms the right to equal access to health care services. While timely access to appropriate daily oral care is essential to treat existing oral disease, most oral diseases are largely preventable by daily removal of dental plaque (2,15).

Therefore, there is a need to improve oral health and general wellbeing for many adults attending or resident in healthcare settings by establishing effective daily oral hygiene practice.

The HSE Training Needs Analysis (TNA) survey on oral care (Refer to 2.3) raised the issue of inconsistency in the provision of daily oral care across settings.

Stakeholders have identified the need for a HSE National Guideline, and have collaborated with the National Oral Health Office, in the interests of standardisation of practice and documentation of daily oral care across the healthcare settings identified in the scope of this Guideline. There is a clear need to develop a daily oral care programme to deliver equitable services and equitable outcomes for people in healthcare settings in Ireland. Healthcare team members in hospital/palliative care settings can also optimise their patients' health outcomes, reduce the risk of hospital acquired infections (such as aspiration pneumonia) and promote comprehensive patient care by including oral health into general health and daily care (21,26).

Here's what HSE Training Needs Staff Survey tells us:

"Oral hygiene does not appear to be standard practice. There is confusion I think around persons responsible for providing oral hygiene."

"I do understand the importance of oral care, however I do not provide it and do not feel skilled in demonstrating or providing specific strategies on same, falls between stools with multiple people's roles being involved (nurse, HCA, SLT)"

"Poor oral health in hospitals, particularly among older adults, can result in inadequate nutritional intake due to oral discomfort and malnutrition."

"Emphasis not enough on importance and problems caused by poor oral care."

1.1.5 Who provides and supports oral care?

Oral health is everybody's responsibility and should be the concern of all members of the core multidisciplinary team (MDT) (26,32). Below is a broad list of Health and Social Care teams who may work together in a care setting:

Role	Responsibility in oral care and oral health
Person *This guideline supports the premise that oral health is the person`s own personal responsibility and promotes independence through accessible necessary supports*	Engage with supports to enable independence in oral care, inform carers and family members of personal preferences and goals to achieve optimal oral care
Person in Charge/Senior Management	Ensure that oral care is prioritised in the setting through nominating and supporting the development of an oral care lead/champion, flexible scheduling of oral care training, procuring necessary equipment and products for oral care, auditing and evaluating oral care delivery
Local Dental team	Accept referral from healthcare settings. Provide advice, support and treatment where needed as part of multidisciplinary team and refer onwards to secondary and tertiary team as required(19,33).
Doctors/medical team	Recognising oral pathology such as swellings, ulcers, oral candida (thrush), oral pain and swallowing abnormalities. Treating these conditions, monitoring and prescribing appropriate oral care products where relevant. Liaising with the dental team where necessary to confirm diagnosis or to arrange onward referral if required.
Nursing Staff	Registered nurses are regulated professionals who carry out oral health assessments, developing oral care plan and assisting/providing oral care according to the oral care plan. Referring to medical/dental team and ensuring prescribed products are administered and monitoring person`s response.
Healthcare Assistants (HCAs)	HCA is a member of the healthcare team with role of assisting and supporting nursing professionals under their direction, supervision or delegation. Assisting/ providing oral care according to the oral care plan. Highlighting need for referral to medical/dental team and ensuring prescribed products are administered and monitoring person`s response.
Social care worker	Carry out oral health assessments, developing oral care plan and assisting/ providing oral care according to the oral care plan. Referring to medical/dental team and ensuring prescribed products are administered and monitoring person`s response.
Speech and Language Therapist (SLT)	Collaborate with nursing/medical staff to support with oral care planning and the person`s engagement for those with swallowing/communication difficulties. Advise on swallowing difficulties and aspiration risk and oral care for people, including those with dysphagia or oral hypersensitivity. Advocate for oral health.
Dietetics Team	Advocate for regular oral care/care plans for those who require tube feeding in particular. Nutritional advice concerning oral health (coordinate Oral Health Assessment Tool (OHAT) with Malnutrition Universal Screening Tool (MUST)).
Occupational Therapists (OT)	Give support with the inclusion of oral care in the person`s ADL assessments and oral care plans. Help to devise strategies to improve oral care for persons with physical disabilities for example toothbrush grips – Assess ability to brush own teeth as part of personal care assessment pre-discharge.

Role	Responsibility in oral care and oral health
Pharmacists	Advise persons/carers on medication related oral problems including a dry mouth.
Physiotherapists	Give support with appropriate positioning to accept oral care where relevant.
Infection Prevention and Control teams	Provide specific advice and training during outbreak scenarios, or for persons with communicable infections.
Porters	Be vigilant about dentures that are often left on trays/bed linen and are disposed of and lost between ward transfers.
Family or other provider of home support	Advocate for any necessary support of oral hygiene by staff for the person while in hospital/residential care. Provide any necessary support of oral hygiene for the person at home or following discharge.

Many vulnerable adults require support or are fully dependent on others to carry out their personal care and their daily oral care. It is essential that family members and health and social care teams including doctors, nurses, healthcare assistants, carers, social and support workers have the knowledge and skills required to deliver this care. Available evidence suggests that education of carers may change carers' attitudes and improve their skills (34,35). However provision of training of carers alone has not always produced improved oral hygiene for person's receiving care (36). Oral hygiene promotion involves any combination of education, organisational, economic and environmental supports including access to appropriate equipment (e.g. aspiration/suction toothbrushes, special care toothbrushes and oral care products), for behaviour conducive to oral health including the need for standards to be agreed and set (37). The evidence points to the need to improve and standardise daily oral care for vulnerable people in all care settings (34) to enable people access to the same standard in daily oral care as they transition between services and to home. This can be achieved through the delivery of planned and personalised daily oral care measures such as tooth brushing, mouth care and denture care. Acute, residential and other health care settings can be very busy, time pressured environments. Staff are often overworked with many competing assessments to complete. However, high-quality daily oral care should be a life-long consideration by health and social care staff in all settings. This will require long term commitments to provide daily oral care training and education to all relevant healthcare staff. The need to incorporate daily oral care into activities of daily living and the importance of the provision of repeat training and education of health and social care teams and those who provide care will improve the oral health of the people we care for.

1.2 Scope

1.2.1 Within Scope of this HSE national guideline

- All adults (18 years and over) who reside in or attend healthcare settings as listed **where their personal care is supported or provided** – examples include but not limited to;
  - Older Person Residential/Day Care Facility
  - Disability Residential/Day Care Facility
  - Approved Mental Health Centres/Mental Health Residential/Day Care Facility including Addiction and Homeless Services
  - Acute inpatients (Intensive Care Unit, Surgical and Medical wards)
  - Palliative Care/Haematology/Oncology settings
- Development of key recommendations (3.0) for implementation.

1.2.2 Out of Scope of this HSE national guideline

- Children, any person under 18 years* in these related settings are currently out of scope. *The literature research focused on adults aged 18 years and over
- Development of a Clinical Guideline on Oral Care, e.g. National Clinical Effectiveness Committee (NCEC) Guidelines.

1.3 Target users

- The person – All adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided.

  The use of 'person' in this guideline can refer to patient/client/service user depending on the healthcare setting
- Health and Social Care teams who support or provide daily oral care as part of personal care across settings.
- Heath care setting service providers/managers.

1.4 Aims

- To improve the oral health of all adults (18 years and over) who reside in or attend healthcare settings.
- To up-skill healthcare and social care teams in these settings, bringing an increased awareness of the importance of good daily oral care and how it impacts on general health and quality of life.

1.5 Objectives

- To set out the processes that:
  - Ensure consistency in the standard of oral health assessment and daily oral care carried out and delivered by health and social care teams in healthcare settings where personal care is supported or provided.
  - Agree appropriate key performance indicators.
  - Ensure ongoing monitoring, audit and evaluation necessary to underpin delivery of a quality service across Health Regions.

- To integrate oral health as part of wider systemic health care and wellbeing awareness in health care settings by:
  - Coordinating an Oral Health Assessment with other standardised health assessments on admission/first contact, with reassessment 6 monthly or more frequently as clinically indicated thereafter.
  - Raising awareness about the impact of medications on oral health (e.g. the impact of medication on salivary production) and the bi-directional relationship between oral health and certain medical conditions.
  - Raising awareness of the role of MDT members in oral health, e.g. awareness of the effect of some medications which cause dry mouth (Pharmacist), the role of Occupational Therapy in assessing a person`s functional ability to perform own daily oral care before discharging from hospital/care setting as part of discharge process.

1.6 Benefits and Outcomes

1.6.1 Benefits

- Standardised daily oral care practice.
- Improved oral care knowledge and skills of health and social care teams in all settings to support people with their daily oral care needs.
- Replacement/alignment of local daily oral care policies with this HSE national guideline.
- Potential for cost saving through oral health;
  - reducing the need for dental interventions such as extractions and fillings.
  - reducing the number of acute dental reviews and hospital admissions related to oral and facial infections.
  - reducing the cases of aspiration pneumonia among people in Acute and Long Term Residential Care.
  - reducing prolonged hospital length of stay

1.6.2 Outcomes

Person-centred outcomes:

- Improved health and wellbeing
- Oral care assessment and tailored oral care plan.
- Improved oral health and comfort.
- Reduced oral infections.
- Reduced morbidity and mortality.
- Reduced average length of stay in acute settings.
- Improved denture cleanliness and reduced loss of dentures in healthcare settings.
- Improved oral intake.

Health and social care teams outcomes:

- Improved oral care knowledge and support.
- Improved skills in delivering daily oral care to all people who require oral care.
- Increased awareness of the benefits of daily oral care and person outcomes.

Management outcomes:

- Appropriate training and resources in place to support implementation of the guideline.
- Staff enabled to achieve the outlined standards and recommendations in oral care provision.
- Sláintecare targets met in delivering high-quality, safe, effective, responsive and person-centred daily oral care.

1.7 Disclosure of interests

No conflicts of interest were declared. A conflict of interest declaration form was signed by each member of the Development Group.

1.8 Strategic alignment

This HSE national guideline is aligned to the:

1. **Department of Health National Oral Health Policy 'Smile agus Sláinte'** outlined in the policy actions; Action: 6, 16, and 34.
2. **Sláintecare** – This HSE National Oral Care Guideline (Supporting Smiles) aims to improve oral health by delivering high-quality, safe, effective, responsive and person-centred oral care which is aligned with the Sláintecare Principles 2, 3 and 5 of providing care at the lowest level of complexity.
3. **HSE National Consent Policy 2024.** The Assisted Decision-Making (Capacity) Act 2015 provides a legal framework for interacting with people, and comprehensive guidance on the decision-making process and its documentation in such circumstances is contained in the National Consent Policy.
4. **Safeguarding Vulnerable Persons at Risk of Abuse** https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf
5. **Health Information and Quality Authority (HIQA) National Standards for Safer Better Healthcare Version 2 2024.**
6. **Health Information Authority (HIQA) National Standards for Residential Care Settings for Older People in Ireland V2 2016**
7. **Health Information Authority (HIQA) National Standards for Residential Settings for Adults with Disabilities 2013**
8. **Health Information and Quality Authority (HIQA) National Standards for infection prevention and control (IPC) in community services**
9. **HSE Corporate Plan 2025-2027** – Implementation of the HSE National Guideline Oral Care (Supporting Smiles) supports the delivery of oral health care reform.
10. **HSE Organisation Development and Design (2018, reprinted 2023). People's Needs Defining Change – Health Services Change Guide**
11. **The HSE National Integrated Care Programme for Older Persons (NICPOP).**
12. **The HSE National Framework for the Integrated Prevention and Management of Chronic Disease.**
13. **The Patient Safety (Notifiable Incidents and Open Disclosures) Act 2023.**
14. **HSE Patient Safety Strategy 2019-2024.** Advocacy and Policy Unit, National Patient Safety Office.
15. **Understanding Trust and the HSE, Health Service Executive, 2021**
16. **HSE National Framework for Governance, Management and Support of Health Research, 2021.**
17. **Department of Health** NCEC National Clinical Guideline No. 30 Infection Prevention and Control (2023).
18. **HSE National Guideline for Infection Prevention and Control in HSE Dental and Orthodontic Services** (2024).

19. **Guidance issued by the Government, Health and Safety Authority (HSA), the Health Surveillance and Protection Centre (HPSC) and Antimicrobial Resistance and Infection and Control (AMRIC)** to ensure the safety, health and welfare of our staff, service users and others who may be affected by the delivery of our services in the community.

20. **Global Oral Health Strategy for EB150 – World Health Organization** reflecting a paradigm shift in oral health policy planning toward an oral health promotion and preventive model including innovative workforce solutions integrated into health systems at all levels. The HSE National Oral Care Guideline (Supporting Smiles) promotes oral health for people who need support and assistance in caring for their oral health by providing evidence informed education in oral care.

21. **Global Oral Health Action Plan** https://www.who.int/publications/i/item/9789240090538

22. **United Nations Convention on the Rights of Persons with Disabilities** is the first international, legally binding instrument setting minimum standards for rights of people with disabilities, and the first human rights convention to which the EU has become a party. (UNCRPD) was agreed in 2007 and Ireland ratified it in March 2018, affirming that people with disabilities have rights to access safe effective and high-quality care. The HSE in its role of providing care for people requiring support has a duty to provide all elements of care including oral care in a way that respects their rights and autonomy.

23. **The World Health Assembly Resolution WHA74.8** on the highest attainable standard of health for persons with disabilities calls for Member States to ensure that persons with disabilities receive effective health services as part of universal health coverage; equal protection during emergencies; and equal access to cross-sectoral public health interventions.

2.0 Methodology

2.1 Key research question

A primary literature search was undertaken in collaboration with HSE library service to address the research question, using the PICO **(P**opulation, **I**ntervention, **C**omparison, **O**utcome) search strategy outlined below. The PICO model is by far the most widely used model for formulating clinical questions and allowed the steering committee to focus on a consensus question related to the most important issue and outcome.

This is not an exhaustive systematic review, key stakeholder representatives extracted this data to reflect current published best practice. References for the included studies are included in the appendix.

Question: Among adults 18 years of age and older who require oral care support, and those involved in the provision of this care in community and healthcare settings (P), what oral care strategies (I) deliver optimal oral care status (O) when compared to current or standard care (C).

Search Year (s): 2016-2024

Key Healthcare Settings

Community	Disability	Acute
• Residential • Long term care – nursing home • Assisted living • Palliative care	• Intellectual • Physical • Cognitive • Visual/hearing impairment • Mental Health	• Inpatient • Palliative care

Keywords: mouth hygiene, oral hygiene, mouth care, oral health status, oral health care, daily mouth care, tooth brushing, denture, floss, guidelines, practice guidelines, strategy, assessment, interventions, hospital, hospitalisation, acute care, palliative care, inpatient

Scope: Systematic Literature Review

Inclusion/Exclusion Criteria: Children, English language only

Question Category: Treatment Benefits

Key Concepts: oral health, oral hygiene, mouth care, guidelines, hospital, acute care, palliative care.

Sources: Ovid Embase, EBSCO Medline; EBSCO Cinahl Complete, TRIP, Cochrane, Grey literature.

Patient or Population (P):	Adult
Intervention or Indicator (I):	Oral care strategies/interventions to deliver optimal care
Comparator or Control (C):	Normal oral care
Outcome (s) (O):	Optimal oral care
Time (T):	Protocol

2.2 Evidence search and appraisal

This guideline is the combined result of a literature review of recent published international evidence (2016-2024) and also a pragmatic and progressive approach to oral care provision in community, disability and healthcare settings. Refer to Appendix 1 for literature search strategy. The steering group established core messages and actions for which evidence had revealed a preventive benefit. Evidence in relation to barriers to and facilitators of provision of oral care for people with physical, intellectual, sensory or cognitive disabilities, e.g. dementia was also assessed. Relevant papers were assessed for robust methodology and results. Statements were refined to ensure the wording correctly reflected study or guideline conclusions. In most sections, guidance is drawn from a range of studies or reviews and statements were collated from the totality of best available evidence by multidisciplinary team consensus.

2.3 Other key reference documents and relevant references

Key reference documents were identified, a number of which are outside of the timeline for the agreed search, but are included for review due to the relevance of their content.

- National Institute for Health and Care Excellence Guideline (NICE) NG48 – Oral health for adults in care homes, 2016 (34)
- Government of South Australia, SA Health, Better Oral Health in Residential Care (BOHRC), 2008 (38)
- Royal College of Surgeons: Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities, 2012. Published in collaboration with the British Society for Disability and Oral Health (BSDH) (39)
- NHS Health Education England, Mouth Care Matters, 2019 (26)
- Public Health Scotland, Caring for Smiles – Guide for care homes, 2020 (40)
- NHS Wales, Gwen-am-Byth A lasting Smile, 2015 (41)
- Australian Commission on Safety and Quality in Health Care. Oral Health care for adult inpatients: recommendations, NSW, 2023 (42)
- GOV.UK, Delivering better oral health: an evidence-based toolkit for prevention, 2021 (19)
- British Association of Critical Care Nurses (BACCN) Evidence-based consensus paper for oral care within adult critical care units, 2020 (21)
- Oral Health; Supporting Adults who Require Assistance (37)

Other relevant references were sourced from the bibliographies of the reviewed literature for additional content where necessary.

2.4 HSE Training Needs Analysis (TNA) Survey

The Guideline Steering Group led by the National Oral Health Office developed a training needs analysis survey. The purpose of this survey was to identify current practice and potential gaps that exist in relation to daily oral care provided in health care settings and to identify the education and training needs of Health and social care team in Ireland. With over 1000 respondents to the survey, the knowledge gained will enable the HSE to develop an evidence informed daily oral care programme that supports standardised daily oral care. Survey results are available in Appendix 4 and throughout the Guideline.

2.5 Copyright or permissions sought

Copyright permissions in relation to this guideline were sought.

3.0 Key Recommendations

The Guideline Development Group identified the following evidence informed recommendations, within the scope of the guideline.

Table 1: Key Recommendations

No.	Section	Key recommendation	Who	When	With What (Tools and resources)
1	5.1	Carry out an Oral Health Assessment (OHA) for all adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided and document oral health risk (21,26,33,36-41)	Health and Social Care Team Member – setting dependent	On admission/ first contact with the person – Integrate OHA with all general assessments and review at a minimum 6 monthly or as the person's clinical needs change	• Oral Health Assessment Tool (OHAT) • OHAT Picture library • Care resistance strategies (5.2.2) • Standard IPC precautions using Point of Care Risk Assessment • Oral Health Referral Form
2	5.2	Develop and document an individualised daily oral care plan based on OHA (21,26,33,36-41)	Health and Social Care Team Member – setting dependent	On Completion of OHA and updated when indicated on advice/ prescription	• Completed OHAT • Knowledge of oral care products (5.3) • Oral care plan template • Care resistance strategies (5.2.2)
3	5.3	Deliver oral care according to completed oral care plan (21,26,34,37-42), and follow guidance sheets (5.3.1) at least twice daily • Specific medical conditions may require additional oral care (11,17,18,20-24,26,33,37-40,42-51) • Document the delivery of daily oral care (21,26,34,37-42) • Document persistent 'resistance/' refusal to accept oral care, challenges encountered and steps and strategies used when care is resisted or refused (38-40)	Health and social care teams	Minimum twice daily as outlined in oral care plan	• Completed oral care plan • Guidance Sheets • Key oral care products, tools and adjuncts appropriate to the person's care needs and preferences • Care resistance strategies (5.2.2) • Standard IPC precautions using Point of Care Risk Assessment • Daily Oral Care Record Template

No.	Section	Key recommendation	Who	When	With What (Tools and resources)
4	**7.0**	It is the role and responsibility of management to ensure health and social care teams are suitably trained with appropriate equipment available to deliver daily oral care (26,34,36-38,40-42,52,53)	Management	On-going	• National Oral Care Guideline (Supporting Smiles) • HSEland eLearning Programme (in development) • Full range of Key oral care products, tools and adjuncts appropriate to the person's care needs and preferences
5	**10.0**	It is the role and responsibility of management to ensure ongoing monitoring, audit and evaluation including monitoring risk assessments or risk ratings and trends arising from these (54,55)	Management	On-going	• Audit tool • Suggested KPIs • Risk assessment

4.0 Risk Factors and Barriers

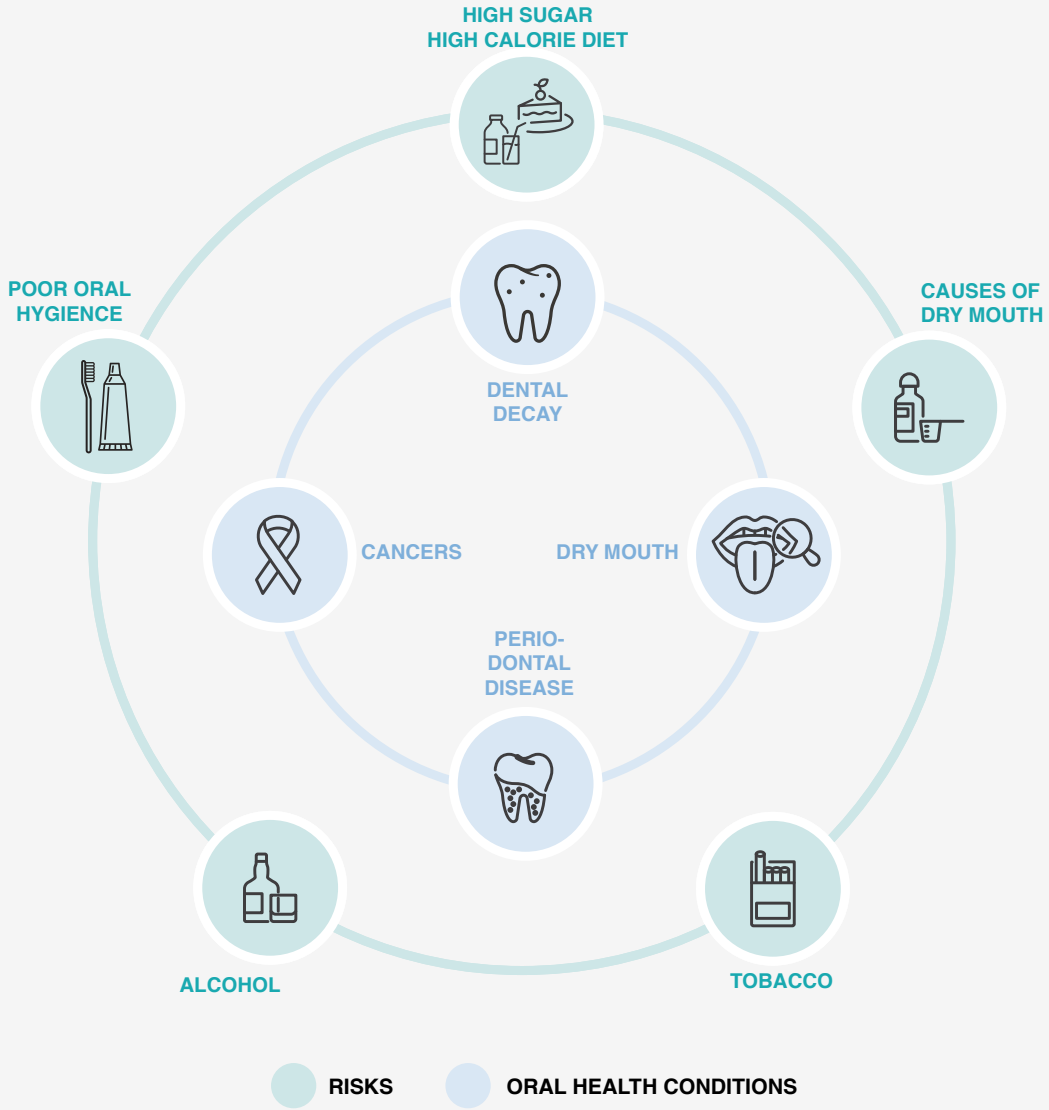
4.1 Risk factors for poor oral health

Specific risk factors for poor oral health include poor and suboptimal oral hygiene, interdental cleaning and denture cleaning. Other risk factors common to oral diseases and non-communicable diseases (NCDs) such as cardiovascular disease, cancer, chronic respiratory disease and diabetes, include tobacco use, alcohol consumption and an unhealthy diet high in free sugars (15). The common risk factor approach should be adopted wherever possible. This approach is an integrated way of promoting general health by controlling a small number of common risk factors that can potentially impact a large number of chronic diseases

These risk factors are evidence based and are grounded in data drawn from The Irish Longitudinal Study on Ageing (TILDA) (56) as well as internationally (3,31).

