

ORAL CARE FOR PEOPLE WITH SPECIAL NEEDS

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1. INTRODUCTION

These notes come out of many years of caring for people with special needs who had a wide variety of developmental, psychiatric, trauma related, or degenerative conditions. It has been a gift to be involved with the people I have met, and with the staff who dedicate their lives to the care of people with special needs. The notes assume a setting such as a residential home.

2. PUTTING ORAL HYGIENE INTO PERSPECTIVE

2.1 A sensitive indicator of the quality of care

Oral care is often added on to other activities such as bathing, toileting, dressing, feeding and tends to have the **lowest status of all the activities involved in caring for people with special needs**. It is often given to the newest, least experienced person to join a team of carers and yet is not easy to do well. Because of its low status **oral care is one of the most sensitive indicators of the quality of care**.

2.2. Effective oral care cannot be faked

The thin almost invisible layer of bacteria that grows around the gum margins of the teeth becomes thicker with time until it can be seen with the naked eye.

After 2 days the cells at the bottom of the layer start to decompose

After 4 days the cells in the middle of the layer are starting to contribute to bad breath

After 7 days anaerobic spirochaetes (they don't need oxygen to survive) start to invade the gum margins causing bleeding.

After 10 days the plaque is thick and can be seen as a creamy rim around the gum margins of the teeth (visible plaque), and the gum margins take on a deeper red colour. If it weren't for the profuse blood supply in this tissue bringing defence cells to the area, we would all have died of blood poisoning a long time ago.

Inflamed gums will bleed readily when they are brushed. The bleeding does not imply that the brushing is rough, that the brusher is doing damage, or causing pain. Mostly, bleeding gums mean that mature plaque is being removed, or that tartar (calculus) deposits are preventing mature plaque from being removed.

The characteristic sign of inflammation from mature plaque is a rim of red around the gums. This is called a marginal gingivitis. It remains even when all traces of the plaque have just been brushed away.

2.3 Neglect of oral care always results in expensive dental treatment

Unless plaque is removed by brushing each day, the person is going to suffer damage to their dentition and possible loss of teeth from gum disease and decay.

Loss of bony support for the teeth

The toxins from mature plaque cause damage to the fibres that attach the gums to the teeth. Unless repair happens faster than the rate of destruction, the crevice between the tooth and gum deepens. The underlying bone may recede and tooth eventually become mobile. Mostly this happens without any pain, but sometimes bacteria may cause an abscess and severe pain.

Tartar (calculus) deposits

Calculus is a mineralised deposit around the gum margins of the teeth. The most common place is the teeth at the front of the mouth, and the upper chewing teeth where the salivary ducts enter the mouth.

Calculus prevents all the plaque from being removed by a brush. For a dentist or hygienist to remove tartar from around the gum margins is never comfortable, and may require the same level of pre-medication of anaesthetic as the treatment of tooth decay.

Phenytoin (Dilantin) enlargement of the gums

A fibrous enlargement of the gums which makes them enlarged between the teeth is induced for about 50% of the people taking this anti-epileptic medication. Unfortunately, this can only be corrected by surgical intervention, and may recur within a year.

2.4 The dependent person always suffers personally and financially

People with special needs are often more vulnerable to dental problems, especially gum disease. This affects them personally, socially, and financially.

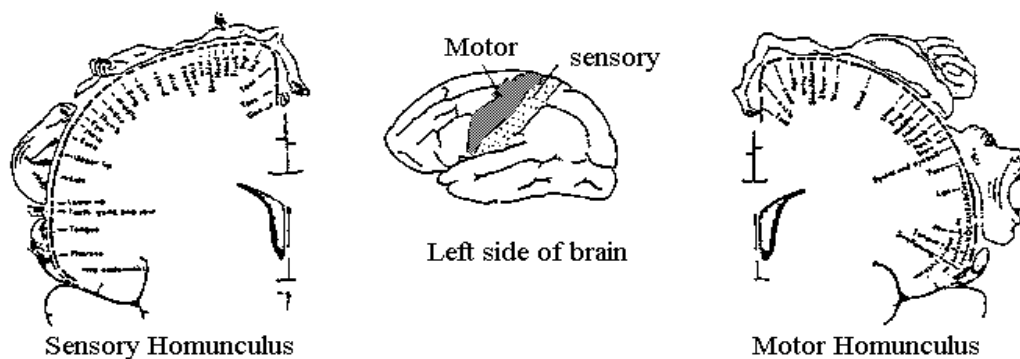
Commonly, the teeth to be lost are at the front of the mouth. This adversely affects appearance, speech, and may predispose the person to dribbling.

