Mouth Care Matters at GWH

As a previous ward sister for a 30 bedded stroke rehabilitation ward, I was very aware of the care needs of a complex and medically vulnerable group of patients.

One particular area of concern for me was the oral hygiene needs of these very patients. Especially those patients who were nil by mouth being fed enterally via a PEG or an NG tube. These patients were at high risk of aspiration pneumonia and poor oral hygiene. Seeing patients in bed in the Hospital who were very unwell, who were mouth breathing, on high flow Oxygen or with dysphagia who had no teeth cleaning products by their bed side upset me, seeing staff unsure and nervous when attempting to brush these patients’ teeth was frustrating but not a complete surprise to me.

Working alongside the ward staff to remove the days of built-up plaque and dried secretions was unpleasant for me and the staff and especially for patients and their families.

 What I didn’t know back then then was the direct link between poor oral health and the effects on systemic health. The aspiration of dirty mouth contents was contributing to the frequency of chest infections our Stroke patients were experiencing.

 I carried out a ward-based audit and saw that oral hygiene was being regularly missed in this patient group. Why was this? After the audit we implemented an essential nurse rounding tool to include oral hygiene as well as repositioning the patient and offering fluid intake and invested in an oral suctioned tooth brushing kit. At this time in 2019 the establishment I worked in was a social enterprise and staff had an enormous amount of autonomy to implement change locally. Oral health training was provided by me and the medical reps who supplied the products we used , and oral hygiene improved.

Several years later my role changed, and I had progressed to role of The Community Stroke Coordinator which meant I was the specialist nurse in the Community stroke team and responsible for completing 6 month stroke reviews for all patients in the area which now brings in a QCUINN.

 Working across the stroke pathway I still observed the challenges with maintaining good oral hygiene. This continued to be a concern for me and when the opportunity arose to join the Hospital Mouth care Matters working group, I jumped at the opportunity to join in. I found myself feeling very protective of this area of work and when Health education England provided a dental hygienist on an honorary contract to join us I felt frustrated at her input and apprehensive at losing my role. I had done so much work in this area previously, I felt I knew the way forward and how we could develop this thread of work. I had to acknowledge very early on that the only way to improve this aspect of patient care across the trust was to accept HEE help and work collaboratively with the wider team.

 3 years on the work we have achieved locally is impressive to say the least. Together We have written an oral hygiene policy and developed an oral hygiene assessment tool based on the HEE MCM publications. I have delivered training to most of the wards within our trust, delivered training to junior doctors, newly qualified nurses, at HCA induction and to all nutrition champions at the Hospital. I have presented at the consumables group to implement new oral hygiene products. I have helped with serious incident reviews and shared the learning at patient quality committee, and the nursing and midwifery committee. During patient world safety week my colleague and I shared the learning from a serious incident review that took place in 2021 whereby a patient in our care swallowed a lower partial denture. This clinical incident accelerated the importance of oral hygiene for the patients in our care and the importance of having accurate policies and procedures to support the learning and development of our staff. I have become an identified lead for the trust for oral hygiene and Mouth Care Matters. As a direct result of this involvement, I applied to be seconded to HEE/MCM as clinical training lead for the South West providing training to nursing and care homes , implementing the CQC requirements for the enhanced care home programme. I was successful in this application and now spend one day a week from my role as stroke coordinator delivering training to nursing and care homes across Swindon and Wiltshire. The role is varied, I have autonomy to deliver the training via any means I feel is appropriate and am an advocate for patients and their carers. I see such great work and enthusiasm across the board and all the staff I meet are passionate about delivering good quality patient care to their residents and service users. They are always shocked at how much they have learned from attending one of my sessions and as nurse I am able to give another perspective on what it is like to care for patients, that is completely different to seeing patients in clinical dental practice. I have an understanding, of the complications associated with trying to take frail elderly individuals from their homes to appointments and understand what it feels like to care for this group of people. This is where partnership working with dental Health professionals comes to the for front let’s consider visiting the frail and the vulnerable in their own homes, let’s consider doing this together to support each other, consider equipment that can be taken from the clinic into the community, this could safeguard community dental work for the future. Care regardless of what it is needs to be delivered closer to home. It needs to be patient centred and offer a positive lived experience for the individual. Many of my patients are house bound, they may have portable suction at home, they are never able to attend routine health checks. These patients are marginalised in terms of our own practice and not being able to meet their needs prevents them accessing care that others can access. These patients are the forgotten few. They are discharged home following illness and disability and are never expected to be seen in any clinic ever again and in some cases for the rest of their lives. Currently I am working with the housing team to rehouse a young woman with multiple comorbidities who is wheelchair dependent. If she can be moved to an adapted property, she will then be able to access hospital transport and attend future dental and health appointments. Prior to this she would have been written off at the age of 50.

Last week I presented some audit findings to our mortality and morbidity board, as a result of this the team are going to look at any deaths from pneumonia in the trust and track through the notes to see if an oral hygiene assessment was completed and to see if there was any evidence of oral hygiene taking place and if poor oral hygiene could have contributed to pneumonia diagnosis. This could give us data in the future which directly links poor oral hygiene to pneumonia.

One of the challenges with this workstream, is accessibility not only of products we use but also of the environment we need work in. External visiting professionals cannot walk onto a busy hospital ward or day unit and expect the staff to trust them and accept changes straight away. There is etiquette to follow and there are therapeutic relationships to build. As a senior nurse within the organisation, I have that immediate connection, the trust and the respect which works both ways. I understand the ways in which the wards work, how busy they are, when they take their breaks, where their stock room is, what their specialist areas are. This is why the hospital in which I work has worked well in implementing the changes in mouth care provision and education. Another element of difficulty for me was trying to engage the support of the Hospital oral dental and surgical teams in the Mouth Care Matters work. However, over the last three years I have become more appreciative of now specialist this area of work is, how highly skilled this team of professionals are and how over used the resources are. In that sense we are not a million miles apart in our professions and maybe we should share our resources and help each other out, we are all understaffed and undervalued.

The frustrations and the joy this work has brought to me professionally in terms of job satisfaction is huge. I have a passion for teaching and educating others and imparting not only the knowledge I have learned but the “tricks of the trade” that we collect over years of delivering essential care to our patients and their families. The frustrations for me are the infrastructures in place to prevent us working collaboratively, the lack of passion in others deemed to be leaders and managers. The lack of patient centred compassion and care to others that sems to be inherent in areas of poor leadership. This comes down to learning by example and shadowing of peers and more experienced staff. My hope is that Suggestions and advice will be listened to and taken on board by the staff I work with and can only hope they follow my suit.

 I begin by telling my staff that sometimes it is the smallest things we do, that make the biggest difference to someone. Cleaning someone else’s teeth is satisfying to me and hopefully to the person I am caring for. It can be a time for quiet contemplation and reflection and gentle chit chat. It is an intimate personal act not to be taken lightly or undervalued. It means that the person is clean, feels fresh and ready for their day. It might mean the person can now participate in eating and drinking and being sociable to the staff and their visitors. It can be the difference in someone having a last positive interaction with their loved ones at the end of life.

Mouth care matters to everyone.

Jo Prior

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