Modifying risk factors through implementation of this guideline may help improve oral health.

Figure 1: Risk Factors



4.1.1 Poor oral hygiene

Persistently poor oral hygiene is a major risk factor for poor oral health because this allows pathogenic bacteria which cause tooth decay and gum disease to build up in dental plaque (57). The professional consensus is that twice daily tooth brushing is necessary to prevent harmful build-up of plaque (19,58). An unclean mouth may also increase the risk of oral infections such as thrush (candida) in denture wearers, or secondary infection of ulcers caused by mucositis (26,59) and is a leading cause of aspiration pneumonia (17,18). Oral care is an important part of the care of critically ill patients, both ventilated and non-ventilated. An effective oral care programme reduces the incidence of pneumonia and promotes patient comfort (21,22). Persons with disabilities who depend on others for their daily oral care may be at greater risk of poor oral hygiene, particularly if the person is resistant to oral care. The more able, less dependent adults were found to have more fillings, fewer extractions and better oral hygiene (8,39,60-62). Appropriate training for health and social care teams in the delivery of daily oral care is essential (21,26,34,36-38,41,50,63,64).

4.1.2 High sugar/high calorie diet

Diet, nutrition and oral health are closely linked. The American Dental Association endorses the bidirectional relationship between diet, nutrition and oral health (65) confirmed by the WHO Guideline: Sugars intake for adults and children (66,67). Globally, approximately half of the older adult population has untreated dental caries (dental decay) and diet is one of the caries risk factors in older adults (67,68). There is unequivocal evidence showing that fermentable carbohydrates (sugars and starch) are essential in caries initiation and progression (69). Nutritional education is paramount to increase the awareness of the public as well as oral and health care professionals. The World Health Organization (WHO) recognised that free sugars are the key elements in caries development and it defined free sugars as “all monosaccharides and disaccharides added to foods and drinks by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates (70)”. The WHO recommends free sugar intake below 10% of total energy intake. Frequency of sugar intake is also crucial in the development of caries. Older adults often develop snacking habits between meals as reduced appetites lead to smaller meal portions. This pattern can lead to more frequent sugar exposure throughout the day. Chronic medical conditions and certain medications can lead to hyposalivation, which increases caries risk also (71), and where the gums have receded there is an additional risk of decay occurring on the exposed roots of the teeth (68,72).

The integration of oral health into general health care services is paramount to ensure good nutrition and oral health status in older adults (73). Healthcare professionals should be mindful of a co-ordinated plan comprising oral, nutritional and medical status to maintain oral and general health, particularly among vulnerable groups such as those with dementia, intellectual disabilities and those living in residential care (32). The input from nutritionists on dietary modifications would be vital for high risk individuals. Frequent consumption of acidic beverages such as carbonated drinks or fruit juices can also cause severe wear of the teeth over time due to acid erosion (74).

Where feasible, dietary intake should be considered in oral care plans, to reduce high sugar and acidic beverage intake. Ideally, sugar-containing foods and drinks should be avoided at bedtime when saliva flow is reduced and its protective effects are lost (19) (Refer to Section 4.1.3 Dry mouth (xerostomia)).

High calorie nutritional supplements may be essential to maintain weight and prevent malnutrition. It is important to balance the nutrition and hydration risks of individuals with good oral care to reduce problems with the teeth and gums. Prevention is better than cure, so persons who require nutritional supplements may need additional preventive measures such as high fluoride toothpaste to reduce the risk of tooth decay, particularly if they also have a dry mouth (19). Balancing dental review in combination with dietary review may further improve oral health and nutritional status. It may also reinforce to all healthcare staff involved in an individual’s care the importance of interprofessional training and education to provide optimum oral and dietary care.

4.1.3 Causes of dry mouth (xerostomia)

Xerostomia is the subjective feeling of a dry mouth. A dry mouth may occur as a result of hyposalivation or as a change to salivary composition. Xerostomia may be of varying frequency, varying severity and can lead to varying levels of distress.

Saliva has cleansing, diluting, lubricating and protective mechanisms. Saliva coats the oral mucosa and aids lubrication and digestion. It assists with smooth airflow, speech, eating, drinking, and swallowing. Salivary enzymes assist the digestion of starches and fats in food, in both the oral cavity and stomach. It improves food bolus formation and oral clearance of food. It acts as a solvent allowing interaction of food with taste buds thus facilitating taste.

Dry mouth increases the risk of tooth decay, root decay and gum disease, as the protective and lubricating function of saliva is lost (74). It may also increase the risk of oral infections, cause oral discomfort, difficulty with eating and speaking and problems with denture wear (26).

Dry mouth may be a side effect of a number of medications (see Appendix 3 for list of drugs) and cancer treatments including radiotherapy to the head and neck (45). Other causes of dry mouth include nil by mouth status, dehydration, mouth breathing, Oxygen therapy, medical conditions, e.g. diabetes, Sjogren's Syndrome (26). Smoking and alcohol consumption can also exacerbate dry mouth. The underlying cause of dry mouth should be identified before proceeding with management interventions (75).

Non-pharmacological management of dry mouth may include frequent sips of water throughout the day (if appropriate), reducing consumption of juices, sugary/fizzy drinks, caffeine and alcohol and avoiding smoking (26,75).

Management of dry mouth may also involve altering food texture or other oral intake strategies to facilitate an easier, safer more comfortable oral, pharyngeal, and oesophageal transit of food, as well as the protection of the lining of the mouth, pharynx, and oesophagus, e.g. avoiding spicy/salty/very dry or hard-to-chew foods, taking frequent sips of water at mealtimes or moistening food with sauce/gravy (38). Although acidic boiled sweets are thought to stimulate salivary flow, their use should be avoided as they increase the risk of dental decay and also may ultimately have a drying effect on the mouth (75). Sugar-free chewing gum is a good stimulant of saliva and may be useful for some persons with dry mouth who are capable of producing saliva (26) but may not be appropriate in many care settings and is therefore not a general recommendation.

Pharmacological management of dry mouth may involve consideration of saliva stimulants or substitutes or a combination of both. It may also involve a review of medications which cause dry mouth. Saliva stimulants increase the secretion of "normal" saliva, and so will ameliorate xerostomia and the other clinical features of salivary gland dysfunction. In contrast, saliva substitutes, which are very different from normal saliva (physically, chemically), will usually only ameliorate xerostomia. However, saliva substitutes, usually dry mouth gel, spray or rinses, are most commonly used for management of dry mouth (only cellulose-based formulations available in Ireland). Saliva substitutes should be applied as frequently as required, including before meals. Application every 30-60 minutes may be necessary in palliative care (75).Saliva substitutes with a neutral pH are advised for long-term use (26,76).

Having a dry mouth is one of the indicators for use of high Fluoride tooth paste (5000 ppm Fluoride) to therapeutically protect against tooth decay (19,37)

4.1.4 Tobacco and alcohol

For adults, tobacco use and alcohol consumption are risk factors for many cancers, including oral, head and neck cancers. Alcohol intake was cited in the National Cancer Strategy 2017-2026 as being associated with more than 50% of cases of head and neck cancer. Tobacco use is also a risk factor for other oral health conditions, e.g. gum disease (77). Oral cancer survival rates are strongly associated with the stage at diagnosis. Early detection is key to improving oral cancer survival rates and quality of life (78). The National Cancer Control Programme advises that Medical and Dental Practitioners and Pharmacists urgently refer people presenting with suspicious lesions in their mouths (79).

Implementation of this HSE national oral care guideline will assist the health and social care team to carry out an oral health assessment with guidance on when to refer to a Dentist or medical team member if any of the following are noted:

- An unexplained ulcer in the oral cavity lasting for more than 3 weeks (80)
- A lump on the lip (inner or outer) or inside of mouth
- A persistent white/red patch inside of mouth

4.1.5 Behaviours that support oral health

Research highlights the oral health behaviours that Dentists and Health and Social Care Teams (HSCTs) support their patients to change through brief intervention (19). Brief interventions are a technique used to initiate change for an unhealthy or risky behaviour such as smoking, lack of exercise or alcohol misuse. Behaviours that Dentists and HSCTs can support include:

- Improving oral hygiene
- optimising exposure to fluoride
- reducing free sugar intake
- stopping smoking and tobacco use
- reducing harmful alcohol consumption

To understand the complexity of behaviour change, consideration of the broader influences on patient's lives is needed. A person's ability to change their behaviour is influenced by an array of individual, social and environmental factors, with socio-economic circumstances being a major influence. This explains why multiple unhealthy behaviours, such as smoking, alcohol misuse, and lack of tooth brushing, may cluster together in particular groups of people (19).

4.2 Oral Care Barriers

Identifying the barriers to providing oral care will help health and social care teams to overcome them.

Health and social care teams are known to experience barriers to providing effective daily oral care which include; person (service user) compliance, absence of oral care training, limited oral hygiene resources, a lack of standardised protocols, or absence of guidelines for evidence-based oral care (39,61,81).

There is a risk of non-adherence to oral care practices by care and support staff due to local and organisational factors.

Curtin *et al.* 2024 investigated barriers to the provision of daily oral care among a representative group of multidisciplinary healthcare professionals in a stroke unit in Ireland. Participants reported barriers in relation to lack of confidence and concerns related to; the perceived risk for patients with dysphagia, patient and stroke related challenges, lack of resources and time and the perceived importance of daily oral care in recovery and its relative importance with competing demands (82). Health professionals in a stroke unit all felt that they have a role to play in supporting oral care for patients with dysphagia post-stroke (82).

Available evidence suggests that education of carers may change carers' attitudes and improve their skills (34,36), which has led some to advocate for educating care staff as a means of improving the oral health of people dependent on oral care.

These findings support the need for training programmes to be planned at systems level encouraging accountability at all levels, aligned to local policies and guidelines. Carers must find the training meaningful and attractive and they must be acknowledged for the oral care they provide (36).

Here's what HSE Training Needs Staff Survey tells us:

76% of all respondents reported that they had received no further education on providing oral care since finishing their professional training and 97% felt that they would benefit from access to this education

Clear need for accessible on-line training in oral care provision

Access to oral care training inadequate and needs to be priotitised by management

31% of all respondents stated that an OHA is carried out after a significant medical event that can impact on oral care

4.3 Care resistance

Care resistant behaviour is when a person opposes the action of a caregiver and is one of the most common barriers reported by nurses when providing daily oral care to persons (26,61).

This can be common in people with a cognitive impairment such as dementia or an acquired brain injury, intellectual disability or a neuro-disability. In terms of oral care this can include turning the head away, not opening the mouth, tensing the lips and cheeks, pushing the carer away, or verbally declining mouth care (26). People who are care resistant may exhibit responsive behaviours including; fear of being touched, not understanding/responding to directions, biting the toothbrush, grabbing, vocal responses to care, general agitation, or questions and screaming (37,39,61). This was echoed in the HSE Training Needs Survey and highlighted by staff in research conducted by Curtin et al, 2024 (82).

There are many reasons a person may be resistant to receiving daily oral care. They may be confused and disorientated or be in pain and feel unwell (26). They may find oral care very unpleasant and challenging due to sensory issues. Oral tactile sensitivity and sensory processing issues may increase reluctance to engage with toothbrushing and other oral health activities (e.g., flossing), especially if the person has significant cognitive impairments, reducing their comprehension of why the toothbrushing is required. Oral motor difficulties (e.g., hypertonia in people with cerebral palsy) may make toothbrushing more challenging for the person or those who support them as people may bite down on the toothbrush preventing or extending the time needed to provide support (39,61).

Members of the multi-disciplinary team such as occupational and speech and language therapists may be able to support healthcare staff to improve communication with patients about their daily oral care.

Some people may be very resistant to daily oral care. It is important to stop and record that the person has refused and try again at a different time (26).

Each person is different and there are ways health and social care teams can support each person. Tolerance of daily oral care can be improved over time using the steps to providing oral care as outlined in Tables 4 and 5 – Section 5.2.2 – 5.2.3.

4.4 Refusal of Oral Care

A person has the right to refuse daily oral care. However, health and social care teams must be cognisant that failure to provide daily oral care will lead to deterioration of oral health which may result in pain, discomfort, infection and tooth loss, impacting on wellbeing, quality of life and also potentially on general heath. Therefore, it is essential that teams do everything possible to make oral care acceptable to those who are unable to understand the consequences of refusal (Refer to 5.1.1 guidance in relation to consent and refusal of oral care).

Health and social care teams must respect a valid refusal of an intervention. They must do so even if the person's decision appears unwise. In such cases, it is particularly important to accurately document the discussions with the person in their healthcare record including:

- The intervention that has been offered;
- Whether an alternative intervention is acceptable to the person;
- The person's decision to refuse the intervention offered;
- Details of the full implications of the decision to refuse an intervention.

If the decision-making capacity of the person to refuse consent is in question the guidance in Part One, Sections 5 and 6 of the National Consent Policy should be followed. (HSE, National Consent Policy)

5.0 Procedure

5.1 Carry out an Oral Health Assessment (OHA) and establish oral health risks for the person

- Oral Health Assessment Tool (OHAT) 5.1.4
- OHAT picture library 5.1.5
- Oral Health Referral Form 5.1.6

5.2 Develop and document an individualised Oral Care Plan

- Complete the individualised Oral Care Plan template 5.2.1

5.3 Deliver and document daily oral care

- Deliver oral care according to completed oral care plan and follow guidance sheets (5.3.1) using the appropriate key oral care products 5.3.2
- Deliver oral care for specific medical condition 5.3.3
- Document daily oral care in oral care template 5.3.4

5.1 Oral Health Assessment (OHA)

No	Key recommendation	Who	When	With What (Tools and resources)
1	Carry out an Oral Health Assessment (OHA) for all adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided and document oral health risk	Health and social care team member (setting dependent)	On admission/first contact with the person – Integrate OHA with all general assessments and review **at a minimum** 6 monthly or as the person's clinical needs change	Oral Health Assessment Tool (OHAT) OHAT Picture library Care resistance strategies (5.2.2) Standard IPC precautions using Point of Care Risk Assessment Oral Health Referral Form

An **Oral Health Assessment (OHA)** is the first step in supporting and providing daily oral care. The Oral Health Assessment Tool (OHAT), (modified from Chalmers (83)), is used to assess the person's oral health status and record any oral health problems and risk factors identified (classified according to risk level, using a traffic light colour-coding system). HIQA (Health Information and Quality Authority) in Ireland requires that assessments and care plans be regularly reviewed to ensure they are up-to-date and meet the needs of individuals receiving care. These reviews are crucial for maintaining quality and safety in healthcare and social care settings (43)

5.1.1 Consent

5.1.1.1 Oral Health Assessment

Those undertaking the Oral Health Assessment should follow the requirements of the consent policy applicable to their own setting which should be consistent with the principles of the HSE National Consent Policy. It is possible that the decision-making capacity of some people encompassed by this guideline may, at times, be in question and the principles of the Assisted Decision-Making (Capacity) Act 2015, as described in the National Consent Policy, should be applied in such cases. The HSE National Consent Policy should be consulted for a comprehensive overview of the current approach to consent in such cases.

5.1.1.2 Daily Oral Care

Daily oral care, such as toothbrushing, oral cleaning and denture care, is an important component of routine personal care and can therefore proceed on the basis of assent (agreement) for daily tasks (rather than the consent-based approach for Oral Health Assessment).

The various supportive strategies described in this guideline should be utilised to try and maximise a person`s acceptance of oral care. All determinants of successful oral care such as cognition, behaviour and anxiety, should be considered so that a person specific plan may need to be devised to maximise potential for cooperation.

However, **a refusal to accept oral care** should be respected and should be managed in accordance with the following guidance.

If a person is refusing oral care take time to consider the following:

- Are you using the right oral hygiene aids?
- Are you minimising the sensory challenge for the person?
- Are you approaching with a caring attitude?
- Is your language and expression effective?
- Is the person not concentrating or participating because of the environment?
- Is it the right room or location for the person?
- Is your approach familiar to the person?
- Is the time of the day best for the person, such as morning versus evening?
- Ask others, including family, for ideas. Ask for help.
- If all efforts to address refusal of care have been exhausted without success, the situation must be discussed with support persons (family/other trusted person or formal decision supporters, if appointed (may be family or non-family).

Where a person makes a decision to refuse daily oral care, despite continued efforts and guidance from key members of the multi-disciplinary team (MDT), their decision must be respected, documented, discussed with senior staff and discussed during clinical handover. Options to mitigate risks of poor cooperation should be explored.

5.1.2 Oral Health Assessment

The OHA does not take long to complete and should be performed by a trained health and social care team member on admission (or on first contact with the person). It should be repeated every 6 months along with other general health assessments, with additional assessment or more frequently when clinically indicated, e.g. after a significant medical event that can impact on oral care (see Section 5.3.2), or a change in medications, etc. (43). Depending on clinical circumstances, it may be appropriate to use the OHA as an ongoing assessment tool, to monitor an identified condition/circumstances and determine the appropriate daily oral care protocol (37). The Oral Health Assessment (OHA) carried out by non-dental health and social care team members is designed to identify potential oral health issues and prompt a referral for a comprehensive dental examination conducted by a registered dentist.

An Oral Health Assessment is necessary for the following reasons:

- Identifies current oral health problems and also identifies those at increased risk of future problems, e.g. due to a combination of risk factors such as poor oral hygiene and dry mouth.
- Identifies those who are less likely to self-care or unable to do so effectively and require support from staff, e.g. prompting or physical assistance.
- Allows the development of a specific daily oral care plan based on the findings of the OHA.
- Identifies if a person needs to see a dentist/medical team/other health and social care professionals.

Here's what HSE Training Needs Staff Survey tells us:

43% of all respondents stated that an OHA is completed on admission/first contact

Hospice care staff completed the highest percentage of OHA on first contact

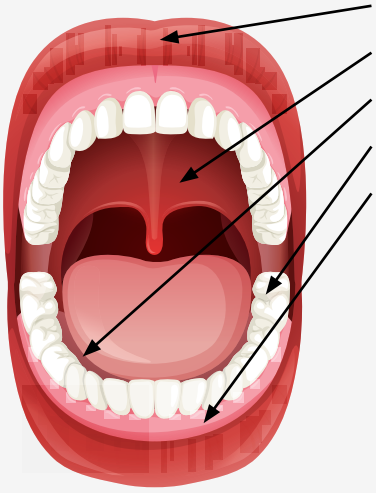
31% of all respondents stated that an OHA is carried out after a significant medical event that can impact on oral care

5.1.3 The Oral Health Assessment process

Carry out an oral health assessment, using the Oral Health Assessment Tool (OHAT) (5.1.4) as follows:

- It is the responsibility of every health and social care team member to undertake a point of care risk assessment prior to performing a care task, as this will inform the level of IPC precautions needed – Refer to Table 2.
- Explain to the person that you are going to carry out an oral health assessment and obtain their consent for this.
- Record person's name, date of birth and name/contact details of their own dentist and date of last dental check-up (if known).
- Ask the person if they have any oral problems (record their pain level on scale 1-10) or note if person has been displaying signs of pain, e.g. difficulty eating, altered behaviour/sleeping pattern, tugging at/pointing to face, facial swelling (if unable to verbally communicate).
- Assess the level of support the person needs for daily oral care – does the person have cognitive difficulties, poor positioning, upper limb/fine motor difficulties or physical difficulties accessing the bathroom, which may indicate assistance for oral care required?
- Record if the person has dysphagia, diagnosed by a swallow assessment by a Speech and Language Therapist/GP/hospital doctor – Refer to Table 3.
- The person should be sitting up if possible and their head should be comfortably supported.
- Look into the mouth with a light source, i.e. pen torch. A tongue depressor/toothbrush may also be used to hold the tongue or cheeks out of the way.
- Ask the person/assist them to remove dentures if present.
- Record if the person has their own teeth or dentures.
- Check the mouth in the following order:

Figure 2: OHA Regions



Assessment regions

1. Lips
2. Inside of Mouth
3. Saliva
4. Teeth
5. Gums
6. Dentures (if present)

- Assess and record the risk status of each region in turn using the OHAT. If the region is healthy, this is recorded in the Low Risk column (green). Any unhealthy oral conditions noted are recorded either as Medium Risk or High Risk according to their listing in the Medium Risk (amber) or High Risk (red) columns of the OHAT.
- Refer to the OHAT Picture Library (5.1.5) for examples of unhealthy oral conditions as well as examples of good oral health to help identify oral conditions and decide their the risk status.
- If it has not been possible to carry out an assessment either fully or partially, record this and the reason for it in the OHAT, e.g. unable to carry out OHAT. If failure to carry out assessment is due to care resistance, review care resistance strategies (5.2.2) and attempt to complete the OHA at another time.
- Refer to the Dentist/Medical team if it has not been possible to carry out an assessment following repeated attempts.
- If referral is indicated, complete an Oral Health Referral Form (5.1.6) indicating the specific area of the mouth on the graphic of the mouth, and record the date of referral, person to whom the referral was sent and reason for referral. If follow-up of the referral is necessary, this is also recorded.
- Speak to the Dentist/Medical team if there are any concerns about oral care or oral problems.