Dental care costs the individual money, even those who are on benefits. This can be a significant financial burden for them.

People with Trisome 21 or Down's Syndrome are more vulnerable to tooth loss from gum disease if oral care is not carefully maintained. This is because they have a deficiency in the way their white blood cells (neutrophils) track and destroy bacteria that invade the tissues. Those with crusty eyelids, skin problems, susceptibility to ear and chest infections, also tend to also be more vulnerable to progressive gum disease.

3. THE SENSITIVITY OF THE MOUTH

How we sense ourselves is represented by the sensory homunculus (on the left) below.



Look at the proportion of cells in the grey matter of our brains (the cortex) receiving touch, pressure and vibration information from just the hand, especially the thumb. No wonder babies prefer to suck their thumbs over other digits!

Look at the proportion of cells in the cortex receiving information from within and around the mouth - especially the large lips, tongue, front teeth and gums and pharynx. This means that touch, pressure, or vibration within the mouth will feel hugely magnified. Discomfort from a dry mouth can be very annoying. Because the lips and gums at the front of the mouth are so sensitive, this will be the part of the mouth most difficult to clean comfortably, and the part that many people who are intellectually handicapped avoid brushing.

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The huge sensory input from the mouth helps to explain tooth grinding and clenching, and why a person may persistently scrub the teeth too vigorously during brushing. There is a lot of self-stimulation from these activities. It also helps to explain some of the more unusual habits such as self-induced regurgitation.

3.1 Three things that all people must do before brushing the mouth of someone else

1. **Brush your own teeth (especially with a motorised toothbrush)**
2. **Brush another person's mouth so they can assure you in words that you are gentle and thorough enough.**
3. **Experience what is like to have your own mouth brushed by someone else.**

This is so that you can appreciate the effects of the feed-back loop that operates in our bodies between sensation and control. When you brush some-one else's mouth s/he does all the feeling, and you do the motor control of the brush. The only feed back will be through words or signs such as sounds, movements, or gestures.

It is important that you know that you are gentle and thorough enough before you brush the mouth of person who cannot do this for him or herself. A person who cannot speak may move or vocalize, but this may or may not indicate how comfortable the oral care is.

3.2 Try the following experiment when you are in the role of the dependent person.

When a person is brushing your teeth with a manual toothbrush, using small massaging movements around the gums, try moving your head and biting them as some of the more dependent residents will try to do. Even though the person brushing is trying to be gentle, your head movements will make it very difficult for them to make the experience feel comfortable. Next do the same thing when the person brushes your mouth with a motorised toothbrush. The latter experience is often more pleasant, because and the brusher can concentrate on placement, even when the mouth is being moved! The motorized brush action will do the small ones.

3.3 Objectives of daily oral care

To remove bacterial plaque from around the teeth and gums before the biofilm:-

- causes marginal gingivitis with bleeding gums
- forms mineralised plaque deposits
- causes loss of support for the teeth from gum recession and bone loss
- causes fibrous enlargement of the gums for people on phenytoin (Dilantin)

4. TEN HANDY HINTS ON BRUSHING THE MOUTHS OF DEPENDENT PEOPLE

1. **Never brush the mouth of another person until you have done the 3 things outlined in Section 3.1 & Never put your fingers between the teeth!!!!!!!!!!**
2. **Let the person know you are about to brush the teeth.** It is helpful to let a person know by speech, gesture, and touch (eg. on the hand unless s/he is blind) what you intend to do. If you immediately approach the mouth with a toothbrush without warning you will elicit a very strong defensive reaction – possibly even lashing out, punting or biting especially with dementia

