UK Oral Care Conference 2010

Oral Care as Therapeutic Care

Claire Fuller, Speech and Language Therapist
Clinical Lead in Dysphagia, Nutrition Support Team – BCUHB
Arfon Acquired Brain Injury Unit, Colwyn Bay
St Cyril’s Rehabilitation Unit, Chester
Introduction

- What is therapeutic care?
- Dysphagia and oral care
- Whole body approach
- Case studies
Therapeutic oral care is ......

A facilitative approach that enables effective oral care/assessment through “normalising” muscular balance and sensation.

This aims to reduce risks of intolerance to oral care resulting in increased risk of discomfort, infection, under or malnutrition and aspiration pneumonia.
Therapeutic Oral Care

- Aims
- Assessing
- Enabling
- Rehabilitation
- Prevention/anticipation
Assessing

- Hygiene and state of dentition
- Soft tissues
- Sensitivity
- Muscle tone
- Spontaneous movements
- Swallowing of saliva
- Communication (breathing)
Enabling –

- Access to mouth
- Removal of debris and secretions or food residue
- Hydration
- Tolerance of oral care,
- Decreased anxiety and negative associations with oral care
- Increased participation and independence
Rehabilitation-

- Managing secretions
- Swallowing function
- Tastes for quality of life
- Introduce oral intake
Prevention/anticipation -

- Slowing down loss of function
- Establishing good practice (surgery, treatments, end of life)
- Reduce risks in vulnerable groups
  - trauma, infection, under or malnutrition, dehydration, discomfort, challenging behaviour, dysphagia, aspiration pneumonia
Rationale

Why therapeutic care?

- Promote healthy patterns of movement
- Promote comfort
- Promote function
- Prevent unhelpful associated movements
Nutrition Support team

- Prevent unnecessary admissions to hospital due to malnutrition, dehydration, dysphagia
- Trouble shooting, training
- Multidisciplinary management decisions on difficult ethical dilemmas
- Promote choice, comfort, dignity, wellbeing
SLT role in NST

- SLT – assessment and therapeutic intervention
  1) Oral Care,
  2) Tastes for pleasure
  3) Swallowing rehabilitation, introducing oral intake (removing naso-gastric & gastrostomy tubes)
  4) Communication skills for mental capacity and participation in decisions
Rehabilitation Units

- Step down rehabilitation
- Medically stable
- Acquired brain injury
- Varying time since onset – 6 months to 20 years
- Varying degree of dependency and disability:
  Persistent vegetative state to high level cognitive impairment.
Complex clients with dysphagia

Often combine many issues:

- Cognitive difficulties
- Physical difficulties
- Sensory integration problems
- Enteral feeding (percutaneous gastrostomy (PEG), naso gastric NG)
- Nil by mouth
- Difficulty managing own secretions - some may have tracheostomy
Normal swallow

- Oral preparatory stage
- Oral executive stage
- Pharyngeal stage
- Oesophageal stage
Dysphagia

Breakdown at any one phase or combination of phases due to

- Muscular imbalance
- Sensory integration difficulties
- Co-ordination difficulties

=> Risks of malnutrition, deterioration of condition of mouth, aspiration and aspiration pneumonia.

Following pictures taken from “Evaluation and Treatment of Swallowing Disorders” by Logemann, J. A
Disordered Oropharyngeal Swallowing

1. Difficulty initiating swallow
2. Nasopharyngeal regurgitation
3. Pulmonary aspiration
4. Residual
Dysphagia and Oral care

- Modified diets
- Nil by mouth
- Managing secretions
- Reluctance/inability to eat/speak/open mouth
- Loss of function
- Psychosocial impact
Modified diets

Why?
- Edentulous
- Ill fitting dentures
- Dysphagia – inability to manage more challenging textures of food

Implications:
Oral supplements – high sugar content
Poor oral clearance of residue
Many studies linking aspiration pneumonia to ineffective oral care

- Dysphagia 1998 13(2) 69-81, Langmore
  “Predictors of aspiration pneumonia: how important is dysphagia?”

The best predictors were dependency for feeding, dependency for oral care, number of decayed teeth, tube feeding, more than one medical diagnosis, number of medications and smoking.
Breaking the cycle

Dysphagia

Loss of function

Poor oral hygiene
Oro-facial muscular imbalance

- Deviant swallowing patterns
- Malocclusion
- Overjet
- Anterior open bite
- Mouth breathing
- Drooling
- Unnatural facial expressions
- Dysarthria
- Gastropharyngeal reflux
- Hypersensitivity
- Hyposensitivity
- Dysphagia
- Bruxism
- Reduced quality of life
Whole body approach

- Bobath approach based on principles of normal movement
  - Bobath dentists in Japan
- Facial Oral Tract Therapy (FOTT) developed by Kay Coombes from these principles.

Kay is a Speech and Language Therapist and Director of the Association for the Rehabilitation of Communication and Oral Skills (ARCOS).
Therapy principles

- Know the normal
- Manipulate abnormal tone
- Promote *experience* of:
  - posture
  - patterns of movement
  - purposeful activities (function)

**NB. PREVENT UNHELPFUL LEARNING**
F.O.T.T. – Prevention & Facilitation

Goals

- Reduce secondary disability including oral deformity and extended head posture
- Facilitate breathing
eating and drinking
oral hygiene
facial expression
voice
Extension and flexion are normal patterns of movement that allow function.
Imbalance

- Extension and flexion patterns of movement are unhelpful when they move body out of alignment and do not allow normal function.
- e.g. extended head makes normal swallowing and selective jaw movements difficult and effortful.
- When one part of the body is out of alignment it has an impact elsewhere.
Alignment of pelvis

Normal alignment
90 degree angles
Good alignment
Anterior tilt of pelvis
Feet flat on floor

Reduced support
Posterior tilt of pelvis
Reduced stability
Seating: Background postural support

The influence of the pelvis is crucial.