Table 2: Infection Prevention and Control

Infection Prevention and Control

All people potentially harbour infectious microorganisms. Oral care is an infection control measure. A Point of Care Risk Assessment (PCRA), as part of standard precautions, is to be carried out before each interaction. Standard precautions ensure a basic level of IPC. Implementing standard precautions as a first-line approach to IPC in the healthcare environment minimises the risk of transmission of microorganisms from person to person, even in high-risk situations. Transmission-based precautions are required when providing care to people with known or suspected respiratory infections (84).

It is the responsibility of every health and social care team member to undertake a point of care risk assessment prior to performing a care task, as this will inform the level of IPC precautions needed, including the choice of appropriate PPE. For further information on PCRA and how to use a PCRA please see links

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/PCRAResistPoster.pdf

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessment-pcra-for-infection-prevention-and-control-copy.pdf

Hand Hygiene posters

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/handhygiene/handhygieneposters/

Table 3: Dysphagia

Dysphagia

Dysphagia is a medical term for difficulty in swallowing. Dysphagia is considered to be an important risk for Aspiration Pneumonia, but generally not sufficient to cause pneumonia unless other risk factors are present as well. These include being dependent for feeding, dependent for daily oral care, number of decayed teeth, tube feeding, more than one medical diagnosis, number of medications and smoking (17,24). Any persons suspected of having dysphagia should be referred to speech and language therapy/GP/Hospital doctor. Daily oral care is extremely important for these people and needs to be prioritised by the multidisciplinary team. The key factor in daily oral care for persons with dysphagia relates to their ability to expectorate reliably. The ability to expectorate reliably, in this oral care context, relies on a variety of factors including though not limited to; an alert state, adequate cognition, orientation to task, appropriate positioning along with the physical ability to use oral musculature to perform the task of expectorating toothpaste. Oral care guidelines for persons identified as having dysphagia may be different from guidelines for persons without dysphagia, depending on the nature and severity of the disorder and needs input from a Speech and Language Therapist.

See further details on clinical signs that a person may have a swallow disorder:
https://www.hse.ie/eng/about/who/cspd/ncps/older-people/resources/hse-supporting-older-people-with-swallowing-difficulties-leaflet.pdf

5.1.4 Oral Health Assessment Tool (OHAT)

Name:		**Person's Own Dentist**	**Date of last OHAT:**
D.O.B:		Dentist:	
Consent for OHA	Yes ☐ No ☐	Address: Tel:	**Date of last dental check-up (if known):**
Oral Health Assessment Performed on:		Admission/first point of contact ☐ Review ☐ Change in clinical needs ☐	
Does the person report any oral problems or display any signs of pain		Yes ☐ No ☐	If yes: how does the person rate it on a scale of 1-10:
Support needed for daily oral care Record all supports needed in Oral Care Plan		No assistance with oral care ☐ Some assistance with oral care ☐ Total assistance with oral care ☐	SLT/OT/Physiotherapist referral for further advice on person specific supports: Yes ☐ No ☐
Does the person have dysphagia?		Yes ☐ No ☐	**If Yes, follow the DYSPHAGIA ORAL CARE PROTOCOL**
Does the person have? Tick all that apply		All/some own natural teeth Yes ☐ No ☐ Upper denture ☐ Lower denture ☐ No denture ☐	

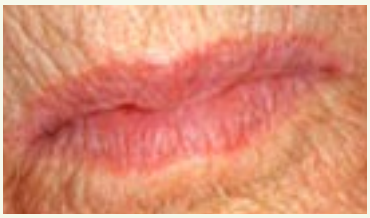
Mouth will be checked with a LIGHT SOURCE (using pen torch) and marked as Low, Medium, or High Risk

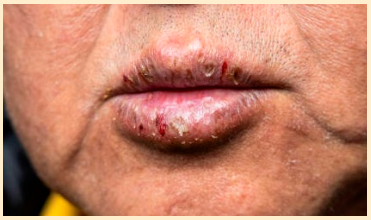
	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Lips	Pink and moist ☐	Dry/cracked ☐ Red/cracked/crusted at corners* ☐ Ulcer < 21 days ☐ Cold sore* ☐	Swelling/lump ☐ Ulcer > 21 days ☐ Bleeding/widespread ulceration ☐
Inside of Mouth: • **Tongue** • **Cheeks** • **Palate** • **Floor of Mouth** • **Inside of lips**	Clean mouth Pink, intact mouth lining ☐	White/red/speckled patches (consider candida (thrush)* ☐ Ulcer < 21 days ☐ Coated tongue ☐ Food lodging* ☐	Smooth, glossy sore tongue ☐ Swelling/lump ☐ Ulcer > 21 days ☐ Persistent white/red patch ☐ Widespread redness/Widespread ulceration ☐
Saliva	Saliva present ☐	Dry mouth* ☐ Thick or dried/crusted secretions* ☐ Hypersalivation or drooling* ☐	Reports very dry or painful mouth ☐
Teeth	Clean No broken teeth No obvious cavities ☐	Broken, very worn teeth ☐ Cavities (no pain)* ☐ Loose Teeth* ☐	Severe/persistent pain ☐ Extremely loose teeth ☐
Gums	Pink and clean ☐	Red/inflamed (puffy) ☐ Bleeding on brushing ☐	Painful ☐ Ulcerated ☐ Swelling present ☐ Bleeding on brushing (not improving with regular, thorough brushing of gums) ☐
Dentures *If Dentures are lost in care setting, complete NIRF*	Clean Comfortable ☐	Loose* ☐ Lost* ☐ Broken/unable to wear* ☐	Person will not remove denture ☐ Denture cannot be removed ☐

OHA completed	Reason unable to undertake OHA:		Referred to:
Fully ☐ Partially ☐ Unable ☐ *(If relevant, refer to 5.2.2 Care resistance)*	Person escalated to:		Date referral (s) sent:
	Completed by (Name)		If referral declined/not possible, reason for same:
	Signature		
	Contact Tel	Date:	Next OHA Review Date:

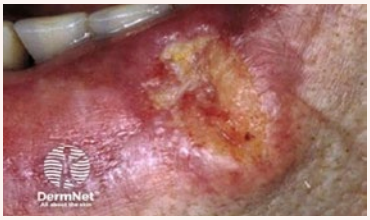
5.1.5 OHAT Picture Library – (copyright for images granted from BOHRC (19,38)

	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Lips	Pink and moist	Dry/cracked Red/cracked/crusted at corners* Ulcer < 21 days Cold sore*	Swelling/lump Ulcer > 21 days Bleeding/widespread ulceration

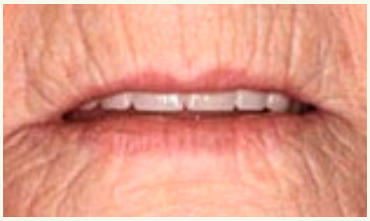


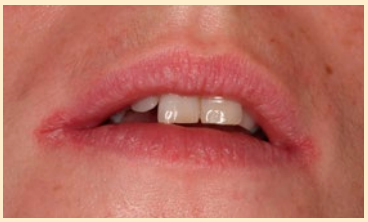


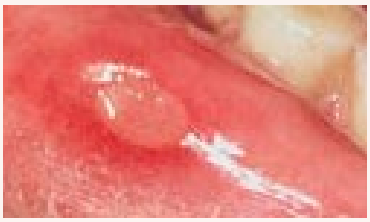
Dry/cracked

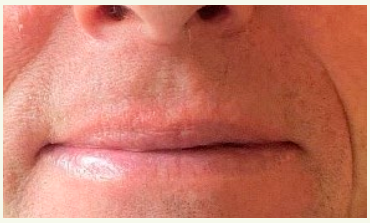


Swelling/lump

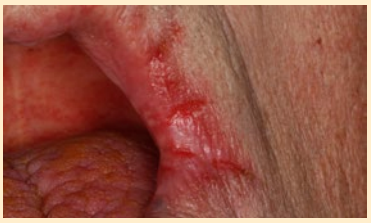




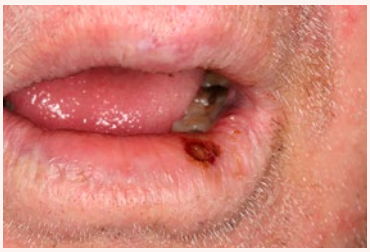




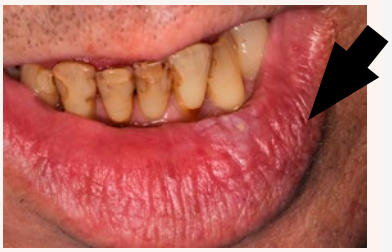
Pink and moist



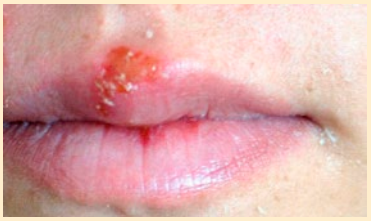
Red/cracked/crusted at corners*



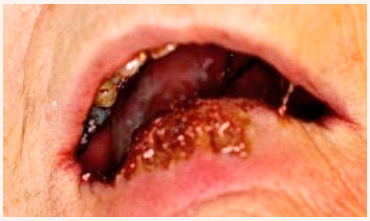
Ulcer < 21 days



Ulcer > 21 days

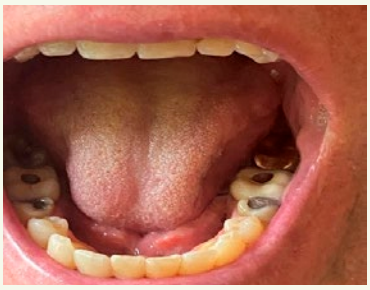


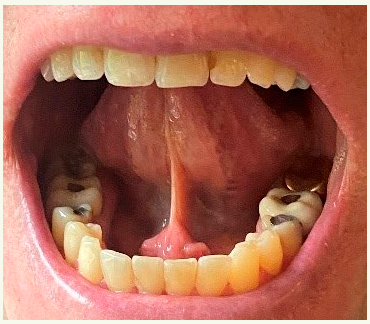
Cold sore



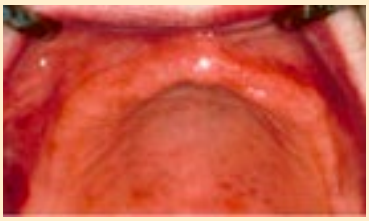
Bleeding/widespread ulceration

	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Inside of Mouth	**Clean mouth** **Pink, intact mouth lining**	**White/red/speckled patches (consider candida or thrush)*** **Ulcer < 21 days** **Coated tongue** **Food lodging***	**Smooth, glossy sore tongue** **Swelling/lump** **Ulcer > 21 days** **Persistent white/red patch** **Widespread redness/ Widespread ulceration**

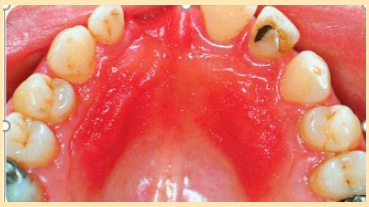


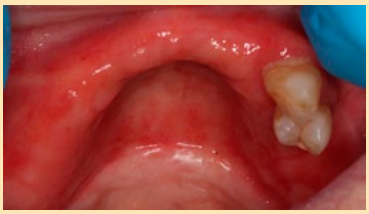


Clean mouth
Pink, intact mouth lining

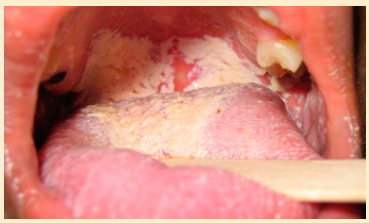


Consider candida or thrush if;
Red/speckled patches

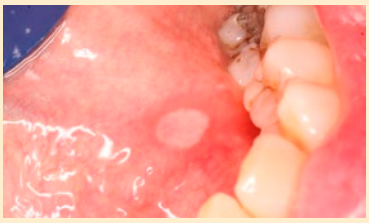




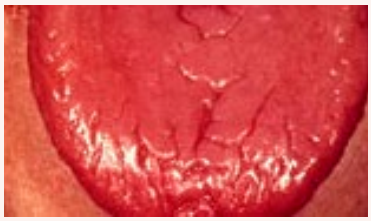
Consider candida or thrush if;
Redness matching outline of denture

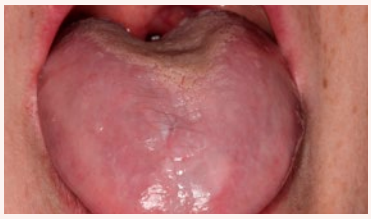


Consider candida or thrush if;
White patches

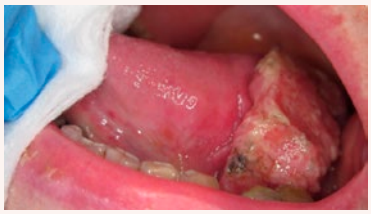


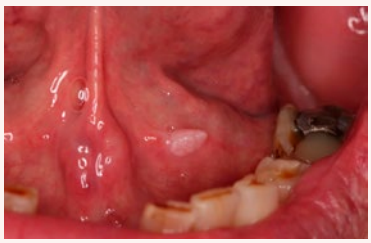
Ulcer < 21 days

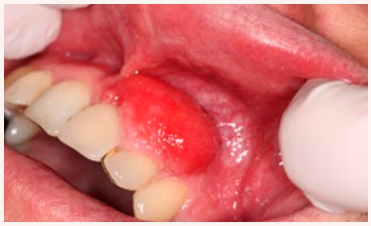




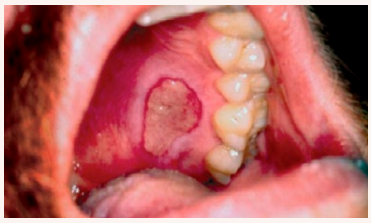
Smooth, glossy sore tongue



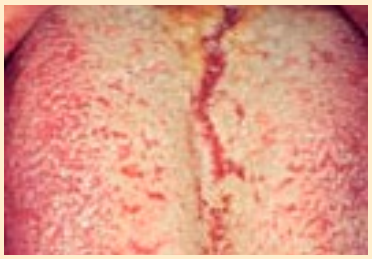
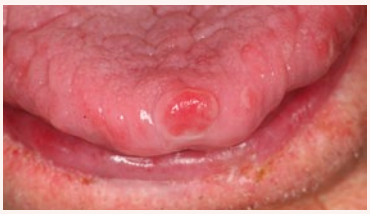
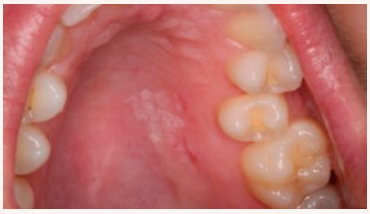
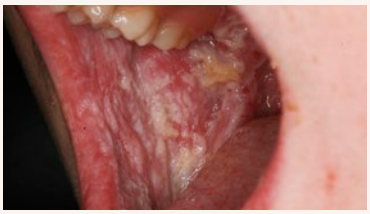
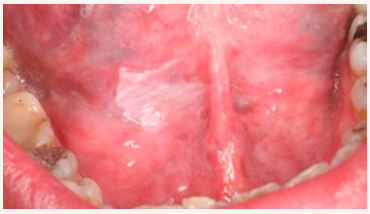
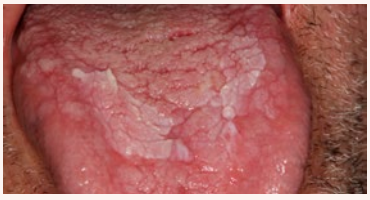
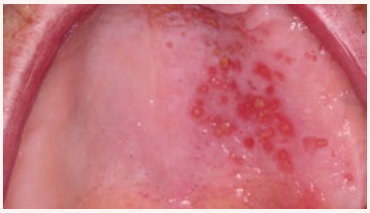
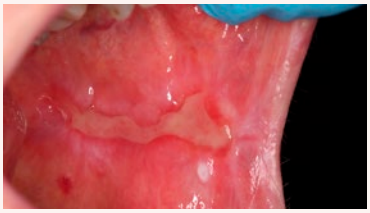


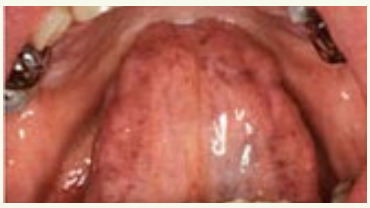
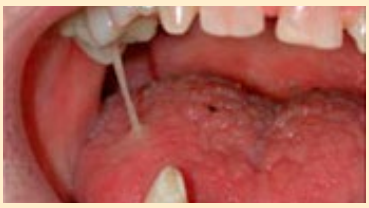
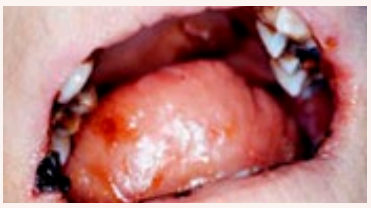
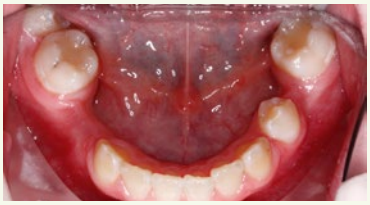
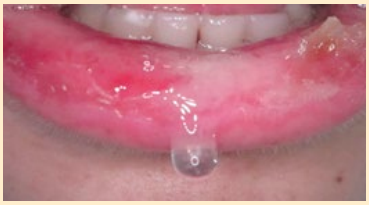
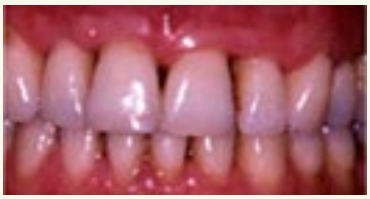
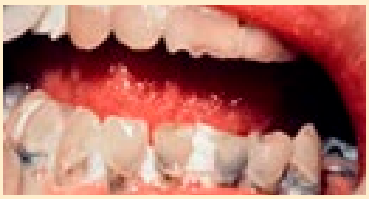
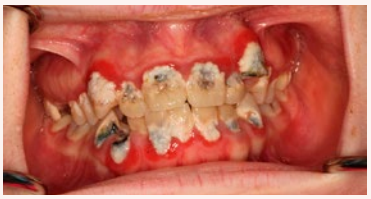
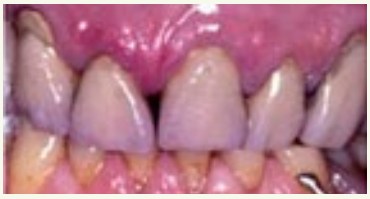
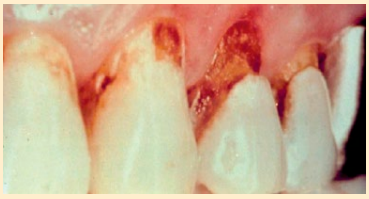
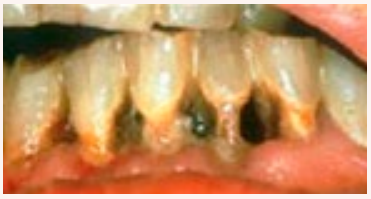
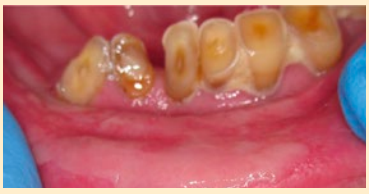
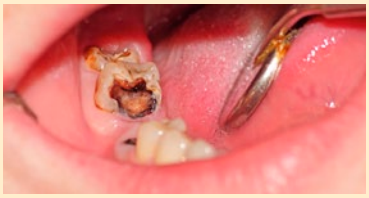