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3. **Use only a smear of toothpaste.** Too much paste makes it difficult to see what you are doing and many people do not or cannot spit out.
4. **Brush only where you can see what you are doing.** This will nearly always mean that you need to put a gloved hand in the other person's mouth to deflect the lips and cheeks. Blood and saliva are body fluids that may be infected with fungi if the mouth is dry, or with Hepatitis B, HIV. It is also wise to wear some sort of eye-protection in case the person spits.
5. **Deflect the lower lip to see the lower front teeth.** Some people will tighten their lower lip so that access to brush the lower front teeth is almost impossible. A firm grip on the lower lip is not uncomfortable and can overcome this problem.

Never grip a person's lower lip until you have done the following

1. **Had another adult show you how it feels as pressure is applied to the point of discomfort. A firm grip does not mean it is uncomfortable.**
2. **Firmly gripped the lip of someone else who can tell in words how it feels as you progressively apply more pressure. The grip needs to be strong enough to stop the person from slipping from your grasp or flicking their head from side to side, but still comfortable.**

6. **Usually, a motorised tooth brush is easier to use than a manual one.** This is because it allows you to concentrate on the placement of the brush in the correct place without having to also do the many small blocked movements needed to move a manual brush. If the person moves the head during brushing a motorised brush is much easier to follow it with correct placement of the brush head. Motorised brushes tend to have smaller heads which make access and seeing what you are doing much easier.

WARNING: For patients (e.g. those with brain injury or cerebral palsy) who bite use only the Broxodent Power + (www.broxo.com) other models use polystyrene brush heads (eg. Braun rotary brush heads) that may snap off and lodge in the back of the throat obstructing the airway.

7. **Switch a motorised brush on after placing it in a person's mouth.** This stops toothpaste from splattering everywhere, and the noise of the brush may startle them unnecessarily. Even if it is not switched on, the smaller head of a motorised brush will make brushing easier. Do the same before removing the brush. This will prevent saliva or blood being splattered everywhere.
8. **Aim to brush the junction of the gum and tooth around the mouth.** This is where the plaque grows. If you can see a rim of whitish plaque it is at least several days old.
9. **Bleeding gums do not mean you are necessarily hurting the person.** Usually bleeding gums merely indicate that the gums are inflamed because of mature plaque or tartar (calculus) deposits. If the bleeding persists a visit to the dentist is usually indicated for scaling of tartar deposits.
10. **Start in a different place each time if the cooperation is limited.** If the cooperation only allows you to partly complete brushing the mouth, start in a different place so that each day the whole mouth has been brushed once. Sometimes another staff member is required to restrain hands. Note: the back of the mouth is less sensitive than the front, the outside surfaces less likely to cause gagging than the inside; the inside upper less likely to fill the mouth with saliva than the inside lower.

5. HOW TO CLEAN THE WHOLE MOUTH WITH UNCOOPERATIVE PEOPLE

Start in a different place each time if cooperation falls off quickly. Don't be rough!

The 3 best places to start are the most vulnerable to gum disease, and are the easiest to get at.

1. The bottom front gums behind the lower lip (*teeth together*)
2. The lingual (tongue) surfaces of the bottom front teeth (*teeth apart*)
3. The top front gums behind the upper lip. (*teeth together*)

Places that can only be brushed with the mouth open

The biting (occlusal) and inside (lingual) surfaces of all the teeth

Places that can only be brushed with the mouth closed

Upper and lower gums at the front and the sides of the teeth, especially the uppers.
Note with the teeth clenched, it is not possible to push a toothbrush too far back in the mouth because of the upright part of the lower jaw (ramus) at the back of the mouth.

6. ASSESSMENT OF THE ORAL CARE CAPABILITIES OF RESIDENTS

6.1 Effective oral care is complex

The mistake that many people make is that oral care is as easy as getting dressed, or feeding oneself. Oral care is actually much more complex and the consequences of poor oral care are very expensive and may have irreversible outcomes for the individual concerned. Six things are needed.....

