



This is dental care for the elderly: Ireland 2016

To properly care for patients in nursing homes, the multidisciplinary teams must include dentists.

There are approximately 27,000 patients living in nursing homes in Ireland at present. These are probably our most vulnerable citizens with limited control over their daily lives. The trend over the past five years is for people to be cared for in their own homes by a combination of home help and family for longer. When their dependency reaches a level where this is insufficient, a nursing home is deemed to be the best living situation for them. Therefore, the type of patient I am now seeing in nursing homes is frailer and older than previously. Along with this, these older, frailer patients are increasingly dentate, with huge unmet dental health needs. These patients are high dependency and have poor access to quality oral hygiene and preventive measures. Administering dental treatment to these patients is fraught with difficulty.

The xerostomia-inducing medications and fortified food supplements that are almost the norm for these patients are pushing their oral health further into the abyss.

In the nursing home setting we want to keep patients pain free and disease free. We wish to maintain a safe mouth to reduce the chance of aspiration pneumonia and provide palliative care in the extremely frail. Increasingly, I am faced with the dilemma of carrying out clearances for these patients to remove sources of pain and infection.

A distressed patient

In one case, a nursing home contacted my dental practice to say a patient urgently needed dental care. The patient was a very frail 75-year-old lady who only weighed 40kg and had end-stage Parkinson's disease with mild dementia. The nursing staff were not sure if the patient had a toothache, as she was unable to communicate. She was very distressed, in an acutely confused state, and refused to allow anyone near her mouth.

On the first visit I was unable to carry out much in the way of an examination, other than briefly lifting the upper lip. I could clearly see swelling above the upper incisors and there was an overwhelming halitosis. It was revealed by nursing staff that this lady's mouth was cleaned twice daily with a sponge but nothing in the way of effective tooth brushing had been carried out in the two years since her admission to the nursing home.

The following day, having contacted her GP to see what my sedation possibilities were, I prescribed oral sedation, which calmed her down sufficiently to allow for comfortable extraction of four upper incisors. On examination, I found the remaining dentition to be in such a poor condition periodontally that phased extractions were the only option. A week later at a follow-up visit, this lady was unrecognisable as she was sitting out eating her dinner and able to speak and engage with her visitors, something she was unable to do for several weeks before the extractions. Moving forward with her care, she now has an electric toothbrush, which I've shown the care assistants how to use. She's using Duraphat toothpaste and chlorhexidine oral gel. There is no possibility that this patient will be able to wear a denture as she does not have the cognitive function, or the motor skills, to adapt to one.

Key issues

This case highlights a number of key issues in trying to provide better outcomes for these patients:

1. According to HIQA, the nursing home had satisfied the existing guidelines for oral care. However, as dentists we know that this was tragically inadequate.
2. The cornerstone of good geriatric care is a functional multidisciplinary team (MDT). Dentists are not routinely included in these teams. This patient had a profound halitosis for months before a dentist was called. Her grandchildren were refusing to visit her or hug her because of it and I found that very sad. Patients will have better outcomes if preventive dentistry is provided at its earliest possible opportunity. We need to discuss with geriatricians, GPs, nurses, dieticians and speech therapists that there is a dental impact from some of their therapeutic methods, and conversely that the resulting poor oral health impacts on patients' health and quality of life. We as a profession need to increase awareness among other healthcare professionals of the dramatically changing oral health

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needs of this cohort of patients.

3. The HSE is renegeing in its duty to provide adequate care for nursing home patients. No other healthcare professionals are expected to carry out domiciliary care for patients and not get paid for travel costs, nor the additional time it takes to care for these patients safely.
4. This was an extreme case to manage but one I am seeing more of every week. There is an urgency to improve the system before it is truly out of control.

Advice welcomed

Assisted by the IDA, we approached HIQA to see if they have any interest in my concerns. Following a meeting with the senior inspectors, they invited me to speak to all the HIQA nursing home inspectors at their headquarters. We were enthusiastically received and they were happy to be more aware of patients' dental health needs.

Engaging with other carers

The key organisation involved in the care of the elderly in Ireland is the Irish Gerontological Society (IGS). As an organisation, they were keen to involve dentists, as they realised we are absent from their multidisciplinary approach to care.

This engagement resulted in my delivering two lectures at their annual conference, one to the allied healthcare professionals and the other to non-consultant hospital doctors (NCHDs). The engagement was lively and there was a general acknowledgement that there is an increasing problem with dentate elderly. In particular, the NCHDs had encountered problems finding a dentist to treat patients in hospitals or nursing homes.

Conclusion

Change needs to happen in the behaviour and attitudes of all those involved in the healthcare of the elderly. This change will not happen until other healthcare professionals have an awareness that good oral health is integral to good overall health and quality of life.

Ideally, other healthcare professionals should be obliged to involve a dentist in their patients' care: when they prescribe xerostomia-inducing medication or high-sugar food supplements; when patients are at high risk of aspiration pneumonia; and, when a chronic debilitating condition is first diagnosed. This will reduce crisis management of these patients and help reduce the amount of dental clearances that are needed. Patients will have better outcomes when members of the MDT work together.

The HSE needs to step up to its obligations in providing access to dental care for these patients. Training programmes for healthcare assistants in oral care should be mandatory and meaningful. Dental schools should include

domiciliary experience in their undergraduate training programmes. A written oral care plan should be created with these patients where family and carers are involved. All those involved in an individual's care should be aware of his/her needs and values.

A low-sugar message should be sent out to all. These patients did not reach old age dentate on a high-sugar diet. Both family and carers should be encouraged to provide low-sugar treats. Irish people have a tradition of always bringing a food gift when visiting. This is very evident in patients' bedrooms in nursing homes, which often resemble a sweet shop. Non-food gifts should be encouraged. A campaign for a low-sugar policy in hospitals and nursing homes could perhaps be driven by the IDA?

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