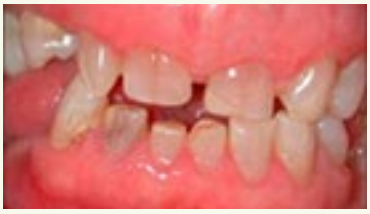
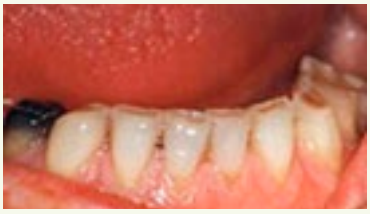
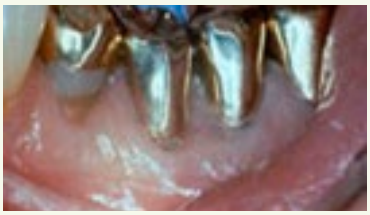
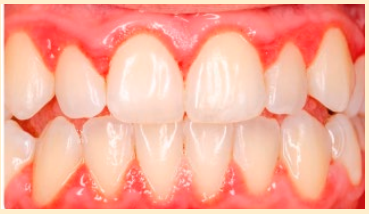
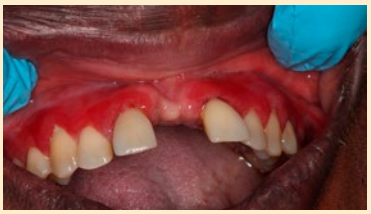
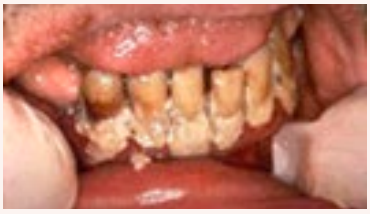
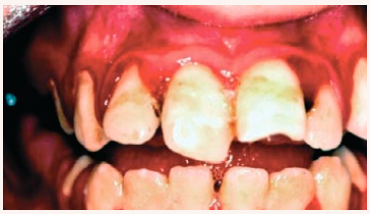
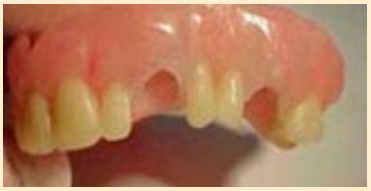
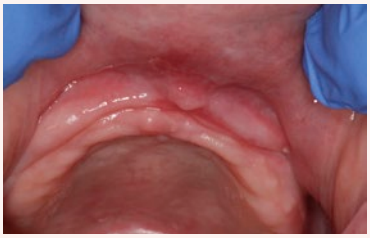
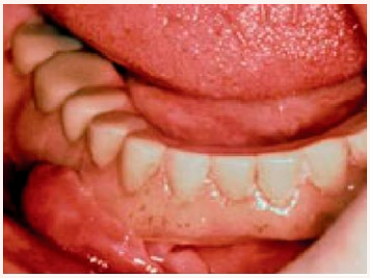
Swelling/lump



Ulcer > 21 days

	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Inside of Mouth (continued)		 Coated tongue	 Ulcer > 21 days  White patches    Persistent white/red patch   Widespread redness/ widespread ulceration

	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Saliva	**Saliva present**	**Dry mouth*** **Thick or dried/crusted secretions*** **Hypersalivation or drooling***	**Reports very dry or painful mouth**
			
		Thick or dried/crusted secretions*	Reports very dry or painful mouth
			
	Saliva present	Hypersalivation/drooling	
Teeth	**Clean** **No broken teeth** **No obvious cavities**	**Broken, very worn teeth** **Cavities (no pain)*** **Loose teeth***	**Severe/persistent pain** **Extremely loose teeth**
			
			
	Clean No broken teeth No obvious cavities		Refer if in persistent pain or if extremely loose
		Broken/very worn teeth	
			
		Cavities (no pain)	

	LOW RISK	MEDIUM RISK *Referral may be needed	HIGH RISK Referral is needed
Gums	**Pink and clean**	**Red/inflamed** **Bleeding on brushing**	**Painful** **Ulcerated** **Swelling present** **Bleeding on brushing** (not improving with regular, horough brushing of gums)
	   Pink and clean	 Red and inflamed  Bleeding on brushing	 Painful, Ulcerated, Swelling present  Bleeding on brushing (not improving with regular, thorough brushing of gums)
Denture	**Clean** **Comfortable**	**Unclean** **Loose*** **Lost*** **Broken/unable to wear***	**Person will not remove denture** **Denture cannot be removed**
	 Clean Comfortable	 Unclean   Broken/unable to wear	  Swelling under denture - poorly fitting

5.1.6 Oral Health Referral Form

If referral is indicated (High risk/specific medium risk*), complete an Oral Health Referral Form recording the reason for referral indicating the specific mouth region on the graphic of the mouth.

Name of Person	
Date of Birth	
Address	
Referred to	
Referred by	
Date of Referral	

Select the primary reason for the referral from the options below and provide any relevant details in the designated space provided

ASSESSMENT REGION	REASON FOR REFERRAL If pain recorded please note score on scale of 1-10	Please Tick ✔
Lips	Swelling/lump	
	Ulcer > 21 days	
	Bleeding/widespread ulceration	
	Red/cracked/crusted at corners	
	Cold sore	
Inside of Mouth: • **Tongue** • **Cheeks** • **Palate** • **Floor of Mouth** • **Inside of lips**	Smooth, glossy sore tongue	
	Swelling/lump	
	Ulcer > 21 days	
	Persistent white/red patch	
	Widespread redness/widespread ulceration	
	White/red/speckled patches (consider candida (thrush)	
	Food lodging	
	Reports uncomfortably dry or very dry/painful mouth/ thick or dried/crusted secretions present	
	Hypersalivation or drooling	
Teeth	Severe/persistent pain	
	Cavities (no pain)	
	Loose tooth/teeth	
Gums	Painful	
	Ulcerated	
	Swelling present	
	Bleeding on brushing not improving with regular, thorough brushing of gums	
Dentures	Person will not remove denture	
	Denture cannot be removed	
	Loose	
	Lost	
	Broken/unable to wear	

RELEVANT DETAILS
Provide any additional details in the box below e.g. location, description and duration of lesion, symptoms etc.

While facing the patient, please indicate location of lesion, pain, symptom or issue in the graphic below:

Additional details:

5.2 Oral Care Plan

No	Key recommendation	Who	When	With What (Tools and resources)
2	Develop and document an individualised daily oral care plan based on OHA	Health and Social Care Team member – setting dependent	On completion of OHA and updated when indicated on advice/ prescription	• Information on key oral care products, tools and adjuncts appropriate to the person's care needs and preferences • Completed OHAT • Oral Care Plan

An Oral Care Plan is developed by the oral health assessor in conjunction with the person based on the findings from the Oral Health Assessment. This is an opportunity to gently educate the person on the importance of daily oral care and includes setting goals with the person to carry out tooth and gum brushing at least twice per day as this is the single most important hygiene intervention (19,32).

The supports needed with daily oral care are documented, including appropriate referrals to SLT/OT/ Physiotherapist where further advice on person specific supports are required.

The appropriate oral care protocols for each finding, which take account of identified oral health risks, are used to create the person's Oral Care Plan which is individualised according to the person's specific needs and preferences and lists the appropriate oral care products and adjuncts to be used.

5.2.1 Oral Care Plan

Having assigned an oral health risk status (low/medium/high) to each assessment region (lips, inside of mouth, saliva, teeth, gums and dentures, if present) using the OHAT, this information is transferred into the oral care plan and the oral care required for that region is outlined according to the assigned risk level. The Oral Care Plan is an individualised condensed guide to daily oral care delivery for the person, outlining and summarising their daily oral care requirements and providing specific information on their preferences and the supports they require for daily oral care.

The colour-coded oral care protocol outlines the appropriate level of daily oral care for each assessment region according to the assigned risk level, including the appropriate products and tool required. Detailed information on the delivery of each element of oral care specified in the Oral Care Plan is provided in Guidance Sheets (Section 5.3). These are to be referred to as necessary when providing daily oral care.

- An overall green Low Risk status indicates that required care is, twice daily:
  - Brushing of teeth and gums (with interdental cleaning where appropriate)
  - Gentle cleansing of the inside of mouth for persons without teeth and
  - Cleaning of dentures if present (with weekly disinfection)

- An amber Medium Risk assigned to any assessment region in the OHAT indicates that specific additional oral care measures are required for the oral condition/s identified in that part of the mouth. These additional measures are detailed in the corresponding amber section of the Oral Care Plan. Some amber risk oral conditions may require advice from (and/or referral to) the Dentist/Medical team/SLT. Any advice received or treatment prescribed is recorded in the Oral Care Plan.

- Oral conditions assigned a red High Risk status must be referred to the Dentist/Medical team/SLT for investigation and treatment and may require onward referral to secondary and tertiary services. Until treatment/input is received, continue to provide daily oral care as per medium risk protocol, e.g. management of dry mouth or persistent bleeding of gums.
- The Dentist/Medical team/SLT may advise increased frequency of daily oral care **– enhanced care (four times daily – after meals and at night)** for some conditions assigned a Medium or High Risk status or for persons with specific medical conditions which may impact on their oral health or where poor oral hygiene may pose an increased risk to their general health (see Section 5.3.2).

An oral care plan should also include agreed goals to improve oral health and encourage the behaviour change necessary to sustain oral health (19).

Outcome goals are:

- Agreed between the person and the nurse/appropriately trained staff member.
- Regularly reviewed and revised to ensure effectiveness.
- Regularly reviewed and revised to ensure they reflect the person's changing needs and preferences.

This should be supported by the wider multidisciplinary team. (HIQA standard 2.2.4 (43))

An awareness of barriers to oral care (4.2), such as dependency for oral care which may include care resistance and steps to address this (5.2.2) will inform the personal supports needed with daily oral care.

"What Matters to You" is a HSE initiative that supports person-centeredness in care. It is a simple approach to capturing issues that are important to the individual and when known by staff can improve patient experiences. As part of the "What Matters to You" HSE initiative that supports person-centeredness in care, the oral care plan could be stored at the person's bedside which is accessible to health and social care teams supporting and providing daily oral care. "What Matters to You" is a simple approach to capturing issues that are important to the individual and when known by staff can improve patient experiences when receiving oral care.

Detailed information on the delivery of each element of oral care specified in the Oral Care Plan is provided in Guidance Sheets (Section 5.3.1). These are to be referred to as necessary when providing daily oral care.

Refer to Section 5.3.2 Key Oral Care Products for information on appropriate product selection for individual needs.

Here's what HSE Training Needs Staff Survey tells us:

- 35% of all respondents said yes all persons have an oral care plan,
- 33% of all respondents said some persons have an oral care plan and
- 32% of all respondents said no, persons do not have an oral care plan based on the oral care assessment

Oral Care Plan

Name		**Date of Birth**	**Date of last OHA(s):**
Does the person have?	All/some own natural teeth **Y** ☐ **N** ☐ Upper denture ☐ Lower denture ☐ No denture ☐		
Oral Care frequency	☐ Twice daily (morning and night - standard care)	☐ Four times daily (after meals and at night - enhanced care) *If advised by Medical team/Dentist/Speech and Language Therapist*	

Dysphagia present Y ☐ N ☐ If Yes, follow protocol Refer to Guidance Sheet No. 4 - Teeth and 5.3.2.2	**DYSPHAGIA ORAL CARE PROTOCOL**	**PRODUCTS EQUIPMENT AND RESOURCES**
	Position person to avoid fluid inhalation. This may be in upright or recovery position. Where possible, seek appropriate strategies and guidance from SLT/OT/Physio	☐ Mouth cleanser ☐ Non-fraying gauze ☐ Soft toothbrush ☐ Non-foaming SLS free fluoride toothpaste ☐ Suction toothbrush (if available)
	Clean inside of mouth with a mouth cleanser/non-fraying gauze or suction (if available) to remove any visible food or fluid debris.	
	Brush teeth using a thin smear of non-foaming SLS free fluoride toothpaste on a dry soft toothbrush or suction toothbrush (if available). Remove any excess toothpaste with a non-fraying gauze or suction (if available) after toothbrushing.	

Low Risk Oral Care Protocol Standard daily oral care	Medium Risk Oral Care Protocol *Referral may be needed	High Risk Oral Care Protocol Referral is needed

REFERRALS			
	Until treatment/input is received, provide standard daily oral care and apply medium risk protocol for mouth region of concern. Document advice and follow prescribed treatment and review plan as directed.		**Referred to:**
	Reason for referral		**Date referral sent:**
	Prescribed treatment and duration		**Date:**

Lips Refer to Guidance Sheet No. 1 - Lips			
	Dry/cracked	☐ Apply a water based lip moisturiser as required	☐ Water based lip moisturiser ☐ Prescribed medication Product Name:
	Ulcer < 21 days	☐ Monitor (Refer if present > 21 days)	
	Red/cracked/crusted at corners*	☐ Follow prescribed treatment if required	
	Cold sore*	☐ Follow prescribed treatment if required	

Inside of Mouth Refer to Guidance Sheet No. 2 - Inside of Mouth			
	• Persons without teeth or dentures should have gentle cleansing of the inside of mouth (using mouth cleanser/damp gauze)		☐ Soft toothbrush ☐ Tongue scraper ☐ Mouth cleanser ☐ Damp non-fraying gauze ☐ Prescribed medication Product Name:
	White/red/speckled patches*	☐ Consider candida (thrush) and follow prescribed treatment if required	
	Ulcer < 21 days	☐ Monitor (Refer if present > 21 days)	
	Coated tongue	☐ Brush tongue with soft toothbrush (or use tongue scraper if heavily coated)	
	Food lodging*	☐ Clean inside cheeks/lips/palate (using a mouth cleanser/ damp gauze)	

Saliva Refer to Guidance Sheet No. 3 - Saliva	**Dry mouth***	☐ Use Sodium Lauryl Sulphate (SLS) free or high fluoride toothpaste (5000 ppm) if prescribed	**Toothpaste** ☐ Non-foaming SLS free fluoride ☐ High fluoride toothpaste (5000 ppm)**
		☐ Saliva substitutes/stimulants may be used if prescribed by doctor. Reapply saliva substitutes as needed by the person	
		N.B. Refer to No.3 Guidance Sheet: Saliva for advice in relation to food/drinks to alleviate discomfort from dry mouth	**Other oral care product/aid:** ☐ Mouth cleanser ☐ Soft toothbrush ☐ Non-fraying gauze (damp/dry) ☐ Saliva substitute/stimulant ☐ Water based lip moisturiser ☐ Skin moisturiser/barrier cream
	Thick or dried/ crusted secretions*	☐ Secretions must be removed for comfort. Dried secretions must be softened prior to removal and saliva substitutes reapplied as needed	
	Hypersalivation or drooling*	☐ Follow prescribed treatment if required	
		☐ Remove pooling saliva/food debris prior to providing daily oral care	
		☐ A water based lip moisturiser may be applied and/or skin moisturiser/barrier cream may be applied to affected skin as needed by the person	**Product Name(s):**

Teeth and gums Refer to Guidance Sheet No. 4 Teeth and No. 5 - Gums	• Brush teeth and gums twice daily using a soft toothbrush and standard (1450 ppm) fluoride toothpaste appropriate to the person's preferences/needs (spit, don't rinse) • Interdental cleaning aids should be used where appropriate		**Toothbrush** ☐ Soft ☐ Electric ☐ 3-sided ☐ Aspirating	**Other oral hygiene aids** ☐ Toothbrush grip ☐ Mouth prop/Second toothbrush ☐ Interdental brush ☐ Floss/Floss holder
	Broken/Very worn teeth **Cavities (no pain)*** **Loose teeth***	☐ Seek routine dental review if concerns • Use high fluoride toothpaste (5000 ppm) if prescribed by dentist/doctor • Do not avoid brushing loose or worn teeth	**Toothpaste** ☐ Standard 1450 ppm Fluoride ☐ High fluoride (5000 ppm)** ☐ Chlorhexidine** ☐ SLS free fluoride (mild-flavoured/flavourless)	**Other oral care product** ☐ Chlorhexidine spray/gel ☐ Chlorhexidine mouth wash 0.2% ☐ Chlorhexidine mouth wash 0.12% ☐ Fluoride mouthwash 0.05%
	Red/inflamed (puffy) gums **Bleeding on brushing**	• Do not avoid or stop brushing red/inflamed/bleeding gums • Interdental brushes of appropriate size to be considered for larger spaces between teeth	Product Name(s):	

Dentures Refer to Guidance Sheet No. 6 - Denture	• Remove, clean and brush dentures with mild soap twice a day. If denture adhesive is used, it should be removed when cleaning both denture and mouth • Rinse denture well before re-fitting. Denture cleanser tablets may be used if preferred • Disinfect denture by soaking for 10 minutes once per week in appropriate disinfectant • Remove dentures overnight, clean and store dry in a labelled, lidded container		**Denture accessories** ☐ Labelled, lidded denture box ☐ Denture brush (if candida noted, replace after infection has cleared) ☐ Denture Adhesive	**Denture cleaning products** ☐ Sodium hypochlorite solution 2% ☐ Chlorhexidine digluconate 0.2% ☐ Denture cleanser tablets ☐ Mild liquid soap
	Dentures Loose* **Lost*** **Broken/unable to wear***	☐ If denture is loose, apply denture adhesive ☐ Seek dental review if necessary • If candida (thrush) noted: leave dentures out for as long as possible and store clean and dry in a labelled, lidded container • In addition to standard cleaning, disinfect denture by soaking in appropriate disinfectant for 10 minutes twice per day until signs of candida are gone	Product Name(s): OCP completed by: Date:		

** on prescription

Detailed information on the delivery of each element of oral care specified in the Oral Care Plan is provided in **Guidance Sheets (Section 5.3.1)**. These are to be referred to as necessary when providing daily oral care.

Refer to **Section 5.3.2 Key Oral Care Products** for information on appropriate product selection for individual needs.

What matters to me:	(person's name)		
Person's goal for oral care			
Support needed for daily oral care	☐ No assistance required from support staff	☐ Needs some assistance from support staff	☐ Needs total assistance from support staff
What parts of daily oral care can the person do on their own?			
What parts of daily oral care does the person need support with?			
What other supports are useful? **How does the person like to be supported?** • *Position?* • *Location?* • *Timing?* • *Other tips?*			
Are there changes needed to diet e.g. high sugar and acidic drinks?			
How does the person communicate? *Any specific phrases that help the person understand the process or makes them more comfortable?*			
Any other relevant details?	e.g. location/description of ulcer being monitored and date first observed.		

SAMPLE

What matters to me:	*Michael Bloggs*		
Person's goal for oral care	Michael would like to have clean teeth and fresh breath with no more bleeding gums. He doesn't want to get a toothache.		
Support needed for daily oral care	☐ No assistance required from support staff	☑ Needs some assistance from support staff	☐ Needs total assistance from support staff
What parts of daily oral care can the person do on their own?	e.g. Michael can get all of the necessary tooth brushing tools ready himself. He can brush his teeth but requires support to brush all surfaces, especially at the very back. Michael wears a bottom denture. He can take out and put in his denture himself and he cleans it thoroughly with mild liquid soap twice daily. Michael benefits from reminders to complete his daily oral care in the morning and at night before bed. Remind Michael to store his dentures dry in a labelled lidded container when he goes to bed.		
What parts of daily oral care does the person need support with?	e.g. Michael brushes most of his teeth quite well but requires support to brush the insides thoroughly and finds it difficult to brush his upper back teeth.		
What other supports are useful? **How does the person like to be supported?** • *Position?* • *Location?* • *Timing?* • *Other tips?*	e.g. Michael is happy to brush in the bathroom most times. If this is difficult, moving the brushing to 'his chair' in the lounge room can also be a good place, using cushions and props to help sit upright. Referral to OT for further assessment and recommendations has been initiated. Michael is not a morning person! Usually he prefers waiting until a little bit later in the morning for the AM brush. Michael is happy to accept help with brushing but it is important to allow Michael to brush first. He sometimes gags a little for brushing of the top back teeth. Brushing in short spurts (counts of 5) helps.		
Are there changes needed to diet e.g. high sugar and acidic drinks?	e.g. "Michael prefers to only drink orange juice. Encourage him to limit orange juice to mealtimes only and to drink water at other times" "Michael likes a sweet snack just before bed. Encourage him to have his treat after dinner instead. If this is not acceptable to him, try to keep the snack at least one hour before bed"		
How does the person communicate? *Any specific phrases that help the person understand the process or makes them more comfortable?*	e.g. Michael prefers to hear one instruction at a time. Can become overwhelmed if asked to do too many things too quickly.		
Any other relevant details?	*e.g. location/description of ulcer being monitored and date first observed.*		

5.2.2 Strategies to manage care resistance and changed behaviours

Table 4: Steps to providing daily oral care for people who are care resistant

Steps to providing daily oral care for people who are care resistant	
1. Communication Strategies *Establish effective verbal and non-verbal communication and develop a relationship.*	Health and Social care teams should be aware of the person's specific communication needs, supports and strategies (39). These strategies should be used when communicating with the person and may include the use of objects, pictures, gestures, or more formal communication systems, e.g. LÁMH https://aim.gov.ie/the-lamh-project/ **Body Language** • Approach the person from the diagonal front and at eye level. By standing directly in front you can look big and are more likely to be grabbed or hit. • Touch a neutral place such as the hand or lower arm to get the person's attention. • Position yourself at eye level and maintain eye contact if appropriate. Consider using a mirror so that they can see what is happening (26,38). • Be aware that the personal spaces of individuals can vary (38,61). • Tailor your approach to the individual, be consistent in your approach and maintain a positive expression and caring language (38,61) **Talk Clearly** • Smile and give a warm greeting using the person's first name. Using the first name is more likely to engage the person (37,38). • Use words that impart an emotion; for example, 'lovely' smile or 'sore' mouth • Speak clearly and at the person's pace. • Speak at a normal volume (38). • Always explain what you are doing (37-39). • Use words the person can understand. • Ask questions that require a yes or no response (38) • Give one instruction or piece of information at a time and repeat clearly as necessary (37,38). • Use reassuring words and positive feedback. It is important to observe the person closely when you are talking with him or her. A lack of response, signs of frustration, anger, disinterest or inappropriate responses can all suggest the communication being used is too complex (38).
	Caring attitude • Firstly, focus on building a good relationship with the person before you start daily oral care. Build a rapport by complimenting or validating the person (37,38) • Use a calm, friendly and non-demanding manner. • Allow plenty of time for the person to respond. • If you cannot remain calm, try again at another time or get assistance (38).