Oral care has five physical aspects:

1. **Gripping**
2. **Placement**
3. **Orientation**
4. **Movement**
5. **Stamina**

1. If a person has difficulty picking up and gripping a toothbrush an elongated or larger handle may help. If unsuccessful that person will need someone else to brush his or her teeth.

2. People who successfully hold a brush but place it in only a few places around the mouth will still need someone else's help, at least until they have learned to reach every part of the mouth.

3. Once the brush is in the correct place it is important that the bristles are oriented correctly towards the gum margin. This is actually more difficult than it might appear.

4. The person will need to move the brush in small stop-start movements. A person who can reach all the areas but not move the brush well, can be aided by using a motorised toothbrush. (see the section below for the effect of sensory input)

People who need their mouths brushed for them may find that an electric toothbrush is more comfortable, and the carers assisting them will find that it is easier to use as long as they have gone through the 3 steps in section 3.1 at the top of page 4.

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5. Some people with organic brain conditions such as Multiple Sclerosis have chronic fatigue made worse by small stop start movements. Fatigue correlates well with the amount of plaque around the teeth in MS patients, better than ability to manipulate the brush. For any patients with fatigue, a motorised toothbrush is recommended.

Regular oral care has two mental aspects:

- 6. Memory**
- 7. Motivation**

6 & 7 Some people capable of effectively cleaning their mouths either don't remember to brush their teeth, or can't be bothered. Conditions affecting memory such as Alzheimers or conditions affecting motivation such as depression or treatment for psychosis with some major tranquillizers will affect the regularity of brushing.

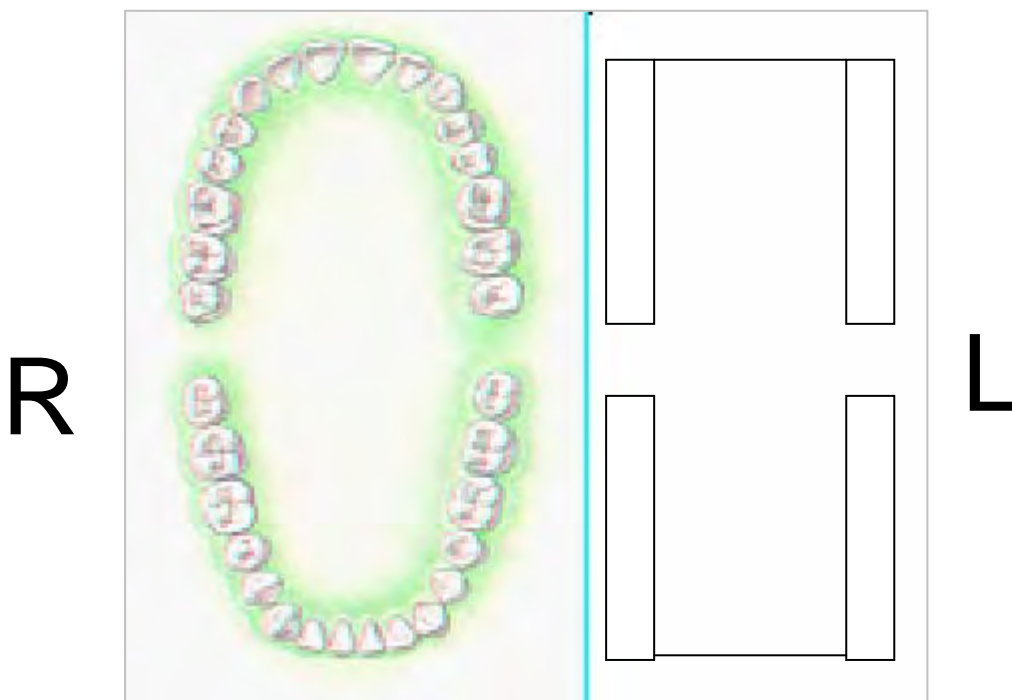
The regular input of another caring and interested person may be very important. There are a few persons from residential situations who keep on doing an effective job with oral care because some-one they like takes an interest in their achievements and praises them or shows them where they have missed brushing.

6.2 Assessing the Oral Care Capabilities

This can be done by anyone.

The process involves a brush without paste so you can see clearly.