Posterior tilt of pelvis has an unhelpful impact on

- Overall stability and so muscular balance
- Head & neck alignment (chin poked forward or head tipped back)
- Jaw posture
- Finely co-ordinated graded oral movements
Head & Jaw Support

- Reduce demand on neck as necessary
- Position for normal head-neck-shoulders alignment
- Practise nasal breathing
- Teach nose blowing as necessary
Hands-on therapy - head and jaw support grips

Diagrams reproduced with permission from Kay Coombes, ARCOS.

A) Helping from the side

B) Helping from the front
The Hungry Brain!

Seeks out stimulation wherever it can – can be helpful or unhelpful for learning function

Need to focus on how we provide intervention
Sensory integration

- Important to consider how client is able to process sensory stimulation
- Reduction in one sense – increased awareness of other senses and attention to these stimuli
- Startle responses
- Hypersensitivity to touch also linked to shortened tight muscles – muscular imbalance
Implications

- Sensory deprivation in mouth – reduced tactile and kinaesthetic stimulation but increased response to auditory, visual stimuli.
- Beware of sensory overload
  - Assess environment and your approach (slow movements)
  - Reduce other stimuli (speech, sound)
- Enable client to tolerate touch/movement
Hands: the route to the mouth

Is there ....

- spontaneous use of hands to face & mouth?
- tolerance of your touch to their hands?
- acceptance of guided contact of their hands to their face/other’s face?
- hand to mouth practise e.g. holding cup, finger feeding/licking, taking tissue to mouth?

If not – WHY?
Oral hygiene: facilitating function and interaction with environment

Supported sitting

- participation – hands (toothbrush, mouth)
- tactile information v verbal direction
- eyes closed = focused attention
Preparation before going near mouth

- Check postural alignment
- Check postural support
- Reduce other sensory stimulation – noise, talking, stroking hands
- Touch (firm press) distal to proximal (hands- shoulders – forehead, cheek, lip)
- Stretches to facial muscles working around jaw, cheeks, lips in a facial stimulation routine
Preparation before entering the mouth

- Facilitate person’s hand to touch mouth with guiding – support elbow and hand
- Involve person as much as possible through guiding (automatic opening of mouth through patterning)
- Oral stimulation routine—stretch inner cheeks, lips, stimulate gums, tongue and palate
Care Plan

- Individual care plan should detail routine and appropriate equipment/materials for person with dysphagia

  e.g. specialist toothbrushes (suctioning, small head with medium to soft bristles)

  low foaming toothpaste (without lauryl sodium sulphate due to foaming and drying effect)

  gels as opposed to mouthwash

  saliva replacement gel
Case Study - P

Severe brain injury following a fall aged 17 years.
Admitted to rehab unit following rehabilitation at his local regional rehab unit where he was said to have plateaued.
Nil by mouth, wheelchair bound and reclined, unable to speak but used communication aid. Not able to open mouth.
Enjoyed lemon glycerine swabs for flavour which were put in sides of mouth!
Intervention

- Initial short term goal to be able to access
  - mouth
  - postural and jaw support
  - facial stimulation
  - reduce hypersensitivity
  - lips, cheek and gum stimulation
  - brush outer surfaces of teeth
  - STOP lemon and glycerine swabs
- Medium term goal
  - Stimulate tongue
  - Stimulate palate and inner gums
  - Brush inner surfaces of teeth
  - Clean tongue and mouth
  - Introduce more appropriate tastes to be followed by oral care
- Long term goal
  - Guided self brushing of teeth
  - Tastes for pleasure
  - Better management of saliva
  - Small amounts of oral intake safely
Changes to presentation at Conference

Videos removed to protect patient confidentiality

Photos included with client consent for training purposes.
Outcome

- All goals achieved
- No chest infections
- Able to tolerate dental assessment and treatment
- Having puree meals and normal fluids
- Some speech

Takes time by carers to do care in a different (therapeutic) way but achieves function and participation.
79 year old man with Parkinson’s Disease in Nursing Home.

- Discharged from hospital NBM to Nursing Home
- No tube feeding in place
- Doctors said for palliative management
- Foetal position, contracted posture, unresponsive.
But ……

- He didn’t die
- Urgent call from nursing home
- NST SLT assessment and nasogastric (NG) feeding.
- He received all 3 packages of care
- 8 sessions in total:

Assessment,
Training in therapeutic care
Therapy.
Outcome

- Managing secretions
- Had oral intake for over a year (texture C diet – puree and slightly thickened fluids)
- NG tube removed
- made choices verbally from options offered
- enhanced quality of life sitting out in chair
- disease progressed and needed NG feeding again before his death.
Care plans

- Implement specific plan to address risks and safety for each person
- *How it is done is as important as what is done* – consistency for learning
- Documentation of care given
- Absence indicates neglect of care
Training

Managers aware of importance leading to
- Support for staff training
- Reducing risks for clients

Staff
- Knowledge to identify risks
- Skills to facilitate care and safety
- Promoting consistency, health, wellbeing, confidence and participation in care
Outcomes

- Therapeutic oral care creates opportunity for
- Assessment
- Facilitation
- Rehabilitation
- Prevention

People who would usually be seen as poor candidates for therapy are set up to succeed and do achieve goals.
Summary

- Team approach
- Promoting helpful patterns of movement and sensory feedback for learning/function
- Need for postural stability to feel safe and for function
- Positive anticipation and tolerance
- 24 hour therapeutic ethos
References

- Davies PM (1994) “Starting Again, Early Rehabilitation After Traumatic Brain Injury or Other Severe Brain Lesion” Springer Verlag, Germany (Chapter 5)


More available on request