Steps to providing daily oral care for people who are care resistant	
	The Right Environment • Choose the location where the person is most comfortable. Daily oral care does not have to be undertaken at the bathroom sink (38,39,61) • For somebody frail, the best location may be sitting at their bedside or in their bed if necessary (38) • Maintain regular routines. Carrying out daily oral care at the same time every day may help (26,38,61) • Carry out daily oral care in a quiet distraction-free environment with sufficient light. The location should be as private as possible to preserve the dignity of the person. If possible, turn off competing background noise such as the television or radio (38) • Use a brightly coloured toothbrush so it can be seen easily by the person and show it to the person alongside verbal instruction (38,40). **Overcoming Fear of Touch** • The person may respond fearfully to intimate contact when the relationship with you has not been established. • Firstly, concentrate on building up a relationship with the person. The aim is to relax the person and create a sense of comfort and safety (38,61) • This process may need to be staged over time until the person becomes trusting and ready to accept daily oral care (38).
2. Behaviour strategies to improve access to the mouth	• Bridging – this helps to engage a person with the task through their senses and helps them to understand the task by letting them feel the brush or brushing their hand so that they know it is not going to hurt (26). Describe and show the toothbrush to the person, mimic brushing your own teeth, give a spare toothbrush to the person, and the person may mirror your behaviour and brush their own teeth (38,41). • Distraction – if none of these strategies work then try distracting with singing or by placing a familiar item in the person's hand while you brush the person`s teeth (26)Other distractions such as music and videos can be used. Brushing at a time when the person is most relaxed, e.g. whilst in the bath may be of benefit (39,61). • Rescuing – this is a common tactic used with other hygiene tasks. If attempts are not going well, the care assistant can leave and the 'rescuer' comes in to take over, bringing in someone else with a fresh approach may encourage the person to accept care (40). Sometimes it may be necessary for more than one caregiver to simultaneously provide support during oral care (38,40)
3. Use oral aids	• A person who is frail or has limited mouth opening may require short rests during oral care, a mouth prop may help gain access to enable tooth brushing (38). Use mouth props only if you have been trained to do so. • A three-sided toothbrush may be useful if co-operation and access to the mouth is limited (19,26,39,85). • A non-foaming toothpaste (SLS free) may be useful as it may be more tolerable or using a toothpaste that is familiar to the person (19,26,39).

Steps to providing daily oral care for people who are care resistant	
4. Additional strategies to make daily oral care more acceptable/ tolerable	If the person has a strong gag reflex it may be helpful to start brushing from the back teeth and move forward, using a smaller toothbrush can be beneficial (39). Brushing the teeth in brief spurts (e.g. for counts of 10) and encouraging the person to breathe through their nose if possible, may also help counteract a gagging tendency. A different area of the mouth can be brushed on different occasions keeping note of the area brushed each time (i.e. several short brushing sessions) (39)
5. Modified oral care application techniques as short-term alternatives to brushing	If brushing the teeth is not possible, try wiping a smear of (high) fluoride tooth paste, or chlorhexidine gel (bleeding gums) along the teeth with a finger, tooth brush or gauze. This is a short-term alternative if brushing is not possible (38,86). If it is difficult to brush or smear high fluoride toothpaste or chlorhexidine gel onto the teeth and gums, a chlorhexidine spray can be used (38).
6. Seek medical team/ dental referral to review daily oral care	If repeated attempts at providing daily oral care are not successful, seek advice from dentist/medical team (26)

5.2.3 Providing daily oral care and dementia

Persons living with early stage cognitive disease will usually be able to clean their own teeth and dentures, but may need to be reminded to do this and may require some supervision. The person's oral care plan will guide you with this. Ideally the person should carry out their own daily oral care for as long as possible. This will help to "keep the familiar, familiar". However, some persons in the early stages of dementia may require support to complete their daily oral care. Daily monitoring and updated oral care plans can help note changes and ensure the person is receiving the correct daily oral care. Awareness of Therapeutic Interventions and Solutions used in Dementia Care is available to access on HSELand here:

Table 5 gives guidance on how to manage changed behaviours which may be seen in First, Second and Third stages of Dementia.

Table 5: Adapted from Better Oral Health in Residential Care Australia (BOHRC) (38)

Manage Changed Behaviour (First Stage – Early Dementia)	
Changed Behaviour	**What to Do**
The person has delusions. The person may think: • you are not who you say you are • you are trying to hurt or poison him or her • he or she has cleaned their teeth already	Mime what you want the person to do. Allow the person to inspect the items. Take the person to another room; for example, move from the bedroom to the bathroom.

Manage Changed Behaviour (Second Stage – Dementia)	
Changed Behaviour	**What to Do**
The person grabs out at you or grabs your wrist.	Pull back and give the person space. Ask if the person is OK. Offer the person something to hold and restart oral care. If grabbing continues, stop the oral care activity and try again later. In the meantime, offer the person an activity he or she enjoys.
The person hits out or tries to bite.	Think about what may have caused the person's behaviour. Was the person startled? Did something hurt? Was the person trying to help but the message was mixed? Was the person saying 'stop'? Did the person feel insecure or unsafe?
The person walks away.	Allow the person to perch rather than sit. Perching is resting the bottom on a bench or table.
Manage Changed Behaviour (Third Stage – Advanced Dementia)	
Changed Behaviour	**What to Do**
The person does not open his or her mouth.	Place toothpaste on the top lip to prompt the person to lick his or her lips.
The person keeps turning his or her face away.	Reposition yourself. Sit the person upright.
The person bites the toothbrush.	Stop moving the toothbrush. Ask the person to release it. Distract the person with gentle strokes to the head or shoulder, using soothing words.
The person holds onto the toothbrush and does not let go.	Stroke the person's forearm in long, gentle rhythmic movements as a distraction and to help relax the person.
The person spits.	Ensure you are standing to the side or diagonal front. Place a face washer or paper towel on the person's chest so you can raise it to catch the spit.

5.2.4 HSE National Guidelines on Accessible Health and Social Care Services

The HSE National Oral Care Guideline (Supporting Smiles) aims to make daily oral care more accessible to all adults (18 years and over) who reside in or attend healthcare settings as listed **where their personal care is supported or provided**. It was developed with attention to 'consideration, compassion and open communication' in identifying a person's needs in the delivery of safe, effective care while preventing unnecessary risks to the person and the staff member. This approach aligns to the HSE National Guidelines on Accessible Health and Social Care Services which can be accessed here.

5.3 Delivery of oral care

No	Key recommendation	Who	When	With What (Tools and resources)
4	Deliver oral care according to completed oral care plan and guidance sheets (5.3.1) at least twice daily a) Specific medical conditions may require additional oral care b) Document the delivery of daily oral care c) Document persistent 'resistance/' refusal to accept oral care, challenges encountered and steps and strategies used when care is resisted or refused	Health and social care teams	Minimum twice daily as outlined in oral care plan	Oral care plan Guidance Sheets Key oral care products, tools and adjuncts appropriate to the person's care needs and preferences Oral care resistance strategies (5.2.2)

This section covers the practical aspects involved in caring for people with natural teeth, dentures (full/partial) and, equally importantly, those who have no teeth or dentures. Always prompt, encourage and support as much independence as possible. If a person is able to carry out their own daily oral care, ensure they have the correct oral care products appropriate to their individual needs, as specified in their oral care plan, e.g. toothbrush, toothpaste and denture products if necessary. Instructional videos are accessible through the Brush My Teeth website to guide a person and their carer through toothbrushing (85).

Mental health conditions can cause persons to lose motivation for personal hygiene including mouth care. This in combination with other risk factors such as medication-related dry mouth which may be further exacerbated by smoking, alcohol consumption and frequent consumption of sugary snacks and drinks can cause a rapid development of tooth and root decay and gum disease and can result in dental infection and pain and result in extensive tooth loss (9,10). People living with severe mental illness may require motivation from hospital and healthcare staff to encourage them to look after their mouths. This may include daily reminders and encouraging persons to carry out their oral care at different times of the day when they are more receptive.

Similarly, many people with milder intellectual, physical or cognitive disabilities will be able to carry out their own oral care with prompting and encouragement but others, particularly those with more severe disabilities will need either partial physical support or will be fully dependent on others for all their mouth care (61).

People living with acute, progressive, or chronic health conditions may also experience significant barriers to maintaining oral hygiene. These individuals may be confused, delirious, or have reduced levels of consciousness, particularly in hospital or palliative care settings (12,26). Some may be NBM (nil by mouth), dependent on oxygen therapy, or taking medications such as anticholinergics, opioids, or antidepressants that reduce salivary flow and increase the risk of oral discomfort, infection, and mucosal breakdown (26). Conditions such as Parkinson's disease, stroke, dementia, and neuromuscular disorders often impair self-care ability due to physical or cognitive limitations (11,44). Persons with these conditions benefit from referral to the dentist to review their treatment plan and oral care with an important focus on enhanced prevention which may include prescription of high fluoride tooth paste and other adjuncts (11). Intubated patients and those undergoing radiotherapy to the head and neck are at heightened risk for xerostomia, mucositis, opportunistic infections, and oral pain (32,33,37). Regardless of a person's level of awareness or cooperation, daily oral care should remain a consistent and compassionate part of their care, adapted to their specific needs and carried out with sensitivity.

If providing daily oral care for a person, always explain what you are going to do first; brushing someone else's teeth is an intimate and intrusive procedure and requires a gentle introduction to reduce anxiety. Orientating the person to the task by showing them the toothbrush and toothpaste while providing a verbal explanation about what you are going to do can be helpful.

It is the responsibility of every health and social care team member to undertake a point of care risk assessment prior to performing a care task, as this will inform the level of IPC precautions needed. Refer to 5.1 for further information.

5.3.1 Guidance Sheets

The guidance sheets for each assessment region describe the oral conditions, including the state of cleanliness, which may present in that area of the mouth, the rationale for providing oral care, including cleaning of this area, the products and adjuncts advised as detailed in the oral care plan and specific instruction for providing any necessary oral care for that area of the mouth.

Refer to the Guidance Sheets (1-6) for detailed instructions on delivery of care for each assessment region. Deliver daily oral care according to care plan at least twice daily (specific conditions may require additional care 5.3.2).

- No. 1 Guidance sheet: Lips
- No 2: Guidance sheet: Inside of Mouth – Tongue, Cheeks, Palate, Floor of Mouth, Inside of lips
- No.3 Guidance sheet: Saliva
- No.4 Guidance sheet: Teeth
- No.5 Guidance sheet: Gums,
- No.6 Guidance sheet: Dentures

No.1 Guidance Sheet: Lips

Description	Rationale	Products/Adjuncts	Guidance
Dry or cracked lips	Ensure lips stay moisturised and healthy	• Water-based lip moisturiser	• Moisturise as required
Corners of the mouth cracked, red or crusting (angular cheilitis) – Most commonly due to fungal infection, but may also be due to bacterial infection	Ensure infection is treated.	• Antifungal or antibacterial cream/ointment	• Seek medical team input • Apply antifungal or antibacterial cream/ointment to corners of mouth as prescribed
Cold sore – Due to herpes simplex virus	Ensure virus is treated.	• Antiviral cream	• Seek medical team input • Apply antiviral cream to cold sore as prescribed
Ulceration, bleeding, swelling, lump or trauma	Regular checking and documenting of the lips ensures changes are detected and referred for investigation or treatment when necessary (19,26).		• Monitor and document any ulcer or small cut or bite/minor trauma to the lip present for less than 21 days • Refer bleeding/ulcerated lips, any swelling, lump, trauma or ulcer present for longer than 21 days (even if painless) to medical team/Dentist • Document advice, follow prescribed treatment and review Oral Care Plan as directed

No.2 Guidance Sheet:: Inside of Mouth – Tongue, Cheeks, Palate, Floor of Mouth, Inside of lips

Description	Rationale	Products/ Adjuncts	Guidance
Checking for changes	Regular checking and documenting of the mouth lining and tongue (including sides and under surface) ensures that changes are detected and referred for investigation or treatment when necessary (19).		• Monitor and document any red, white or speckled patches or ulcers detected anywhere inside of the mouth. Try to check the floor of the mouth and sides/under surface of tongue – these areas may be harder to examine • Refer any persistent red or white patches or widespread redness/ulceration, swelling, lump or ulcer present >21 days (even if painless) to Medical Team/Dentist • Consider softer foods to protect mouth lining while severe ulcer (s) healing • Refer a smooth, glossy, sore tongue to Medical Team • Document advice, follow prescribed treatment, review Oral Care Plan as directed
Tongue brushing	If the tongue is heavily coated, brushing removes bacteria largely responsible for producing bad breath, reduces the build-up of yeast, decreasing the risk of oral thrush and improves the sense of taste (26).	• Soft toothbrush or Tongue scraper	• Ask the person to stick out their tongue • Use a soft toothbrush to clean the tongue carefully from back to front • If heavily coated, e.g. thrush present, a tongue scraper may be more effective • Avoid going too far back as it will cause the person to gag
Food/denture adhesive lodging	**If food or other oral debris, e.g. denture adhesive are lodging in the mouth,** it should be cleaned for comfort and to reduce risk of oral or systemic infection (e.g. thrush or aspiration pneumonia) (17,18,26,59).	• Mouth cleanser • Damp, non-fraying gauze • Mouth prop • Soft toothbrush	• Clean inside of mouth with a mouth cleanser which is gently rotated to collect the debris, alternatively use a damp non-fraying gauze (which has been thoroughly wetted in clean running water) wrapped around a gloved finger • If placing a finger in the person's mouth, ensure that it is safe to do so • Using clinical judgement, a mouth prop may be indicated to support the mouth while cleaning • Gauze should be changed as required and several pieces of gauze may be needed to clean the inside of the mouth • It may be necessary to use a soft toothbrush to remove tenacious material, e.g. denture adhesive from the palate
Candida infection (thrush)	Risk of candida infection may be increased for persons who are taking antibiotics and/ or inhaled corticosteroids, are immuno-compromised, have a dry mouth, poor oral hygiene, smoke or wear dentures (26,59).	• Prescribed antifungal medication	• Seek medical input if candida (thrush) is suspected. If candida infection is diagnosed, follow prescribed treatment in addition to carrying out standard twice-daily oral care • Replace toothbrush when antifungal treatment is completed • Refer to No.6 Guidance Sheet: Dentures in relation to candida infection for people who wear dentures

No.3 Guidance Sheet: Saliva

Description	Rationale	Products/Adjuncts	Guidance
Dry Mouth	Saliva is the key to maintaining a healthy mouth. Dry Mouth can cause pain, difficulty with eating and speaking and denture wear, increased tooth and root decay, gum disease and infections, e.g. candida (thrush) (26,45,57,69) It is a side effect of many drugs (see Appendix 3 for list of drugs). Other causes are nil by mouth status, dehydration, mental health conditions, some medical conditions, e.g. diabetes, Sjogren's syndrome and side-effects of chemotherapy or radiotherapy to the head and neck. Smoking and alcohol consumption can also exacerbate dry mouth (26,45,75) Underlying causes of dry mouth should be identified before proceeding with management interventions (75). Oral care strategies should be based initially on the degree of dryness and the need for supplemental protective factors (e.g. prescribed high fluoride toothpaste (5,000 ppm), if cavities noted) (19,37). If Dentist/Medical team referral/ treatment required, document advice and follow prescribed treatment and review plan as directed.	• Drinks and foods	• Encourage frequent sipping and rinsing with water, if appropriate, to keep the mouth moist • Discourage juices, sugary/fizzy drinks • Limit caffeine and alcohol consumption and avoid smoking if possible • Avoid spicy/salty/very dry or hard-to-chew foods if they cause discomfort • Taking frequent sips of water at mealtimes or moistening food with sauce/gravy, etc. may make eating more comfortable (26,38,75)
		• Water based lip moisturiser	• Keep the lips moist by applying water based moisturiser
		• Non-foaming SLS free fluoride toothpaste or • High fluoride toothpaste	• A mild flavoured/flavourless non-foaming sodium lauryl sulphate (SLS) free toothpaste may be more comfortable to use than regular toothpaste • If using mouthwash, use an alcohol-free formulation for greater comfort • High fluoride toothpaste may be prescribed for persons at high risk of tooth decay
		• Dry mouth gel/ saliva substitute • Soft toothbrush • Mouth cleanser • Damp non-fraying gauze • Suction (if available)	• Saliva substitutes may be applied if mouth uncomfortably dry, but discontinue if ineffective. • If a dry mouth gel/saliva substitute is required, apply to all areas of the mouth including the cheeks, tongue and palate and to fitting surface of dentures. • These can be applied by the person with their own finger, or by support staff with a mouth cleanser/ gloved finger or can be applied with a soft toothbrush • If placing a finger in the person's mouth, ensure that it is safe to do so • Using clinical judgement a mouth prop may be indicated to support mouth • Apply gel sparingly and massage into the mouth as you would rub a cream into dry skin as otherwise, they can form a further sticky layer making the mouth more uncomfortable (26) • Thick or dried/crusted secretions must be removed for comfort using mouth cleanser/damp non-fraying gauze, a soft toothbrush or gentle suction (if available) and before dry mouth gel is applied. • If dried secretions are present, the gels can be gently massaged into the mouth and left for a few minutes to make removal easier, if necessary (26).
		• Dry mouth spray	• A spray formulation may be a more user-friendly alternative to gel • Independent persons may prefer to self-administer a dry mouth spray • These should be sprayed onto the cheeks and tongue
		• Saliva stimulants	• Stimulant drops or tablets may sometimes be prescribed to increase residual saliva production. Side effects may include sweating, nausea and blurred vision (26,75)

Description	Rationale	Products/Adjuncts	Guidance
Hyper-salivation/ drooling	Hypersalivation or drooling can result in pooling of saliva, which is often indicative of impaired clearance rather than excess production and can result in an increased risk of decay if coupled with stagnation of food. Most medical interventions for this condition induce a saliva deficit. Oral care strategies such as addressing posture, improving oromotor function, and recommending oral swabbing are preferred by the dental team (17).	• non-fraying gauze • Water based lip moisturiser • Skin Moisturiser/ barrier cream	• If Dentist/Medical team/SLT referral/treatment required, document advice and follow prescribed treatment and review plan as directed • Remove pooling saliva and food debris with non-fraying gauze or suction, if available, prior to providing daily oral care • A water based lip moisturiser (lips) and/or skin moisturiser/barrier cream (adjacent skin) may be applied if their integrity is affected due to drooling.

No.4 Guidance Sheet: Teeth

Description	Rationale	Products/Adjuncts	Guidance
Tooth brushing	Dental plaque is an almost colourless, sticky bacterial film, which adheres to the tooth surface and needs to be removed twice daily as standard (preferably last thing at night or before bedtime and one other time) to prevent build-up of harmful bacteria that cause tooth decay and gum disease (19,58). Respect the person's dignity, comfort and personal space and if cognitive ability is impaired, ensure your initial approach is not perceived as threatening (refer to Section 5.2.2 Care resistance) (38,61). It is essential to use the most appropriate oral hygiene equipment which best accommodates individual needs to ensure comfortable and effective plaque removal (for full details, refer to Section 5.3.2 Key oral care products) (61).	• A face mirror • Soft toothbrush appropriate to the person's needs; • Standard • Electric • 3-sided • Extremely soft (or baby) • Aspirating (suction) toothbrush • Small headed with long handle • Fluoride toothpaste appropriate to the person's needs • Standard 1450 ppm fluoride • Non-foaming sodium lauryl sulphate (SLS) free, mild flavoured or non-flavoured 1450ppm fluoride • High Fluoride – 5,000ppm fluoride	• First explain to the person what you are going to do • The person should be sitting up if possible and their head should be comfortably supported • Consider the time and location that works best for the person for oral care • Ideally, stand to the side and slightly behind the person for brushing. It may be necessary to brush from in front or provide a mirror for them to see what is happening if they feel threatened by somebody standing behind them. (Refer to Section 5.2.2) • **Use the appropriate toothbrush and toothpaste –** (pea sized amount recommended) **as detailed in the oral care plan (OPC)** • If denture is present remove it (as per No.6 Guidance Sheet: Dentures) before brushing teeth • Gently draw back the cheek and lips with the forefinger on one side of the mouth to first gain access to the teeth. Follow a pattern, ideally working from the back teeth on one side to the back teeth on the other side, brushing 2-3 teeth at a time. Tooth brushing may take at least 2 minutes to complete • Place the toothbrush at a 45 degree angle to the gum line and gently brush the outer surfaces of the teeth and gums in a circular motion, paying particular attention to the gum line, repeat for the inner surfaces and gums and complete brushing sequence by brushing chewing surfaces thoroughly in a horizontal motion • If using a 3-sided toothbrush, press the brush onto the chewing surfaces so that the 3 sets of bristles are in contact with the outer, inner and biting surfaces and brush in a horizontal motion to clean all surfaces simultaneously • If some teeth are missing, ensure all surfaces of single teeth are cleaned and do not avoid brushing loose or worn teeth as plaque accumulation increases the risk of these teeth decaying or getting looser due to gum disease. Seek dental review if concerns with loose teeth • Ensure the person spits out toothpaste and preferably does not rinse after brushing so the fluoride soaks into the teeth. Person advised to 'spit, don't rinse' (19) • If no aspiration risk exists, fluoride mouthwash (0.05% Sodium Fluoride) may be prescribed and used daily at a different time of day to morning and evening tooth brushing (19,89,90)

Description	Rationale	Products/Adjuncts	Guidance
Interdental cleaning	Plaque and food debris also lodges between the teeth, particularly in larger spaces, increasing the risk of tooth decay and gum disease and needs to be removed, where feasible (19,91)	• Dental Floss/floss holders • Interdental brush (single tufted/bottle – brush shaped, long/ short handles.	• Dental floss is suitable for cleaning narrow spaces between the teeth and may be used if tolerated well. Floss holders may be useful to enable flossing • If large spaces are present between the teeth, an interdental brush **of appropriate shape and size as detailed in the Oral Care Plan** should be used to clean these spaces if tolerated well by the person • Dental implants require the same level of daily oral care as natural teeth. Brush as for natural teeth but also clean between/around implants with interdental brushes (19)
Cavities observed/ other tooth related concerns	Teeth with cavities must be brushed thoroughly with fluoride toothpaste to slow down progress of decay (57,72). Exposure to fluoride at an additional time of the day with a mouthwash has been shown to reduce decay (89).	• Fluoride mouthwash 0.05% – (daily use) **if no aspiration risk*	• Seek routine dental review if painless cavities or other significant dental concerns noted • Refer any severe or persistent pain to the medical team/Dentist for urgent review • Continue daily oral care, including mouthwash if appropriate, as detailed in the Oral Care Plan until treatment/input received – Mouthwash is not suitable for persons with dysphagia or those who may not reliably spit out. • Follow any prescribed treatment and review plan as directed
Tooth brushing for persons with dysphagia/nil by mouth	Special precautions are required when brushing for persons with Dysphagia diagnosis to reduce the risk of aspirating toothpaste, oral debris or fluids (17). (Refer to Section 5.3.2.4 for more information).	• Aspirating (suction) toothbrush (if available) or other soft toothbrush • Non-foaming SLS free 1450ppm fluoride toothpaste • Suction, mouth cleanser or non-fraying gauze (if suction unavailable)	• Position person to avoid fluid inhalation. Sit the person up if possible or place in recovery position – where possible seek appropriate strategies and guidance from an SLT/OT/Physio • Use suction (if available) mouth cleanser or gauze to remove any food or fluid debris • Brush teeth using a thin smear of a non-foaming sodium lauryl sulphate (SLS) free fluoride toothpaste on a dry soft toothbrush or suction toothbrush (if available). • Remove any excess with suction (if available) after tooth brushing. If suction is unavailable, excess fluid/food debris can be swabbed out using gauze

Description	Rationale	Products/Adjuncts	Guidance
Difficulty tolerating daily oral care/Care resistance	Refer to Section 5.2.2 Care resistance for comprehensive guidance on overcoming care resistance by adapting practice to accommodate individual difficulties with accepting daily oral care.	• Three sided toothbrush • Mouth prop • Non-foaming SLS free mild flavoured or flavourless 1450ppm toothpaste • High Fluoride toothpaste (5,000ppm) or Chlorhexidine 0.2% digluconate gel or spray • Mouth cleanser	• Use strategies such as bridging, chaining, distraction to help access the mouth (38-40) • If tolerance of other toothbrushes is poor due to cognitive or sensory difficulties, consider a 3-sided toothbrush for more rapid brushing which the person may find less invasive and is less likely to provoke gagging. Brushing in brief spurts and encouraging breathing through the nose where possible may also counteract a gagging tendency (39,61,85) • If placing a finger in the person's mouth, ensure that it is safe to do so • Using clinical judgement a mouth prop may be indicated to support mouth • Non foaming mild/flavourless toothpaste may be better tolerated by persons with sensory difficulties (flavourless best for those who are particularly taste sensitive) (19) • If tolerance is very limited, it may be necessary to brush different areas of the mouth on different occasions keeping note of the area brushed each time (39) • High fluoride tooth paste, or chlorhexidine gel (if bleeding gums) may be smeared along the teeth/gum line with a mouth cleanser/finger or tooth brush as a short-term alternative if brushing is not possible or chlorhexidine spray may be used (38)
Refusal of oral care	• When daily oral care is not carried out/not possible, this must be recorded in the daily Oral Care Record, and any difficulties encountered communicated between staff during handovers. While a person has the right to refuse daily oral care all determinants of successful oral care such as cognition, behaviour, anxiety, should be considered and a person specific plan may need to be devised to maximise potential for cooperation. • Persistent refusal of tooth brushing care should be escalated to dental/Medical team.		