The mouth is schematically divided into the front and side teeth for each jaw - six segments altogether called "sextants". The canine teeth (third tooth from the midline) form the boundaries of the front teeth. Each sextant of the dental arch has an outside and inside surface and there are also 4 biting surfaces. In total this adds up to 16 places that the person has to physically get the brush to. Where there are no teeth in a particular sextant, the total number of places to be brushed reduces by at least two for each sextant missing; eg. if a person has an upper denture and lower natural teeth, the total number of places to be cleaned is 8.



- Give the person a brush without toothpaste and ask him or her to clean the teeth.
- While they are doing this, map where they actually brush,
- Chart this on a diagram like the one shown above using marks or ticks
- If a person can clean nine (9) or more places s/he is independent.

- If not s/he will need assistance with brushing from a staff member each day.

7. THE MOST COMMON ORAL CARE PROBLEMS FOR PEOPLE WITH SPECIAL NEEDS

The most common sorts of problems in rank order of occurrence are:

- a. Inability to thoroughly clean their natural teeth or dentures by themselves
- usually because of poor co-ordination or inability to learn often made worse by reduced motivation or short term memory deficits
- b. Medication side effects
- c. Certain habits such as tooth grinding (bruxism).

7.1 The inability to thoroughly clean their own teeth or dentures

The great majority of people with special needs who remain in long term care in the community cannot clean around the whole of the mouth. Some manage to clean about a quarter of their natural teeth. Those who clean their own dentures don't do much better. This results in bacterial plaque becoming old and thick enough to be seen easily around the tooth margins as a creamy rim of biofilm adjacent to inflamed gums.

People often have bad breath, and their gums bleed when brushed.

The inflamed gums develop deposits of tartar within the crevice between the tooth and gum (sub-gingival calculus). These deposits protect anaerobic bacteria from exposure to oxygen and they destroy the attachment of the tooth to the bony socket. As well, the removal of these deposits is uncomfortable, and may require sedation or a general anaesthetic for a dentist to remove them. Without follow-up ward care, the treatment is useless and the tartar returns and the destruction continues.

Rapid tooth-decay can develop under bacterial plaque that is not removed from one week to the next. The speed of destruction is increased when there is decreased flow of saliva. Saliva is best thought of as the tooth in a liquid form. The teeth are bathed in this saturated solution made of the same minerals so that damage from bacterial acids can be repaired. Thick plaque slows down the repair process, and a dry mouth from medications compounds the problem. A dentition can go from no decay to most teeth decayed in a matter of months!

If the residents have depression or a psychiatric condition they may not be motivated to clean their own teeth even if they are capable. Tardive dyskinesia, dystonia, and parkinsonian tremor may compound their other problems with oral care. Capable long stay residents may respond well to personal interest, but self-care falls off when such interest is withdrawn.

7.2 Oral problems associated with medications

A. Dry Mouth

The psychotropic medications (anti-psychotics, tricyclic anti-depressants, long-term Lithium) and the prophylactic anti-parkinsonian agents all act to block parasympathetic stimulation of the salivary glands (See Table1). Because they cause dryness they are called "xerogenic" medications. There are far more than these though and over 200 medications are known to cause a dry mouth.

More than 80 percent of persons on these medications will experience some degree of dry mouth. The prescribing of a number of xerogenic medications (those that cause a dryness) can leave the mouth totally dry.

Persons may show increased thirst, but they will complain usually only if their mouth is uncomfortable from ulcers or cracks at the corners of the mouth from thrush infection secondary to the dry mouth. Two obvious signs of a very dry mouth are when the lips are crusted with dried out protein, or the teeth stick to the lips when speaking.

