Oral Health for Adults in Care Homes

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 19/01/2016 **email:** **OralHealthResidential@nice.org.uk**

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice? Please say for whom and why. 2. Which areas will be challenging to implement? Please say for whom and why. 3. Would implementation of any of the draft recommendations have significant cost implications? 4. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 5. What type of information would enable you to make a convincing case for money to be invested in improving oral health in residential care homes? 6. An education and oral care programme over 2 years led to an improvement in the dental plaque index of 0.28 scale points, in gingival score 0.29 scale points and in denture plaque index 1.16 scale points. The education component cost £7.50 per resident and the cost of providing oral care £371 per resident. Do you consider this good value for money. If yes, why? If not, why not? See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Faculty of Dental Surgery, Royal College Of Surgeons of England

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Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Nil applicable
Name of commentator person completing form:	Dr Selina Master Specialist in Paediatric and Special Care Dentistry and Board Member Faculty of Dental Surgery Dr Vanita Brookes Consultant in Special Care Dentistry and Board Member Faculty of Dental Surgery
Type	[office use only]

Comment number	**Document** (**full** version, **short** version or the **appendices**	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	Full	16	45	We are concerned that this recommendation may imply that ……..
Example 2	Full	16	45	Question 1: This recommendation will be a challenging change in practice because ……
Example 3	Full	16	45	Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact…….
1	Full	7	4,10, 14, 27	Question 1: The areas which will have the biggest impact will be: • Provision of oral health care education for the care staff which will raise/increase awareness of the need to address oral health issues • Provision of adequate and effective daily oral care by staff and family, which will help to reduce the risk of caries, periodontal disease, pain and infection for residents. • Use of a standardised, validated oral care assessment tool as part of the initial health assessment by staff which will identify issues/concerns at an early stage • Each residential home to have a designated contact and commissioned service with one dental practice and community dental service for provision of specialist care, which should enable easy access to emergency care and continuity of care with regular oral/dental reviews.

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2	Full	11	3,6,7	Question 2: It will be challenging to implement the educational packages for the care staff due to current demands on their time, competing priorities, on costs of replacing staff whilst attending training and finally; rapid turnover of staff. Some staff may not be comfortable with touching/accessing the oral environment. It can be challenging to alter individual beliefs and perceptions, which may impact on how the assessment is carried out and on the effective delivery of daily oral care. Additional challenges could be faced by the staff when residents refuse to have daily oral care. This should be addressed within Care Home Policies. Oral care should be seen as part of the whole daily care package and should not be treated differently. This is one of the key parts of training, inclusive of respect and dignity, but recognising the importance of oral care and the consequences of lack of daily support. Training should encompass active support for care home staff) to enable effective cleaning of the oral cavity when a resident may be reluctant or resistant to receiving oral care.

3	Full	4 10 11	1.1.5 8,15,22 11	Question 3: Although use of the Oral Health Assessment Tool as part of the first Health Assessment could be delivered relatively cost effectively as a combined assessment, we recommend commissioners consider the following in relation to the cost implications of the draft recommendations: • The cost of providing emergency care is significant in terms of unplanned domiciliary visits. • Provision of domiciliary care, both planned and emergency needs to be costed into commissioning packages. • Commissioners should be aware that generally General Dental Practitioners can only provide basic care packages and will need to refer on patients with complex needs to community dental services for access to specialist care and specialist equipment. • The Oral Health Education packages should be commissioned from a dental source, ideally from the local Community Dental Service, or from a group general dental practice with the relevant experience. • Systems should be in place for enabling the reporting of concerns regarding dental services and protection of residents. They can be very vulnerable both in their own homes, and also within nursing and residential care and there are examples of expensive private but basic or poor quality care being provided. **Further cost implications:** There are currently 11 million over 65's in the UK, a figure that is set to increase by to 14 million by 2032. [i].This means that there will be an increasing number of factors to consider when addressing the oral care and needs of older people: • There will be more people retaining their teeth, who will therefore be more likely to require complex restorative care in order to maintain them. • They will experience more pain and active decay, with periodontal problems more common. • They will need more help in maintenance and recognition of oral problems • They will have more long term medical conditions which could affect delivery or treatment such as dementia, diabetes etc. As a result, they will experience other problems such as dry mouth (e.g. side effects resulting from medication) which will impact on maintenance and delivery of good oral care. • There has been a rapid increase in the prevalence of oral cancer, with numbers increasing in the UK by a third in the last decade. • Younger adults living in residential care due to physical or mental health problems and /or learning disabilities which prevent them from living independently. These also need to be addressed with regard to their oral care needs.

4	Full	6 5 29 14 7	1.3.2 1.2.1 Point 6 10	Question 4: We suggest users would be able to overcome any challenges through the following: • An example of existing practical resources is the use of family and friends who are willing and able to support oral care. This is a system which is already in place in Europe. Clearly, this is not available for all residents but by changes in cultural practices, it would be possible to reduce the input required for at least a percentage of residents. There are other benefits in that the person receiving the oral care will often be more receptive to familiar faces. • Using current examples of good practice, i.e. standard templates of policies, oral care plans. • Including individual oral health information on the Health Passport would be incredibly beneficial for sharing information concisely and effectively when a resident is transferred, for example from hospital to residential home or within a dental team (dentist/hygienist) or when referred in from a GDP for specialist care. • The way in which the training package is developed and delivered is critical to how effective it will be and how the challenges will be overcome. • Training to include how to use 'Active Support' (see point 2 above) which would help staff in the delivery of oral care for residents who are less co-operative. • Training to include information on what signs to look for which might indicate presence of pain or infection. • Perhaps involving staff in planning a training programme would create ownership and ensure all relevant areas are covered and addressed. • Collaboration with other services (e.g. social services and education) and integration wherever possible with general medical care should be considered. • Local clinical network for Special Care Dentistry to develop local oral health strategy for oral of residents in care homes • Development of a CQUIN to ensure the implementation and monitoring of oral care for residents in care homes.
5	Full	26 33	16, 17 8	Question 5: We suggest the following information could help to make a convincing case for money to be invested in improving oral health in residential care homes: • Present the cost of a domiciliary visit and the cost of hospital care for a resident who acquires aspiration pneumonia as a result of choking. These calculations can then be used as part of a formal cost benefit analysis to review the options. • Research to show how poor oral health is linked with other medical conditions. • Development of appropriate validated quality outcomes related to the care of older adults. • Research on quality outcomes and effectiveness of regular application of Fluoride Varnish

6	Full	25 10	14 3	Question 6: We believe the case study represents excellent value for money. A total cost of £379 for a resident to have daily oral care for a 2 year period, which includes the educational cost for the staff, equates to £189.50 annually. The cost of NHS Band 3 is more than this amount. The cost of one emergency NHS domiciliary visit to include nurse, dentist, administrative, material and equipment costs would be a similar amount. However, more importantly, appropriate quality of life outcome measures should be developed including absence of pain, infection, ability to smile, eat and communicate effectively, reduced life expectancy etc.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

[i] Public Health England, *Oral health of older people in England and Wales*, January 2016