No.5 Guidance Sheet: Gums

Description	Rationale	Products/Adjuncts	Guidance
Cleaning gums	Dental plaque harbours harmful bacteria that cause both tooth decay and gum disease. It forms continuously and must be removed by brushing the teeth and gums twice daily as standard. Plaque and tartar (plaque which has calcified) cause gum inflammation and bleeding which may eventually lead to breakdown of the gums and eventual tooth loss. It is essential to keep the gum line free of plaque (19,57,58).	• Soft toothbrush appropriate to the person's needs • Fluoride toothpaste appropriate to the person's needs	• Use the appropriate toothbrush and toothpaste- (pea size amount recommended) as detailed in the oral care plan (OCP) • Gums must be cleaned twice a day using a fluoride toothpaste and a soft toothbrush • If gums bleed, continue to brush gently twice a day paying particular attention to the gum line. **Do not avoid brushing bleeding gums and do not stop brushing if gums start to bleed** • Do not avoid brushing loose teeth as plaque accumulation will lead to further breakdown of gums and supporting bone and accelerated tooth loss • Using clinical judgement a mouth prop may be indicated to support mouth
Interdental cleaning	This may also require the use of interdental aids (floss and interdental brushes) where appropriate, as build-up of plaque and food debris between the teeth results in more rapid breakdown of the gums and supporting bone (19,86).	• Dental Floss/floss holders • Interdental brush (single tufted/bottle-brush shaped, long/short handled)	• If the person is familiar with using dental floss encourage and support them to use it • Disposable floss-holders may help flossing • Interdental brushes may be indicated for people with more advanced gum disease where larger gaps have opened up between the teeth • Use an interdental brush of appropriate to fit the spaces between the teeth, as specified in oral care plan
Persistent bleeding, ulcerated, painful or swollen gums	Note that bleeding gums are painless unless ulceration or infection is present. Chlorhexidine has been found to reduce gum bleeding, and dental plaque (92). Persons with complex medical histories, including bleeding disorders, require daily oral care.	• Non-foaming SLS free toothpaste containing 0.12% Chlorhexidine digluconate and 1000ppm fluoride • Chlorhexidine digluconate 0.2% (short term)/0.12%(longer term) mouthwash • Chlorhexidine 0.2% digluconate gel or spray • Mouth cleanser	• Refer to Dentist/Medical team if bleeding gums persist, if the gums are ulcerated or painful or a swelling is present or if there are concerns regarding appropriate care for a person with complex medical history • Document advice, follow prescribed treatment and review Oral Care Plan as directed • A chlorhexidine based fluoride toothpaste may be prescribed for twice daily brushing until bleeding resolves. Long-term use may be advised for persons with more advanced gum disease • **If no aspiration risk exists**, Chlorhexidine digluconate (0.2%) mouthwash may be prescribed and used as directed for 7-10 days (short term). Lower concentration chlorhexidine mouthwash (0.12%) may be prescribed for longer term use. Alcohol-free formulations are preferred. • If brushing is not possible, a chlorhexidine digluconate 0.2% gel may be smeared on the gums with a mouth cleanser/finger or toothbrush as a short-term alternative • If this is also difficult to achieve, Chlorhexidine digluconate spray 0.2% can be sprayed into the mouth. **Please refer to additional tips for 'care resistance' in section 5.2.2**

No.6 Guidance Sheet: Dentures

Description	Rationale	Products/Adjuncts	Guidance
Removal of dentures for cleaning and resting the mouth lining	Removing dentures allows air to the mouth lining under the denture and reduces the risk of infections such as candida (thrush). Dentures should be left out overnight (26,34,38,40,41).		• If necessary, remind the person to remove their dentures for cleaning and encourage to leave denture out overnight • Ask the person to remove their denture (s) if able to do so. If unable to do so, assistance may be required
Assisting with denture removal and/or insertion	Assistance may be required if the person is unable to remove or insert their own denture (s).	• Denture adhesive, if required/ appropriate	• Ask the person to take a sip of water to moisten the mouth and make removal of dentures easier • Full denture (s): Use the thumb and index finger to grasp the denture. Take out lower denture first by holding the front teeth and lifting out. To remove upper denture, break the seal by holding front teeth and rocking the denture up and down until the back is dislodged. Remove the denture at an angle so that the mouth is not stretched uncomfortably • Partial denture (s): Some partial dentures can be difficult to remove, especially if wire clasps are present. If assistance is required to remove, carefully place your fingers under the clasps that are hooked on to the teeth and gently push downwards or upwards for lower. Take hold of the plastic part and pull carefully out of the person's mouth, taking care not to bend the wires • Insert dentures at an angle so that the mouth is not stretched uncomfortably. For partial dentures, insert at an angle and rotate and click into position. • Denture adhesive may be useful for dentures which appear loose (may be due to reduced muscle tone) but still fitting satisfactorily. The advice of the dentist may be sought. Use as per manufacturer's instructions
Cleaning of dentures	Dentures should be cleaned twice daily for comfort, hygiene and to reduce risk of oral or systemic infection (e.g. thrush, aspiration pneumonia).	• Denture brush • Mild liquid soap • Denture cleanser tablets (if person's preference) • Disinfectant – Sodium hypochlorite 2% or • Chlorhexidine 0.2%	• Clean dentures over a sink filled with water or place a wash cloth in the base of the sink to protect the denture from breakage if dropped • Use a denture brush and mild soap to clean all surfaces of the denture twice daily to remove food debris and dental plaque (and denture adhesive, if present) • Alternatively, after cleaning the denture, denture cleanser tablets may also be used as directed by manufacturer, if this is the person's preference • After cleaning, rinse denture well with water before putting back in the person's mouth • Plastic dentures should be disinfected once a week in a solution of sodium hypochlorite 2% (commonly used for baby feeding bottles), diluted according to manufacturer's instructions (93) • For dentures with metal components, undiluted Chlorhexidine 0.2%, with or without alcohol, is a suitable alternative (93) • Immerse denture in enough disinfectant to cover it fully and soak for no more than 10 minutes. Rinse well before placing in the mouth

Description	Rationale	Products/Adjuncts	Guidance
Candida infection (thrush)	If candida (thrush) is diagnosed additional denture care is necessary in conjunction with any prescribed antifungal treatment to ensure denture does not act as a reservoir for reinfection (93,94).	• Prescribed antifungal medication • Cleaning/ disinfection products as above	• Document advice and follow prescribed antifungal treatment and review plan as directed. If antifungal medication is prescribed it may also be applied to the fitting surface of the clean denture and corners of mouth (26) • Dentures should be left out for as long as possible • In addition to standard cleaning, disinfect denture by soaking in appropriate disinfectant (see above) for no more than 10 minutes **twice per day** until signs of candida are gone (93) • The clean denture should be stored dry overnight in a labelled lidded container
Storage of dentures	Dentures left out overnight must be stored hygienically and safely (93).	• Labelled, lidded denture box • Denture cleanser tablets (if person's preference)	• The denture should be removed overnight and stored dry in a clean, labelled, lidded container to ensure dentures are not lost • Storing dentures in water alone may promote growth of candida (cause of thrush) on the denture (93) • Make sure the container is cleaned daily before overnight storage as this helps reduce risk of candida reinfection (93)
Problems with dentures	• If a person is not wearing their denture it may be because the denture is loose (notwithstanding use of denture adhesive), ill-fitting or the person can no longer manage/tolerate wearing it. A dentist can advise on remaking if possible. • It is extremely important to store and maintain dentures that are being worn as adjusting to new dentures can also be very difficult for some older people, particularly those with dementia. There may come a time when it is in the best interests of the person to stop using their dentures. • If dentures are lost in a care setting, a NIRF* (national incident report form) must be completed.		

5.3.2 Key Oral Care Products

Identify the key oral care products, tools and adjuncts required for the person, appropriate to their individual needs.

Toothbrushing is the single most important plaque control method. Tooth and gum brushing should be carried out a minimum of twice daily (19,32). There is a consensus in the literature (19,58) that soft bristled manual toothbrushes are used when a carer is providing daily oral care to a person. Electric toothbrushes are generally discussed in the context of individuals brushing their own teeth (19,44). These toothbrushes may be particularly helpful where people have physical limitations, such as arthritis or following a stroke. An electric oscillating (circular movement) toothbrush may be useful for carers providing care to care resistant persons provided this can be carried out without the risk of trauma to the of the mouth and gums. Delivering Better Oral Health (19) advises while there is evidence that some powered toothbrushes (with a rotation, oscillation action) can be more effective for plaque control than manual tooth brushes, probably more important is that the brush, manual or powered, is used as effectively as possible to brush the teeth and gums twice daily. Thorough cleaning may take at least two minutes (19,58).

It is important to be aware that some people may find tooth brushing difficult to tolerate due to a dry, sore mouth (42,64), restricted mouth opening, strong gag reflex (39), swallowing difficulties or sensory difficulties (58,61) (e.g. with the foaming or taste of toothpaste or with the touch of toothbrush bristles against the gums or other parts of the mouth), and that there are adjuncts and strategies that may improve this and make tooth brushing more tolerable.

Toothpaste should be used as part of daily oral care for persons with natural teeth. Toothpastes are designed to carry key ingredients to prevent oral diseases. Fluoride in toothpaste is the essential ingredient for prevention of tooth decay. A standard strength toothpaste with fluoride concentration up to 1450 parts per million (ppm) can be used. However, there are a variety of different toothpastes to suit different needs of the person depending on their personal preference and oral health risk and other issues such as dry mouth, swallowing difficulties or sensory difficulties. It is important to select the most appropriate products to make daily oral care easier to tolerate (26,61).

5.3.2.1 Toothbrushes and toothbrush care

Table 6: Toothbrushes and toothbrush care

Toothbrush type	Indications for use
Small headed toothbrush with soft bristles	Standard brush for providing oral care (19,26,58)
Electric toothbrush	May be useful for people who have difficulty holding and manoeuvring a regular toothbrush such as those with poor motor control or physical disability (40,58). They are recommended for persons with stroke (44).
Toothbrush grip	A toothbrush grip on any type of toothbrush may also enable the person to perform their own oral hygiene. Seek advice from Occupational Therapist regarding most suitable type of grip (19,40,58)

Toothbrush type	Indications for use
Three-sided toothbrush	May be useful for people with difficulty maintaining mouth opening or with limited co-operation, due to cognitive or sensory difficulties as brushing of all tooth surfaces and gums may be carried out more quickly and be perceived as less invasive by the person (19,39,58,85). These brushes come in various sizes and include models designed for better cleaning of the gums for persons with gum problems.
A very gentle, extremely soft toothbrush (or baby toothbrush)	Recommended for persons with sore or uncomfortable mouth (26,40,42,64)
Aspirating/ Suction toothbrush	A single use disposable tooth brush may be attached to the suction unit, if available May be useful for persons who have dysphagia (17,26).
Small headed toothbrush with a long handle	May be used on ventilated patients as the long handle facilitates reaching the back of the mouth (17)
Interdental brush (single tufted or bottle-brush shaped, long or short handled)	May be useful for persons with larger spaces between the teeth where food debris tends to lodge, appropriate size to fit space selected, – provided tolerance of daily oral care is sufficient to carry out interdental cleaning (19,91)

Toothbrush care

- Toothbrushes should not be left to soak in solution. Thoroughly rinse the toothbrush under running water and dry after every use.
- Cleaned toothbrushes should be stored in a covered container for air circulation rather than a plastic bag and stored separate to other toiletries or brushes. Store toothbrush to prevent any environmental contamination, e.g. avoid splashes if left on sinks.
- Denture brushes and denture containers should also be thoroughly cleaned and dried after use.
- If a toothbrush grip is used, remove the grip and wash, and dry both items after each use.

Replace toothbrushes:

- When bristles become frayed
- Every three months
- Following an illness, particularly oral thrush
- If the patient becomes immunosuppressed; is receiving chemotherapy, or if the patient/resident has experienced any type of oral infection (32).

5.3.2.2 Toothpaste

Table 7: Toothpastes

Toothpaste	Indication for use
Standard 1450 ppm fluoride toothpaste	Evidence supports the use of fluoride toothpaste to prevent dental decay and the stronger the fluoride concentration, the more decay is prevented (86). Standard adult toothpaste contains 1450 ppm fluoride (check side of box to confirm correct content). It is important to brush at least twice a day with fluoride toothpaste, last thing at night or before bedtime and one other time. Spitting out after brushing rather than rinsing with water, to avoid diluting the fluoride concentration is also strongly recommended (19,58).
High Fluoride 5,000ppm Toothpaste (prescription only)	Indications for use of 5,000 ppm Fluoride toothpaste includes adults with existing decay (including root decay) or risk factors such as dry mouth, high sugar/high calorie diet and those who have received head and neck radiotherapy and chemotherapy (19). Dry mouth can occur as a consequence of disease, such a Sjogren disease, medication or following radiation induced damage of the salivary glands often seen in head and neck cancer patients receiving radiotherapy (45). Persons who are nil by mouth and persons who are undergoing some cancer treatments and persons who are approaching the end of life, may be particularly at risk of severe dry mouth as a result of changes in the quality or quantity of their saliva. Without the buffering capacity of saliva, these patients experience higher levels of dental decay (45). Numerous studies have demonstrated the benefits of high concentration fluorides to these patients in preventing dental decay (46,52,53,95,96) and British guidelines (19) clearly recommend the use of 5000ppm toothpaste (46,52,53). May also be considered for persons with a high rate of decay where difficulty tolerating thorough tooth brushing is a significant additional risk factor. High fluoride toothpaste must be stored securely.
Low-foaming sodium lauryl sulphate (SLS) free, mild flavoured, 1450ppm fluoride toothpaste	It is recommended as good practice for persons who cannot tolerate foaming toothpastes due to swallowing or sensory difficulties or who find standard mint-flavoured toothpastes too strong (19). Also suitable for persons who have a dry, uncomfortable or sore mouth, where it may be necessary to substitute the high fluoride toothpaste temporarily for a mild SLS free toothpaste for better comfort.
Low-foaming SLS free, non-flavoured 1450ppm fluoride toothpaste	Also suitable for persons who have a dry, uncomfortable or sore mouth, swallowing or sensory difficulties. Particularly suitable for those who are very taste-sensitive (19).
Low-foaming SLS free 0.12% *Chlorhexidine digluconate and 1000ppm fluoride toothpaste	There is high-quality evidence of a large reduction in dental plaque with chlorhexidine use and has been found to reduce gum bleeding, and dental plaque (92). A chlorhexidine based fluoride toothpaste may be prescribed for twice daily brushing until bleeding resolves. Where inflammation/bleeding persists or where a person is confirmed to have established gum disease, use of toothpaste containing chlorhexidine digluconate may be indicated on the advice of a dental professional, either for short-term use over 7-10 days or long-term.

Other key oral care products

Additional products are also needed for specific purposes such as; to disinfect dentures, mouthwashes and sprays, saliva substitutes and pain-relieving mouthwashes and sprays. The introduction of any product, including salivary replacement products, aimed at symptom management or relief, should be prescribed by a dentist/ doctor. Symptom response to the product should be monitored. Monitoring includes increased frequency of physical examination and should also include an account of the person's experience. Products should be appropriately discontinued if not effective

Table 8: Other key oral care products

Product ingredient	Indication for use
Mouthwashes are not suitable for persons with dysphagia or those who may not reliably spit out.	
Fluoride mouthwash usually 0.05% Sodium Fluoride (for daily use)	A fluoride mouthwash used in addition to other fluoride toothpaste is an effective method for reducing tooth decay particularly in young adults and is supported by evidence from the Health Research Board (89). Mouthwash should be used at a different time of the day to toothbrushing in order to maximise the decay preventing benefits of fluoride (90).
Chlorhexidine* digluconate alcohol free mouthwash 0.2% *Chlorhexidine should not be given at the same time as toothbrushing*	There is high certainty evidence of a large reduction in dental plaque with chlorhexidine mouthrinse used as an adjunct to mechanical oral hygiene procedures for 4 to 6 weeks and 6 months (92). Chlorhexidine digluconate 0.2% mouthwash may be recommended by a dental professional for **mouth rinsing over 7-10 days for persons with painful or bleeding gums** (92). May be used undiluted for weekly **disinfection of dentures with metal parts** (or twice daily where thrush is diagnosed until infection has cleared, continue until signs of candida are gone). Soak for 10 minutes, rinse thoroughly and allow to air dry (94).
Chlorhexidine* digluconate 0.12% alcohol free mouthwash *Chlorhexidine should not be given at the same time as toothbrushing*	The 0.12% Chlorhexidine digluconate formulation may be **indicated for long term use** for people with gum problems on the advice of a dental professional. Chlorhexidine digluconate can impair taste and stain teeth if used long-term. This is less likely with the 0.12% formulation and all formulations are available as 'Alcohol Free'. There is high-quality evidence of a large reduction in dental plaque with chlorhexidine mouth rinse used as an adjunct to mechanical oral hygiene procedures for 4 to 6 weeks (92). The chlorhexidine mouth rinse should be used at least 30 minutes after toothbrushing with fluoride toothpaste for best effect of both (97)
Chlorhexidine* digluconate 0.2% gel or spray	Dental Chlorhexidine digluconate gel may be recommended by the dental team if the person has gum problems and a low risk of dental decay, and can be smeared on the teeth and gums as a **short-term alternative if brushing is not possible**. People with stroke may be prescribed Chlorhexidine gel short term as an adjunct to tooth brushing with a low foaming fluoride toothpaste, requiring regular review (44). If this is also difficult to achieve, Chlorhexidine digluconate spray 0.2% can be sprayed into the mouth.
Water-based mouth gel or spray (saliva substitute)	May be used **to help to relieve dry mouth**. These are also available in spray formulation – which may contain xylitol or sorbitol (alcohol and SLS free). May also be used to **soften dried secretions** prior to removal.
Benzydamine Hydrochloride rinse or spray 0.15%	May be used to **relieve generalised soreness,** e.g. mucositis, or if a localised area of soreness present, e.g. ulcer, it can be sprayed directly onto the area (47). Use as directed by the dental team.

***HPRA Safety Notice (SN201714)**

The Medicines and Healthcare Products Regulatory Agency (HPRA) has issued an alert for products or medical devices containing chlorhexidine, following reports of serious but rare anaphylactic reactions due to chlorhexidine allergy. **Before using any product containing chlorhexidine, ask and document if the person has an allergy.**

5.3.2.3 Key oral care tools and adjuncts

Table 9: Key oral care tools and adjuncts

Tool/Adjunct	Indication for use
Pen torch	Used to assist with looking inside the mouth.
Tongue depressor	Used to hold the tongue or cheeks out of the way.
Tongue scraper	Used to remove debris and or coating from the surface of the tongue.
Mouth prop	Single use disposable mouth prop used to help gain access to the mouth for daily oral hygiene. (A second toothbrush handle may also be used as a mouth prop) (38).
Finger guard	Used to protect carer's finger and keep person's mouth open when providing daily oral care.
Mouth cleanser	A single use applicator stick with a cone-shaped head and smooth rounded filaments. By applying a rotating action the Mouth Cleanser can collect debris as it cleans and can also be used to apply oral gels gently massaging the gels into the mouth lining.
Damp non fraying gauze squares	Used to remove debris from the mouth, e.g. food, sticky and crusted secretions on the palate and stringy saliva.
Dental floss	May be useful for persons with good dexterity to clean smaller spaces between their own teeth but may be very difficult for support staff to use on behalf of the person (63,91). There are many brands of disposable floss-holders available which may make flossing for the person more feasible.
Interdental brushes	If large spaces are present between the teeth, an interdental brush **of appropriate shape and size** should be used to clean these spaces. Dental implants require the same level of daily oral care as natural teeth. Brush as for natural teeth but also clean between/around implants with interdental brushes (19,91).
Denture cleanser tablets	If a person wishes to use denture cleanser tablets, soak denture for 3-10 minutes only after cleaning with a brush and mild soap. Care must be taken if using denture tablets or cleansing solutions, to avoid the person accidently ingesting the tablets or drinking the solution, especially where the person has visual impairments or cognitive issues.
Sodium hypochlorite 2% Sodium hypochlorite is not suitable for dentures with metal parts.	May be used to **disinfect dentures** once weekly. During an episode of candida infection (thrush), the denture should be disinfected twice daily by soaking for 10 minutes in 2% sodium hypochlorite solution, rinsed and allow to air dry (94). Continue until signs of candida are gone. Sodium hypochlorite must be kept in a locked cupboard and not left in a person's room unattended.
Denture container	Used to store dentures overnight (93). The container should have a lid and be labelled with the person's name. We advise storing dentures clean and dry overnight and not storing dentures in water to reduce candida infections. There is also a risk if dentures are stored in water that the water will not be changed daily, especially if patients are not wearing their dentures.