Reduced salivary flow goes with:

1. Irritation of the mucosa lining the mouth from chewing food and from dentures. The major tranquillisers also produce changes in the health of the oral mucosa because of depletion in B group Vitamins especially Folic acid and Riboflavin which are metabolised faster.
2. Reduced taste of food; constipation; dry, gritty, and sometimes burning eyes, & blurred vision; dry throat; dry nose; and for women, vaginal itching, burning, and recurrent fungal infections.
3. Increased intake of fluids. When the mouth and pharynx dry out a reflex is activated which stimulates an individual to take fluids. If these are sweet the person can gain weight and decay their teeth very rapidly.
4. More rapid decay of the teeth because bacterial acids are not neutralised. Most persons respond to a dry mouth by increasing their use of lollies and chewing gum, and increased amounts of sugar.
5. Rapid disease of the gums and bone supporting the teeth. This is compounded by heavy smoking (more than 30 cigarettes a day) which suppresses the body's immune response. In the mouth this is associated with rapid loss of attachment of the teeth within their sockets to produce "pocketing" and with loss of bone around the teeth.
6. Poorly retained partial or full dentures because there is no fluid to provide "suction" and because muscle control may be affected by medication, or by involuntary movements such as parkinsonian tremor or tardive dyskinesia. Reduced motivation and co-ordination also mean dentures are likely to be coated with plaque.
7. Increased bacterial growth within the mouth and a tendency to oral candida (thrush). Saliva contains antibodies, especially IgA which inhibit bacterial colonisation. Reduced salivary flow results in an increase in monilial infections, fissuring of the lips and corners of the mouth, and a sore tongue.

B. Movement Disorders

The long-term use of psychotropic medications may be associated with parkinsonian tremor, cog-wheel movements of the arms, and the characteristic shuffling gait.

Long term use of major tranquillisers has resulted in tardive dyskinesia for many people with chronic mental illness. These movements may be as minor as "worm-like" contractions of the intrinsic muscles of the tongue through to severe dyskinetic movements affecting the mouth, eyes, neck, limbs and trunk. The typical sweep and thrust of the tongue can dislodge full lower dentures, and constant clenching of the jaws may result in ulcers under dentures. Hopefully, new medications and more careful poly-pharmacy this will reduce the prevalence of this with time.

7.3 Certain Oral Habits

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All human beings clench and grind their teeth, especially during dreaming when asleep. This may cause a person to complain that all their teeth feel "on edge" and painful to cold. A few may experience muscle spasm and severe discomfort around the temporomandibular joint when opening the mouth. Some dentists have theorised that this is to sharpen the teeth as weapons. Certainly, we clench and grind with more force and more often when we feel pressured or threatened.

A number of severely handicapped people may regurgitate food and the teeth may be quickly eroded and decayed by the stomach acid.

8. SOME COMMON COMPLAINTS:

8.1 Oral pain: People almost never fake oral pain. Some people may be in pain but not report symptoms early e.g. those with autism. Being upset when having hot or cold foods is a clue, hitting the face can be a clue to toothache, or pain from clenching and grinding.

Oral pain, includes painful gums, teeth, tongue, throat, salivary glands and tonsils, temporomandibular joint, muscles of mastication, sinus.

CARER'S ACTION

Phone for an appointment with the Special Care Unit between 7:30 am & 9.00 a.m. each day, or with a private practitioner. If there is no appointment space that day the receptionist will often wait-list the person and fit them into a cancellation.

8.2 Facial Trauma: Whether from violence or epilepsy or, rarely, self mutilation.

A dentist will often be able to provide definitive care for fractured teeth, lacerated skin and mucosa around the mouth, or suspected facial fractures. The knowledge of anatomy and analgesia means that they need for suturing is often better assessed and accomplished by a dentist than a doctor.

CARER'S ACTION

Contact the Special Care Unit or Public Hospital and say the person has suffered trauma. The person will be seen at once or as soon as is practically possible. If a private practitioner is phoned enquire how quickly they can be seen. Don't just turn up!

Use the emergency department in the hospitals after hours, or a GP's after-hours practice.

8.3 Dry mouth: This is a frequent medication side effect.

The person may complain of a dry mouth, thirst, difficulty swallowing food, lack of taste, and constipation.

CARER'S ACTION

Refer problem to the doctor to check on the cause, and for review of medication if this is appropriate.