Tool/Adjunct	Indication for use
Denture brush	Used with mild soap to clean dentures.
Denture adhesive	Denture adhesives are pastes, powders or adhesive pads that may be placed on the fitting surface of a denture to help keep it in place.
Sponge sticks (may be included in single use oral hygiene packs)	**Sponge sticks are not advised – they are a known choking risk** (40)**.** In 2014 the UK Medicines and Healthcare Regulations Agency published a medical device alert on the safety of oral swabs with a foam head and the risk of choking secondary to detachment of the foam head. There is increased risk of detachment if soaked before use.

5.3.3 Delivery of daily oral care for specific medical conditions

The oral care protocols for the following specific medical conditions should be delivered in consultation with the medical/dental team.

- 5.3.2.1 Frailty Care – fortified diet
- 5.3.2.2 Dysphagia Care
- 5.3.2.3 End of life Care
- 5.3.2.4 Neurological Care – Stroke Care
- 5.3.2.5 Cancer Care
- 5.3.2.6 Critical Care
- 5.3.2.7 Discharge planning

5.3.3.1 Frailty Care – persons needing a fortified/modified diet and fluids

Adding sugar makes food or drink more likely to cause tooth decay. People who need a nutrient dense diet will often be prescribed oral nutritional supplements. These are frequently high in sugar content and often sipped during the day. People prescribed these supplements are consequently at high risk of developing tooth decay and will therefore need extra care with oral hygiene and may require additional preventive measures. It may be appropriate to balance the caries risk of supplements with prescribed high fluoride toothpaste in their oral care plan.

- Thickeners used in food and drink are very sticky and can leave a thick layer on the teeth. A person who is on both thickeners due to dysphagia and oral nutritional supplements needs particular care with oral hygiene and should see the dental team to discuss preventative care.
- Enteral nutrition: Some people may require all of their nutrition in liquid form via an enteral tube due to poor appetite, acute illness, or swallowing difficulties. These people will also need to be seen by the dental team to discuss their daily oral care needs. See section 5.3.2.4 Dysphagia & Nil by Mouth for specific advice.

5.3.3.2 Dysphagia Care and Nil By Mouth

Dysphagia is a medical term for difficulty in swallowing. It can be as a result of stroke or develop as part of a progressive medical condition. A swallow assessment by a Speech and Language therapist or hospital doctor/nurse or GP (depending on setting) should be carried out for a person experiencing dysphagia and a specific oral care plan should be developed (17). Thickeners may be used in food and drink to reduce the risk of aspiration, potentially leaving a thick layer on the teeth. Reduced oral clearance (removing food from the mouth) in people with dysphagia negatively impacts their oral health and potentially their general health due to aspiration. Effective brushing of the teeth and gums is essential to remove plaque and food debris. When cleaning the mouth of a patient at risk of dysphagia, extra care should be taken to reduce the risk of a patient aspirating toothpaste or any debris that may be present in the mouth.

Nil By Mouth (NBM) – including PEG fed (Percutaneous Endoscopic Gastrostomy)

Lack of feeding by mouth results in reduced oral stimulus, subsequent changes in the saliva constituents and calculus (tartar), which tends to build up more easily than usual. Despite not taking food by mouth, it is important that staff, the dentist, and the person work together to develop an oral hygiene plan that meets the individual's needs (98). Daily oral care is extremely important for persons who are nil by mouth to ensure that bacteria don't build up in their mouths and lead to infections. In addition, for comfort and dignity the speech and language therapist may be able to recommend strategies to facilitate taste for pleasure for individuals who are nil by mouth as result of severe oropharyngeal dysphagia.

Enhanced oral care for people at risk of aspiration pneumonia from liquids: Position person to avoid fluid inhalation. This may be in upright or recovery position (seek guidance from an SLT/OT/Physio). Use suction (if available) or gauze to remove any food or fluid debris. Oral suctioning is necessary for some people as they may be unable to clear saliva or secretions from their mouth. They may be at risk of aspirating or build-up of secretions may be causing obstruction or discomfort (26) If using oral suctioning it is important that local policies on suctioning are adhered to and that staff are appropriately trained.

- Brush teeth using a thin smear of a low-foaming sodium lauryl sulphate (SLS) free fluoride toothpaste on a dry soft toothbrush or suction tooth brush (if available).
- Remove any excess with suction (if available) after tooth brushing. If suction is unavailable, excess fluid/food debris can be swabbed out using gauze.

5.3.3.3 End of Life Care

Oral care at the end of life can be extremely challenging but it is very important in the pursuit of patient comfort, safety and dignity.

End of life care is a critical time for the health and dignity of all adults. It is imperative to maintain good oral hygiene in order to ensure comfort for those adults entering the end of life period. It is helpful for staff to explain to family members how and why they are undertaking this oral care regime for their loved ones. Families can be shown how to give dry mouth care as some will want to be involved in their care.

Persons at end of life are susceptible to a range of problems with their mouths including dysphagia, dry mouth, thick mucus secretions, nutritional and taste problems, mucositis, and denture related problems. Poor oral health can have a big impact on oral function and quality of life for these persons at end of life. Maintaining a comfortable mouth is not only reassuring for the person but also their family (21).

The Australian Commission for Oral Care (42) for adult inpatients advises that discomfort from dry mouth is common at the end stage of life and to continue to maintain a clean mouth to reduce discomfort from secondary infections.

End-of-life care policies and/procedures should identify strategies to maintain oral comfort and reduce dry mouth. The benefit of any intervention especially in the final days of life or unconscious person should be weighed against the burden to the person who is dying. These may include:

- Candidiasis can proliferate in advanced illness. Medical and pharmaceutical advice should be sought at the earliest signs of candida.
- The use of individualised oral health interventions to promote comfort, safety and dignity.
- The use of a soft bristled toothbrush to gently clean teeth using low-foaming (SLS free) fluoride toothpaste, for as long as tolerated.
- Monitoring the mouth frequently for signs of oral thrush (candida), dry mouth, dried secretions or sores.
- Prescription of dry-mouth relieving products, applied sparingly to oral mucosa, to soften dried secretions or provide comfort for dry oral mucosa.
- Regular removal of thick or dried/crusted secretions with gentle suctioning (if not burdensome) or a soft toothbrush/damp gauze swab (soften dried secretions with dry mouth gel before removal).
- Regular application of a water-based moisturiser for the lips. Apply a water-based gel or beeswax lip balm as needed. Massage onto the lips. The use of petroleum jelly should be avoided.
- Avoidance of pineapple, lemon, and other citric juices as they may irritate oral tissue and overstimulate salivary glands causing the dry mouth condition to worsen.
- Avoidance of mouthwashes and swabs containing alcohol, hydrogen peroxide, or lemon and glycerine as they may irritate oral tissues and increase the risk of infection.
- Medical prescription of topical pain relief.

The Royal College of Nursing recommendations on Mouth Care during End of life Care (64) advise that good mouth care and “taste for pleasure” are very important when a person is dying and can help them feel more comfortable. Many people have swallowing difficulties; “taste for pleasure” is a way of providing comfort in the last days of life. This should be done along with regular mouth care. “Taste for pleasure” uses the person’s preferred drink or taste used to moisten their mouth. SLT may be able to offer person-centred strategies to support taste for pleasure in the context of dysphagia at the end of life.

Tooth brushing during End of Life Care

Brush teeth and gums twice a day with a small soft toothbrush and a smear of low-foaming SLS free fluoride toothpaste. If the person whom you are caring for is awake, try and carry out tooth brushing at least twice a day, at a time that suits them best. Take care not to place the brush too far back into the mouth. If the person for whom you are caring has difficulty swallowing liquids, use a dry toothbrush and a small smear of low-foaming toothpaste. Remove any excess toothpaste from the mouth with a soft toothbrush, suction or gauze swab. The act of mouth care can be tiring, it may not be possible to clean the whole mouth in one go. You may need to clean a different part of the mouth each time and allow the person to breathe freely without compromising the airway.

Denture Care

At the end of life, it is up to the person you are caring for whether they continue to wear their dentures. If they are not worn, it is important to store them dry and clean in a clean container and ensure they are still cleaned regularly. Aim to take the dentures out before sleeping to help aid comfort. Refer to No. 6 Guidance Sheet: Dentures for further instruction.

5.3.3.4 Neurological Care – Stroke

A person who has had a stroke may have a physical disability. The physical weakness, lack of coordination and the cognitive problems (e.g., attention, memory, language, orientation, perception) (49) that can accompany a stroke may prevent a person from maintaining good daily oral care on their own (50). Additionally, weakness of the muscles of the mouth, face and throat may affect ability to clear food from the mouth, control dentures and swallow effectively. Sensory changes may also make acceptance of daily oral care provided by support staff more difficult. Working with the multidisciplinary team to devise strategies to support daily oral care will benefit the patient and Speech and Language Therapist involvement is essential where dysphagia (difficulty in swallowing) is present. Refer to 5.3.2.4 for further information on the dysphagia protocol.

The National Clinical Guidelines for Stroke 2023 (44) for the UK and Ireland recommend:

- People with stroke, especially those who have difficulty swallowing or who are tube fed, should have mouth care at least three times a day (particularly after mealtimes), which includes removal of food debris and excess secretions, and application of water based lip moisturiser (enhanced care – after meals and at night, if advised by medical team/dentist/speech and language therapist. Refer to Guidance Sheets – No.2: Inside of Mouth, No.3: Saliva).
- People with stroke, including those who have full or partial dentition and/or wear dentures and especially those who have difficulty swallowing or who are tube fed, should have mechanical removal of plaque at least twice a day by the brushing of teeth and cleaning of gums and tongue with a low-foaming, fluoride-containing toothpaste. Chlorhexidine dental gel may be prescribed short term and requires regular review. A powered toothbrush should be considered (19,44). (Refer to Guidance Sheets – No.4: Teeth, No.5: Gums).
- People with stroke who have dentures should have their dentures put in during the day, using a fixative if required; cleaned regularly and the individual referred to a dental professional if ill-fitting or replacement is required (Refer to No.6 Guidance Sheet: Dentures). Any remaining teeth should be cleaned with a toothbrush and fluoride-containing toothpaste
- Staff delivering daily oral care in hospital or in a care home or domiciliary setting should receive training on oral care, which should include assessment of oral health, selection and use of appropriate oral hygiene equipment and cleaning agents, provision of routine oral care and awareness and recognition of swallowing difficulties.
- People with stroke and their family/carers should receive information and training in oral care and maintaining good oral hygiene before transfer of their care from hospital. This information should be clearly communicated within and across care settings, e.g. within an oral care plan which includes regular dental reviews.

The NICE Guidelines on Stroke Rehabilitation in Adults 2023 NG236 (44) recommend:

Swallowing

1. Provide information to people with dysphagia (difficulty in swallowing) after stroke, and their families and carers, on what the condition is and its risks.
2. Healthcare teams with relevant skills and training in the assessment and management of swallowing disorders should regularly monitor and reassess people with dysphagia after stroke who are having modified food and liquid until they are stable.

See Section 5.3.2.4 Dysphagia and Nil By Mouth for provision of oral care for people with dysphagia.

- Chlorhexidine in combination with oral hygiene instruction and/or assisted brushing tends to be the product most comprehensively researched and clinically used in patients with stroke, particularly to reduce gum bleeding, and dental plaque (20,51).

5.3.3.5 Cancer Care

Persons undergoing treatment for cancer may experience side effects related to their treatment including dry mouth, mucositis or taste disturbance. Persons undergoing radiotherapy for head and neck cancer are at particularly high risk of experiencing side effects as detailed above. Mucositis is an extremely painful side-effect of chemotherapy and head and neck radiotherapy, and it is very important to maintain a clean mouth to reduce the risk of secondary infections. It is reported that 40% of chemotherapy patients will experience oral mucositis (inflammation of the lining of the mouth) and many patients rate this as the most distressing aspect of their cancer treatment (47). The prevalence of radiation induced oral mucositis in head and neck cancer patients was found to be as high as 94% (48). Mucositis can result in a person finding daily oral care extremely challenging due to pain and adaptations to an oral care regime can help as detailed below. Hospitals providing chemotherapy and/or radiotherapy may have a local policy or procedure in place in conjunction with their dental service for the management of mucositis.

Basic principles that should be considered are the following:

- Gently brush the teeth and gums twice daily with an extra soft bristled toothbrush (consider baby toothbrush), and use a low-foaming SLS free toothpaste.
- Holding and swirling ice chips in the mouth (excluding patients with high risk of aspiration pneumonia on small amounts of water or saliva). Oral cooling (ice chips) can be used 30 minutes prior to chemotherapy when mucositis inducing chemotherapeutic agents are used.
- Benzydamine Hydrochloride mouthwash may be effective in reducing the discomfort associated with mucositis.
- Dry mouth relieving products may be used to keep the mouth moist.
- Referral to the medical team for topical or systemic analgesia may be indicated
- Poorly fitting dentures or sharp teeth may exacerbate symptoms and should be corrected. A referral to dentist/medical team is needed.
- Hard, acidic, salty or spicy foods can irritate and traumatise the lining of the mouth. Cool or lukewarm foods and soft, bland pureed foods may be better tolerated.
- Alcohol and tobacco should be avoided.

5.3.3.6 Critical Care – Intensive and Critical Care Units (ICCU)

Critically ill patients may have fluctuating or persistently reduced levels of consciousness due to sepsis, neurological injury, sedative medications, or organ failure. Others may be severely respiratory-compromised and dependent on non-invasive ventilation (e.g., CPAP, BiPAP) or high-flow oxygen therapies. These patients are at increased risk of oral dryness, bacterial colonisation, and aspiration. They may be unable to independently maintain oral hygiene and require assistance or full support. Regular oral care in these patients remains essential to reduce the risk of infection, maintain mucosal integrity, support comfort, and prevent complications such as hospital-acquired pneumonia (HAP) (21)

Critically ill patients who are unconscious or sedated in critical care units often need to have mechanical ventilation which exposes them to the risk of developing Ventilator Associated Pneumonia (VAP). Ventilator-associated pneumonia (VAP) is defined as pneumonia that occurs 48-72 hours following endotracheal intubation (20). VAP contributes to approximately half of all cases of hospital-acquired pneumonia and is associated with significant morbidity in critically ill patients (23). VAP increases the length of ICU stay, duration of mechanical ventilation, and mortality (23).

Effective oral care and oral hygiene regimes are a recognised part of Ventilator Care Bundles (18), which is defined as a grouping of evidence-based practices, with the goal of encouraging a consistent delivery of care to improve clinical outcomes (22).

The British Association of Critical Care Nurses evidenced based consensus paper for oral care within adult critical care units 2020 recommends (21):

- All critically ill patients should be assessed using a standardised oral health assessment tool used in the critical care unit within 6 hours of admission. This should be documented accordingly.
- A formal oral care assessment should occur at least every 12 hours and be documented accordingly.
- Document oral care and record any abnormalities in the oral health assessment.
- Ensure effective handover of oral care and oral health assessment at shift changes.

Oral Care for non-ventilated patients

- Position the person to avoid fluid inhalation – sit the person up and support their head with pillows (if possible). This may be in upright or recovery position. Seek guidance from an SLT/OT/Physio
- Use a small, soft toothbrush appropriate to the person's preference and needs as specified in their oral care plan. A small head is recommended for people in hospital as they are able to reach further in patients with limited mouth opening.
- Brush teeth using a thin smear of a low-foaming sodium lauryl sulphate (SLS) free fluoride toothpaste on a dry soft toothbrush or suction toothbrush (if available).
- Remove any excess with suction after tooth brushing.
- Brush teeth a minimum of twice a day for at least 2 minutes and consider use of interdental aids if practical (Refer to No.4 Guidance Sheet: Teeth)
- Person-centred oral care should take consideration of a person`s sleep patterns and preferences if the person is conscious and able to communicate.
- If the person's tongue is heavily coated, gently brush with toothbrush.
- If indicated and prescribed, a thin layer of water-based dry mouth gel may be used throughout the oral cavity and lips. Moisten lips frequently with water-based lip moisturiser (Refer to Guidance Sheets – No.2 Inside of Mouth, No.3: Saliva).
- Dentures – Refer to No.6 Guidance Sheet: Dentures.

Oral care for ventilated patients:

- Oral care frequency in the ventilated person is determined based on the individual, specific person`s needs, and may need to be increased if the person is nil by mouth.
- Tooth brushing should be undertaken a minimum of twice daily, as feasible, with a low-foaming sodium lauryl sulphate (SLS free) fluoride toothpaste to remove bacterial plaque.
- Use a small-headed dry toothbrush, with a long handle, and suction or a suction toothbrush to facilitate reaching the back of the mouth.
- Edentulous individuals should have their tongue and gums gently brushed.
- If indicated and prescribed, a thin layer of water-based dry mouth gel may be used throughout the oral cavity and lips. Moisten lips frequently with water-based lip moisturiser (Refer to Guidance Sheets – No.2 Inside of Mouth, No.3: Saliva).
- Minimise traumatic ulceration caused by endotracheal tubes by either regular repositioning or by using a tube holder.
- Collaborate with ITU team protocol for VAP prevention.

5.3.3.7 Discharge planning from acute care

Oral conditions that arose or were noted during an inpatient stay often require further management post discharge.

Based on the findings of the oral health assessment, discharge planning should identify:

- Problems or risks with the person's oral health.
- The oral health care strategies or interventions implemented to manage identified oral health conditions.
- The person`s support needs.
- Requirements for follow-up dental examination with own dentist.

The person should be able to access medical summary information to take to any dental appointments, including updated medication lists. A copy of the person`s oral care plan should also be provided to promote and ensure consistent oral care

5.3.4 Document daily oral care

Standard oral care should be undertaken twice daily as standard, whether by the person or support staff, as indicated by the Oral Care Plan and health and social care teams must ensure all oral care is documented.

The requirement to document care twice daily serves as a useful prompt to support staff and as evidence that care is being carried out, and also stands as a record of legitimate reasons for not carrying out oral care.

Sample Oral Care Daily Record Template			
Name:			
DOB:			
Date/Time	**Appearance of mouth, concerns, comments**	**Oral Care Completed Y/N** *Refusal of care**	**Staff Signature**

*When daily oral care is not carried out/not possible, this record **should** be completed, and any difficulties encountered communicated between staff during handovers. Persistent refusal of care should be escalated to dental/medical team. Important to explore all the determinants of successful oral care. See section 5.1

Document and record any incident relating to oral care, e.g. lost/misplaced dentures or failure of staff to complete oral care for person who are dependent or require assistance for same, in accordance with National Incident Report Form 03 (NIRF 03).

6.0 Consultation

6.1 Stakeholder involvement

Once the guideline was agreed by the Guideline Development Group it went for wider consultation to internal and external stakeholders in Q2 2025. The consultation process for this document was carried out over an extended period, internally and externally. The document was made available and stakeholders were invited to submit their comments and suggestions. The consultation process was open to all interested parties and relevant stakeholders. Feedback was reviewed and the guideline updated.

7.0 National implementation plan

For HSE and HSE Funded settings, each Health Region should adopt and implement the recommendations within this guideline from the date of approval and publication. Sample tools to assist in the implementation will be available. This guideline does not replace the clinical judgement of a qualified healthcare professional, and where there are clinical concerns, it is the responsibility of the health and social care teams to escalate to their line management and/or seek appropriate medical/dental/professional input.

7.1 Governance of national implementation team.

No	Key recommendation	Who	When	With What (Tools and resources)
4	It is the role and responsibility of management to ensure health and social care teams are suitably trained with appropriate equipment available to deliver daily oral care (26,34,36–38,40–42,52,53)	Management	On-going	• National Oral Care Guideline (Supporting Smiles) • HSEland eLearning Programme (in development) • Full range of Key oral care products, tools and adjuncts appropriate to the person's care needs and preferences

Resources required to implement this guideline within each Health Region are for determination at REO level. It is recommended that healthcare setting nominated staff members will become oral care Supporting Smiles leads, with experience and/or upskilled in Oral Health Assessment, and who would be best placed to lead and co-ordinate the management of oral health within their setting.

This national guideline will be piloted in a number of settings including Older Persons residential settings, Disability residential settings, Acute and Palliative Care settings. Champions/Leads have been documented in the literature as an important strategy for implementation with associations between exposure to champions/leads and increased use of best practices at organisational levels and residential settings documented(54,55). These pilot projects will enable validation of the classroom based teaching methods and evaluation of the champion led approach to implementation. The pilots will provide initial implementation resources which will further support implementation to other healthcare settings. The pilot project will inform the level of resource requirements (healthcare settings and dental service requirements) for national roll out.

Classroom based teaching resources on this guideline, developed in collaboration with ONMSD, will be required locally to train relevant staff in diverse settings. Key staff should be provided with access to the relevant training required to support them in implementing the recommendations of this guideline.

Access to the training and implementation resources is also available to support implementation of this guideline in non-HSE healthcare settings where personal care is supported and provided.

7.1.1 Roles and responsibilities

The National Director Access and Integration is responsible for communicating this HSE national guideline to all HSE Health Regions and HSE funded locations.

The Regional Executive Officer (REO) for in each Health Region/Healthcare Facility Manager is responsible for the implementation and ongoing evaluation of this guideline within their area by assigning personnel with responsibility, accountability and autonomy to implement this guideline locally and supporting recruitment and upskilling of key staff where necessary. It is the responsibility of all Managers to ensure that the relevant staff reporting to them are aware of this guideline, and to ensure that their staff have received training as appropriate to their role. As oral care is an infection control measure to prevent aspiration pneumonia it requires a full multi-disciplinary team approach. It is intended that this guideline will assist all health and social care teams in delivering a safe and quality oral care service. It is the responsibility of each health and social care professional to adhere to their professional regulators code and scope of practice, to maintain competency and to be aware of the role of appropriate delegation.

7.1.2 Tools and resources developed to support local implementation of your National 3PG

The following tools and resources can be accessed to support local implementation

- HSeLanD training modules (in development)
- Toolkit
- Audit tool
- Presentations on using the toolkit
- HSE Podcast on oral health

7.1.3 Expected date of full implementation of your National 3PG

It is expected that the HSE National Oral Care Guideline (Supporting Smiles) should be fully implemented by end 2026.

8.0 Governance and approval

The governance and approval arrangements rest with HSE Supporting Smiles Development Group. This group reviews the PPPG, signs the checklist used in assessing the PPPG is meeting the standards outlined in the HSE National Framework for developing PPPGs and recommends it to the Supporting Smiles Steering Group.

The final document is submitted to Assistant National Director Oral Health, Chief Clinical Officer and National Director, Access and Integration for approval.

Once approved the final version is converted to a PDF document to ensure the integrity of the PPPG. A signed and dated copy of the checklist is attached to the master copy, which is retained with HSE National Oral Health Office.

9.0 Communication and dissemination plan

The HSE National Oral Health Office will ensure widespread awareness of the guideline to relevant audiences and other stakeholders using existing communications channels.

The guideline will be available and accessible via www.hse.ie. The guideline document can be accessed only on the HSE National Central Repository which is the single trusted source for accessing, storage and document control for National 3PGs. No duplicate copies of the National 3PG should be accessible in any secondary electronic locations, only the link to the document on the Repository should be used on other locations. This link will automatically update in all locations if changed on the Repository.

10.0 Sustainability

No	Key recommendation	Who	When	With What (Tools and resources)
5	It is the role and responsibility of management to ensure ongoing monitoring, audit and evaluation including monitoring risk assessments or risk ratings and trends arising from these (54,55)	Management	On-going	• Audit tool • Suggested KPIs • Risk assessment

10.1 Monitoring

Each Health Region/Healthcare facility should implement a systematic process of gathering information and tracking over time to achieve the recommendations of this guideline.

10.2 Audit

Refer to Appendix 5 for a sample audit tool. It is intended that this audit tool will provide each Health Region with a baseline tool through which they can identify areas that require improvements.

Users of this audit tool are free to add in additional statements, as they deem appropriate and adopt this tool for use in their own setting. This audit tool is to be used to retrospectively audit processes.

10.3 Evaluation

Each Health Region/healthcare facility will define a mechanism to measure how daily oral care has changed for all adults (over 18 years) in healthcare settings. The service provider/manager should link with their Quality and Patient Safety Department for further information on developing key performance indicators and designing quality improvement initiatives. The HSE Quality Improvement Guide and Toolkit explains a number of quality improvement methods and approaches used in health care and the theory behind them. It also contains quality improvement tools to help you design and deliver a quality improvement project.

One of the most significant developments in relation to performance monitoring has been Avedis Donabedian's division of healthcare into structure, process and outcome, for the purpose of defining and measuring quality (99).

In relation to performance monitoring and key performance indicators for the implementation of the HSE National Oral Care Guideline (Supporting Smiles), consider the following:

Structural indicators refer to the resources used to meet the recommendations of the guideline	• % staff who have ready access to download the evidence-based National Oral Care Guideline (Supporting Smiles) • % staff who have ready access to training resources • % staff who have ready access to Oral Health Assessment Tool • €Expenditure on provision of daily oral care (e.g. oral care products and tools)
Process indicators measure the activities carried out	• % of staff who completed the HSELand Supporting Smiles elearning programme • % of persons who had an oral health assessment using the oral health assessment tool carried out on admission or first point of contact • % of persons who had an oral care plan developed based on the oral health assessment • % of persons who had oral care delivered and documented as least twice daily
Outcome indicators relate to person outcomes and also staff outcomes as a result of implementing the guideline	• Person surveys in relation to improved oral health related quality of life, improved comfort, and increased level of knowledge • Number of persons referred to dentist and wait time • Number of oral health incident forms (NIRF) completed • Number of denture losses – indicated by completion of NIRF • Clinical indicators may be developed with Dentist/Medical team input and support • Pre and post implementation staff knowledge oral care survey

11.0 Review/update

11.1 Next review date

This guideline should be reviewed three years from date of issue.

Any new supporting evidence identified by findings from audit and evaluation, scope of practice changes or advances in technology or research will be reviewed, amended, and updated as necessary.

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13.0 Glossary of terms

Aspiration Pneumonia: A pneumonia caused when food, liquid, or other material enters a person's airway and eventually the lungs

Aspiration Risk: The risk of food, liquid, or other material entering a person's airway and eventually the lungs

Autonomy: The ability to make one`s own decisions about what to do rather than being influenced by someone else or told what to do

Bridging: this is a strategy used to engage a person with the task of tooth brushing through their senses and helps them to understand the task by letting them feel the brush or brushing their hand so that they know it is not going to hurt. Describe and show the toothbrush to the person, mimic brushing your own teeth, give a spare toothbrush to the person, and the person may mirror your behaviour and brush their own teeth.

Candida Infection: Also known as Thrush, Candidiasis is a fungal infection caused by an overgrowth of yeast in your body

Care Resistance: *A person`s unwillingness to be assisted by healthcare staff* and manifests in a range of defensive behaviours

Dementia: Dementia is a term for several diseases that affect memory, thinking, and the ability to perform daily activities.

Dental decay/dental caries: Damage to a tooth that can happen when bacteria in the mouth make acids that attack the tooth's surface, or enamel. Root decay occurs when cavities form on the root surfaces of teeth. Decay above the root is known as coronal decay.

Dental Plaque: Dental plaque is an almost colourless, sticky bacterial film, which adheres to the tooth surface and needs to be removed twice daily as standard to prevent build-up of harmful bacteria that cause tooth decay and gum disease

Distraction Strategy: this strategy involves distracting with singing or by placing a familiar item in the person's hand while you brush the person`s teeth. Other distractions such as music and videos can be used, and brushing whilst in the bath can be of benefit (39).

Dysphagia: is a medical term for difficulty in swallowing

Fluoride: A natural mineral found in soil, fresh water, sea water, plants and many foods.

Gum disease (Periodontal disease): An inflammatory disease that affects the gum and bone structures that support the teeth

Health Service Executive (HSE): The organisation responsible for running the State's health and personal social services.

Hypersalivation: Hypersalivation or drooling can result in pooling of saliva, which is often indicative of impaired clearance rather than excess production of saliva

Lancet publication: The Lancet is a weekly peer-reviewed general medical journal and one of the oldest of its kind. It is also one of the world's highest-impact academic journals. It was founded in England in 1823.

Lesions of the lining of the mouth (oral mucosa): Mouth lesions are sores on any of the soft tissues of the mouth

Mucositis: Mucositis is inflammation of the mucosa, the mucous membranes that line your mouth and your entire GI tract. It's a common side effect of cancer treatment

Oral health status: Oral health status is the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions such as eating, breathing and speaking, and encompasses psychosocial dimensions such as self-confidence, well-being and the ability to socialise and work without pain, discomfort and embarrassment.

Oral hygiene: Oral hygiene is the practice of keeping one's oral cavity clean and free of disease and other problems (eg bad breath) by regular brushing of the teeth.

Pathogenic: Causing or capable of causing disease

PEG Fed: A percutaneous endoscopic gastrostomy (PEG) feeding tube is a way to give food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

Rescuing: Term refers to a common tactic used with other hygiene tasks. If attempts are not going well, the care assistant can leave and the 'rescuer' comes in to take over, bringing in someone else with a fresh approach may encourage the person to accept care.

Sjogren's syndrome: Sjögren's disease is a long-term autoimmune disease that primarily affects the body's exocrine glands, particularly the lacrimal and salivary glands. Common symptoms include dry mouth, dry eyes and often seriously affect other organ systems, such as the lungs, kidneys, and nervous system.

Sodium Lauryl Sulphate (SLS) Free tooth paste: These are low-foaming toothpastes suitable for persons who have a dry, uncomfortable or sore mouth, or who cannot tolerate foaming toothpastes due to swallowing or sensory difficulties

TILDA Study: The Irish Longitudinal Study on Ageing (TILDA) is a large-scale, nationally representative, longitudinal study on ageing in Ireland, the overarching aim of which is to make Ireland the best place in the world to grow old.

Ventilator associated pneumonia: Ventilator-associated pneumonia (VAP) is defined as pneumonia that occurs 48-72 hours following endotracheal intubation

14.0 Guideline Governance, Steering and Development Groups

Guideline Steering Group

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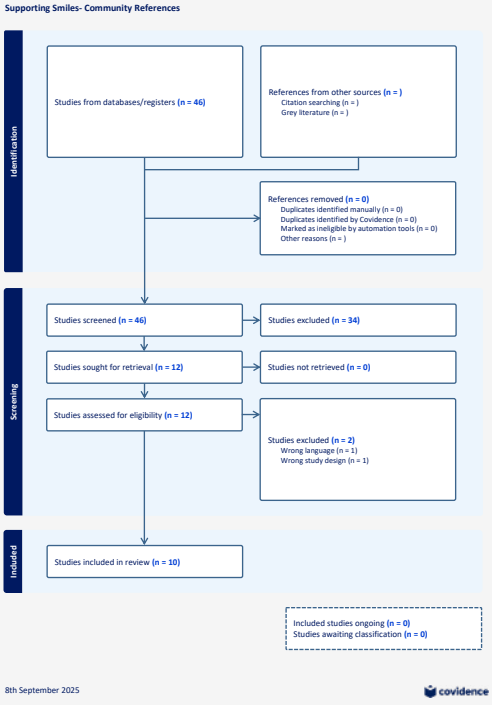
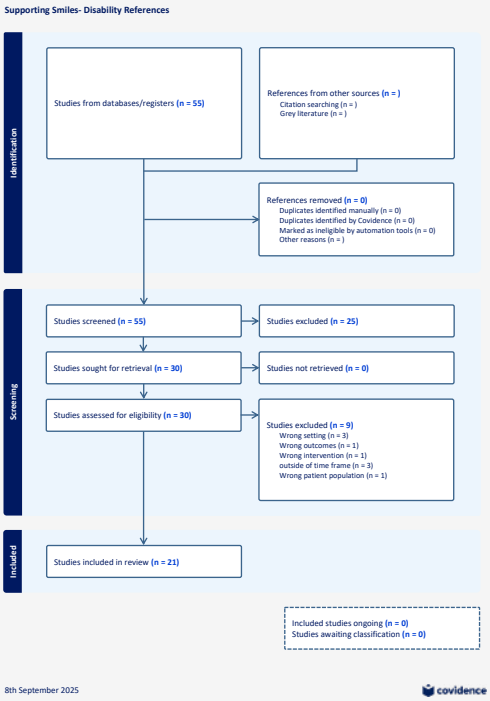
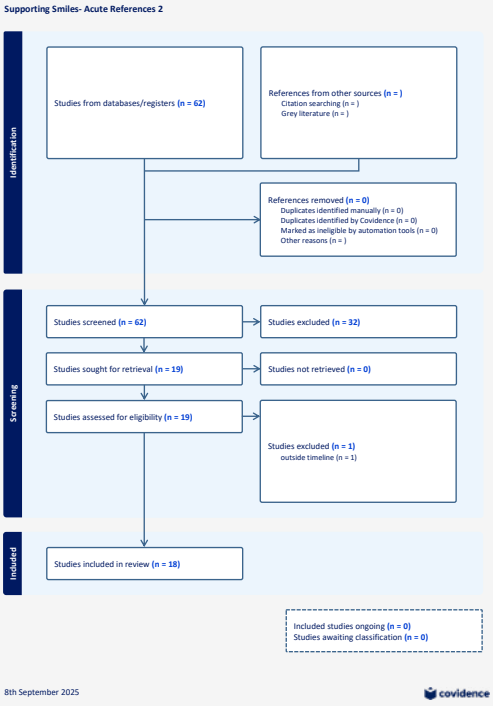
15.0 Appendices

Appendix 1: Literature review







Appendix 2: Additional Resources

1. Malnutrition Universal Screening Tool ('MUST') eLearning course on HSELand – Click Here
2. HSE Dysphagia leaflet – Click Here
3. Brush My Teeth website and resources – https://brushmyteeth.ie/. brushmyteeth.ie was made to show people how to keep their mouth healthy. It is a website where the person, or someone who supports the person, can watch videos that show how to brush their teeth, whatever type of brush or support they use.
4. HIQA's learning hub – Additional learning materials which may be useful can be found in the HIQA's learning hub https://www.hiqa.ie/learning-hub. These include national standards, guidance and online learning modules, including a human rights-based approach, advocacy and safeguarding. Additional guidance on 'communicating in plain language' is currently in development.
5. National Cancer Control Programme – Head and Neck Cancer advice for primary Click Here

Appendix 3: Medications that cause Dry Mouth

Drugs commonly associated with xerostomia include:
Alpha adrenergic blockers
Alpha adrenergic agonists
Anticholinergics (Antimuscarinics)
Antidepressants
Antihistamines
Antiparkinsonian medications
Antipsychotics
Benzodiazepines
Beta adrenoceptor blockers
Diuretics
Glucocorticoids
H2 receptor antagonists
Lithium
Non-Steroidal Anti-Inflammatory Drugs
Opioid analgesics
Proton Pump Inhibitors
Sucralfate

https://olh.ie/wp-content/uploads/2023/03/What-are-the-treatment-options-for-the-management-of-dry-mouth-2019.pdf

Appendix 4: HSE Training Needing Analysis Survey Results

Guideline Section/ Recommendation	Question	Survey Response		Emerging themes to inform Education Programme
• **Oral health and general health.** • **Importance of oral care – current status**		Oral hygiene does not appear to be standard practice. There is confusion I think around persons responsible for providing oral hygiene- I do understand the importance of oral care, however I do not provide it and do not feel skilled in demonstrating or providing specific strategies on same, falls between stools with multiple people's roles being involved (nurse, HCA, SLT) 97% of respondents agreed that oral health is an integral part of general health I have difficulty identifying who's role oral care is. I feel there is a significant gap in education and awareness of the important of oral care practices across settings. In the disability sector, I feel oral care isn't prioritised as much as other health areas – potentially because this is not a standard that is investigated by HIQA; however, I do feel it should be.	Poor oral health in hospitals, particularly among older adults, can result in inadequate nutritional intake due to oral discomfort and malnutrition. Emphasis not enough on importance and problems caused by poor oral care As an SLT I am not involved in oral care on a daily basis as this is very clearly a daily nursing role. However, SLTs need to be aware and able to advise about it when it affects speech or swallowing. Oral hygiene does not appear to be standard practice. There is confusion I think around persons responsible for providing oral hygiene – my own lack of knowledge included. Therefore, where should this support come from? SLT dept in administering oral hygiene or support of nursing staff to implement routine as recommended by SLT? What kind of training to nursing staff receive in relation to this. Can HCAs support this request Doesn't appear to be a priority.	Oral care not standard practice Importance of oral health and general health Need to set a standard recognised by HIQA Lack of clarity about whose role oral care is

Guideline Section/ Recommendation	Question	Survey Response		Emerging themes to inform Education Programme
• **Carry out an Oral Health Assessment (OHA) for all adults (18 years and over) who reside in or attend healthcare settings where their personal care is supported or provided and document oral health risk.**	Do you carry out an Oral Health Assessment for each person on first contact with the service/after a significant medical event that can impact on oral care?	43% of all respondents stated Yes on admission/first contact Hospice care staff completed the highest percentage of oral assessments on first contact 31% of respondents stated Yes OHA carried out after a significant medical event that can impact on oral care (stroke accident/change in meds	Should all health care professionals be expected to do informal oral care Assessment? The only time I tend to discuss oral care is when a client is dying.	Oral Health Assessments are being carried in some but not in all settings. Palliative care setting has greater awareness of Oral health Assessments
• **Establish the oral health risk of the person**		Speech and Language therapists play a vital role in advocating for their patients and encouraging frequent oral care as it is known that Importance of oral care in the care of the patient with dysphagia post stroke education	I do not think oral care is viewed as a priority by all medical professionals in the acute hospital setting. It is known that poor oral care is one of the most significant risk factors for developing aspiration pneumonia.	Staff members need to be aware of the risks associated with poor oral health
• **Identify oral care products, tools and adjuncts required for the person, appropriate to their individual needsIdentify the key oral care products**			As an IPC CNS we receive queries in relation to IPC advice with oral care. It would be great if there was national guidance in relation to this topic with lists of equipment with these equipment being available to HSE	List of adjuncts and equipment needed

Guideline Section/ Recommendation	Question	Survey Response		Emerging themes to inform Education Programme
• **Deliver oral care according to guidance sheets at least twice daily (specific conditions may require additional care).** • **Document the delivery of oral care, including persistent refusal to accept oral care and challenges encountered.**	Does each person have an oral health care plan based on oral care assessment?	35% of all responses said yes all persons have an oral care plan, 33% said some persons have an oral care plan and 32% of all responses said no, persons do not have an oral care plan based on the oral care assessment Communication is lacking in terms of specific oral care needs of patients between nursing staff and HCAs at ward level	Following the oral assessment by the admitting staff nurse, most oral care is delivered by healthcare assistants who have not completed the assessment, nor so they have access to the patient`s care plan and therefore in my opinion – how can this care be patient specific? Advice on oral care in case of dentures, various types of implants, service available for dentures, oral hygiene for dementia residents who may swallow hygiene products.	Important to place oral care plan in accessible location Clear instructions on how to deliver oral care required
• **Identify barriers and solutions to providing oral care** • **Care resistance strategies** • **Providing oral care and Dementia**	What are the most significant barriers to providing oral care to persons	Barriers in order of importance (most important first) were: • Service user compliance • No training • Lack of time • Lack of oral care equipment • Do not like providing/ supporting oral care Have guidelines form Dentist but minimal support with behaviours of concern in this regard	Need to know about Dental services for people with ID especially those who do not **consent.** Patient/family information leaflets re the importance of oral care in reducing HAI's while an inpatient in acute hospital setting and in reducing rate of hospital admission in care of the elderly setting. No plan if desensitisation program is unsuccessful Just told to perform oral care no guidelines from company on what to do if service user refuses.	Consent and right to oral care Importance of collaboration with the dental team Need for information and posters Care Resistance training required specifically to help persons to accept oral care

Guideline Section/ Recommendation	Question	Survey Response		Emerging themes to inform Education Programme
It is the role and responsibility of management to ensure health and social care teams are suitably trained with appropriate equipment available to deliver oral care	Was oral health education as part of your professional training	57% of Nurses, 19% of Healthcare Assistants, 17% of Support workers, 17% of Dieticians and 30% of Speech and Language Therapists (SLTs) did have oral health education as part of their professional training	Doctors and GPs who responded report receiving little/no training in oral health Speech and Language therapists also reported little training	Undergraduate training in oral care not sufficient Undergraduate training programmes need oral care training input
	Further oral health education since finishing professional training	76% of all respondents reported that they had received no further education on providing oral care since finishing their professional training and 97% felt that they would benefit from access to this education Biggest issue is staff can't be released for training sessions and no available training spaces. Insufficiently staffed to promote awareness/ training	No oral care training provided, when I had my first role 20+ years ago as HCA in old institution oral care was provided as part of orientation but in current organisation there is no training given to front line staff on how to support oral care. Onus is on staffs experience to ensure residents attend regular dental checkups.	Clear need for accessible on line training in oral care provision Access to oral care training inadequate and needs to be priotitised by management
It is the role and responsibility of management to ensure ongoing monitoring, audit and evaluation		I wouldn't say there is a big drive for oral care and there is no KPI/ standard per say and as mentioned above not in our CGA No policies, no training, no equipment, not a focus at all	Auditing current practice, education, compliance, ensuring all products and forms available, prompting, re-auditing, communication and improving patient care	Need to develop KPIs around oral care to underpin the importance of oral care provision Audit tools needed to ensure compliance

Appendix 5: National Oral Care Guideline (Supporting Smiles) Audit Tool

Methodology

Population: A sample of target users

Sampling: A total of 10% or 10 target users, whichever is greater, should be selected.

Frequency: To be determined locally at least annually.

Method: Record **Y** for **Yes**, if the criteria are met. Record **N** for **No**, if criteria are not met or **N/A** for **Not applicable**.

Compliance requirement: 100%

Is standard/criteria being met for the following statements:	Yes	No	N/A	Evidence
Recommendation 1				
Has an oral health assessment using the oral health assessment tool been carried out each person on admission or first point of contact?				
Is there evidence that the oral health assessment is documented?				
Is there evidence of reassessment of OHA appropriate to person, at a minimum 6 monthly or as clinical needs change?				
Recommendation 2				
Has an individualised oral care plan been developed for each person?				
Is there evidence that the oral care plan is documented?				
Recommendation 3				
Is oral care delivered according to the guidance sheets at least twice daily?				
Is there evidence that key oral care products, tools and adjuncts are available and appropriate to the person's care needs and preferences?				
Is there evidence of that the delivery of oral care is documented (at a minimum twice daily) for each person?				
Governance				
Do HSCTs have ready access to a copy of HSE National Oral Care Guideline (Supporting Smiles)?				
Does the setting have a nominated lead responsible for oral care?				
Date of Audit: Audited by (name/title): Compliance Rate %:				
Calculation of Compliance Rate %: The score, expressed as a percentage, is calculated by dividing the number of "yes" and "no" answers. "Not applicable" answers are excluded from the calculation of the percentage score. **Example:** If there are 6 "yes" and 2 "no" answers, the score is calculated as follows: 6 (yes answers) divided by 8 (total of yes and no answers) multiplied by 100 = 75%				