Recommend that the person uses non-sugar sweetened beverages such as "diet" soft drinks, an artificial sweetener such as "Equal" and chews sugar free chewing-gum; e.g. "Extra". A straw reduces damage to the teeth by directing the flow of fluid to the back of the mouth. Low fat milk can be soothing. "Dentacal" moistener (www.nsidental.com) has calcium phosphopeptide to help coat mucosa. It is very effective.

TABLE 1. RANK ORDER OF XEROGENIC POTENCY OF CNS AGENTS

The order of decreasing xerogenic (causing dryness) potency runs from top to bottom of the page. ALL the drugs below are known to cause a dry mouth.

CATEGORY	GENERIC NAME	TRADE NAME
Anti-Muscarinic	Scopolamine	
	Atropine	
Anti-Parkinsonian	Benzotropine	Cogentin
Tricyclic Antidepressant	Amitriptyline	Amitrip
	Laroxyl	
	Tryptanol	
	Doxepin	Anten
	Quitaxon	
	Nortriptyline	Allegron
	Norpress	
	Imipramine	Imipramin
Anti-Psychotic	Thioridazine	Melleril
	Chlorpromazine	Largactil
	Perphenazine	Trilafon
	Trifluoperazine	Stelazine
	Haloperidol	Serenace
Anti-Emetic	Prochlorperazine	Antinaus
		Stemetil

Compiled from Table 5, American Psychiatric Association Task Force Report 18, "Tardive Dyskinesia". 1700 18th St, N.W. Washington, D.C., 20009, Dec. 1979, pg 18.

9. NEW RESIDENTS

9.1 Things to OBSERVE and ASK about:

1. Does the person have ANY NATURAL TEETH?

- If s/he has any natural teeth, where are they in the mouth? - maxilla? mandible?
- Can the person clean them thoroughly? Are they coated with "visible plaque", a whitish rim of material around the gum line of the teeth? Mature plaque like this is at least 10 days old. Find out why it has been there for so long.
- Is it because the person....
 - habitually missing parts of the mouth?
 - poor motivation and not being bothered?
 - not remembering?
 - not having a brush and paste?
- Does the person have oral habits such as grinding, finger sucking, regurgitation?
- Does the person experience any discomfort from the teeth?

2. Does the person have ANY DENTURE/S?

- Do they have partial or full dentures.
- Does an upper denture drop when the person is speaking?

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- Does a bottom denture move within the mouth? Is this because the tongue has the involuntary movements of Tardive Dyskinesia, or the rigidity and tremor of Parkinsonism or both?
- Are the dentures clean or coated with "visible plaque" and a yellowish deposit of tartar? Is the person's name on each denture?
- Does the person experience any discomfort from the denture/s?

3. Does the person have DRY LIPS AND MOUTH?

- Are the lips crusty and dry?
- Do they stick to the front teeth when the person talks?
- Does the top denture feel loose?
- Does the person complain of a dry mouth? This may occur after some medications (see tables 1 & 2); eg. Tricyclic Anti-depressants.

4. Does the person have CRACKS AT THE CORNERS OF THE MOUTH?

These cracks (angular cheilitis) are commonly associated with a loss of the vertical dimension of the face because of shrinkage of the gums under dentures. They may also occur with a dry mouth in someone with their own teeth. It is usually fungal in cause, but may be aggravated by depletion of the B Vitamins, Riboflavin and Folic acid, which commonly occurs with high levels of psychotropic medication. The tongue may also be smooth and beefy red if candida is more widespread.

9.2 CARER'S ACTION

1. If the person has ANY NATURAL TEETH

Arrange for the new resident to have a dental check-up once settled in, or within a year if s/he has been seen regularly to date.

Assess whether the person is dependent in relation to oral hygiene. Look to see if there is a rim of whitish "visible plaque" around the gum margins of the teeth. Such a bacterial deposit must have been present for at least a week to be visible, and the gum margins will usually be inflamed and bleed when the mouth is brushed.

The presence of visible plaque may indicate either that the person is not motivated to clean them, or forgets to clean them, or habitually misses parts of the mouth, or all three. This can be checked by a nurse (see Assessing oral care capabilities on pg7).

2. If the person has ANY DENTURES

These can permanently be named at a dental technician or marked in a temporary way in the residence:-

Permanent

Naming involves typing the person's name and initials, or driver's licence number on tissue paper and setting this under clear acrylic in each denture. The process is simple and can be done while the person waits, or between meals if necessary. Place the denture/s in an envelope with the person's name and initials clearly printed on it.

Temporary

Clean denture with fine abrasive disk or fine emery paper

Wipe with alcohol and allow to dry

Name with pencil or laundry marker

Cover with clear nail polish

Usual sites are palate of upper and lingual flange of lower F/F because the posterior ½ to 1/3 remains intact if in a body which is burnt. If out of the mouth all is destroyed

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If the upper denture drops during speech and eating, arrange for a dentist to examine the person. The denture will usually require rebasing to make it fit properly. If the person is in a secure ward, the dentist may be able to visit the ward.

If the lower denture moves this is commonly because of the bucco-linguo-masticatory (BLM) movements of Tardive Dyskinesia (TD), or Parkinsonian tremor or both.

3. If the person has DRY LIPS AND MOUTH

Refer to doctor or dentist to find out the cause.

Review current medication if this includes drugs known to cause a dry mouth.

If the person has natural teeth obtain 5000ppm F toothpaste (e.g. Colgate Neutrafluor)

Recommend and if appropriate arrange for non-sugar sweetened drinks if the person is thirsty.

4. If the person has CRACKS AT THE CORNERS OF THE MOUTH

A course of anti-fungal cream is usually indicated (eg. Daktarin). There may also be localised fungal infection under any dentures which requires treatment with an anti-fungal gel. Dentures should be removed at night and soaked in a bleach or "Steradent" solution.

10. KEEPING THE MOUTH HEALTHY

10.1 Care of the natural teeth

Persons in with special needs are extremely vulnerable to oral problems with their natural teeth because of inability to clean their own mouths. Poor motivation, poor memory, and medication side-effects may compound the effects of this poor self care.

CARER'S ACTION

Make sure that residents who are unable to clean their own mouths adequately are assisted by staff (who know what they are doing) at least once a day.

Regularly check that residents capable of brushing have a brush and fluoride toothpaste and actually use it.

Residents with root-surfaces exposed should use 5000 ppm F paste after a meal e.g. breakfast. A "Tartar Control" toothpaste such as Colgate "Total" reduces the rate of tartar build-up in the mouth. 0.2% Chlorhexidine gel (e.g. Colgate 0.2% Periogard gel) is helpful for bleeding gums as is "Baking-Soda" toothpaste.

Ensure that people have their teeth examined by a dentist at least once year, and that they attend for any treatment.

10.2 Care of Dentures

Most people with special needs tend to clean their dentures poorly. If they have a dry mouth as well they may be susceptible to recurrent low grade candida infections associated with reduced salivary flow. This is often accompanied by a yeasty smell to the breath. It pays to have a time when all dentures are checked and cleaned by staff. I suggest that bath-time is the best time to do this (see below).

CARER'S ACTION

Ensure that ALL dentures are named.

Dentures should not drop when the person speaks. Phone for a dental appointment if dentures are loose. The tongue movements and munching of the jaws associated with Tardive Dyskinesia can dislodge dentures and make the lower denture in particular seem to be loose.

Cracked lips, or corners of the mouth usually indicate a candida (thrush) infection. Soaking dentures each day in bleach and antifungal treatments (eg. Daktarin or mycostatin) are the best way to resolve this.

Dentures can be soaked overnight in diluted bleach solutions (e.g. Milton's) or in solutions such as "Steradent". However, some persons become concerned that their dentures will be stolen! One way to get around this is to soak dentures in bleach (Milton's) for the short time that people are in the bath or shower. The dentures must be rinsed very thoroughly under running water until not slippery to remove any traces of bleach and given back to the person.

Carers should change the Milton's daily, and safely store it in a labelled opaque container with a lid. A used and clearly labelled icecream or yoghurt pottle may be suitable for this. However, this must be supervised - bleach must not be swallowed by residents!

Tartar deposits can be softened and dissolved by using a 1:1 mixture of white vinegar and water for soaking. This is very effective and does not damage denture acrylic.