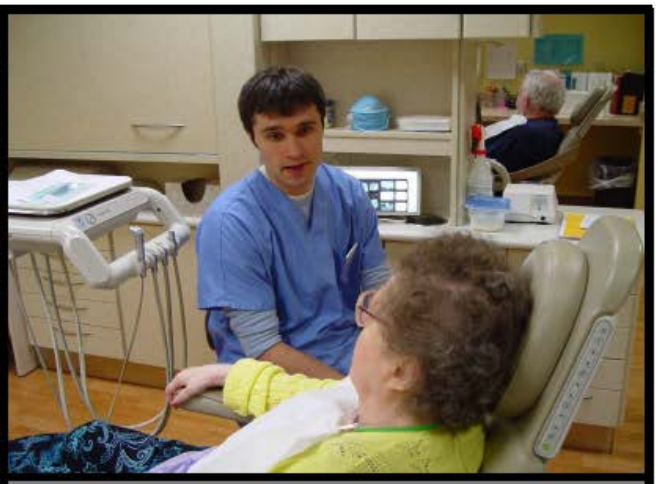
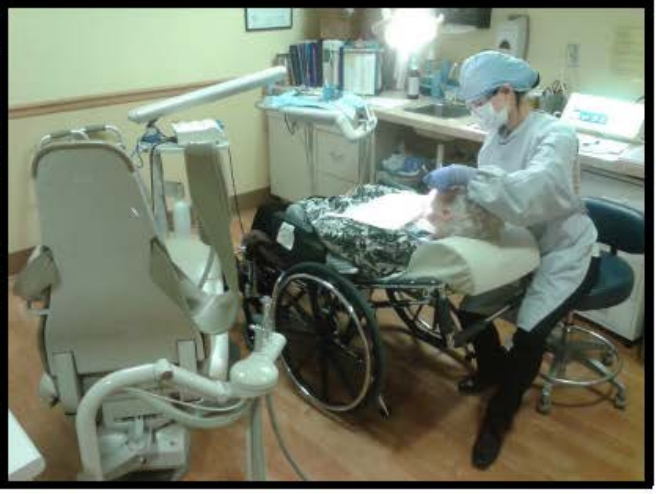


Walker Methodist Dental Clinic

Supplement on Long-term Care Practice

Oral Health Services for Older Adults Program



This clinic manual supplement has been developed by our faculty and staff to provide you with key information and tools to understand and address the unique issues related to dental practice in long-term care settings, such as nursing homes, transitional care units, assisted living facilities, adult day programs, and hospice programs, among others. Additional materials and a copy of our oral care DVD "Growing Old with a Smile," will be provided to you when you arrive at our clinic. Please review the materials in this manual before your clinic rotation starts and if you have any questions, please bring them to the attention of our faculty and staff as soon as possible. We will review and discuss the information in this supplemental manual during your rotation with us.

CONTENTS

Preparation of these materials was generously supported by grants from the Stevens Square Foundation, Minneapolis and Otto Bremer Trust, St. Paul

Educational Goals & Objectives for Long-term Care Practice

A. Understand the unique characteristics of the long-term care environment:

1. Describe the spectrum of long–term care options now available.
2. Identify the key characteristics of nursing homes and their residents, the goals of nursing home health care and dental care.
3. Identify the roles of key long-term care personnel, including the Administrators, Directors of Nursing, Medical Directors, nursing staff as well as others, and also describe ways to interact with them more effectively.
4. Describe key nursing home rules and regulations, as well as the regulatory processes that have developed since OBRA 1987.
5. Describe and discuss the Minimum Data Set comprehensive assessment tool with emphasis on the Oral/Dental assessments.

B. Develop skills in long-term care dental program planning and implementation:

1. Identify and describe basic strategies employed for dental program implementation in a variety of long-term care environments.
2. Identify factors to be considered in estimating demand for and utilization of long-term care dental services.
3. Describe and discuss key elements of long-term care contracts.
4. Discuss key factors impacting on reimbursement for dental services.
5. List and discuss advantages and disadvantages of fixed facility installation and key primary and secondary factors to be considered.
6. List and discuss advantages and disadvantages of portable and mobile clinical care delivery and key factors to be considered.
7. Describe how a long-term care practice can be integrated into the traditional private practice.
8. Identify key elements for documentation of dental care in long-term care settings and discuss appropriate documentation strategies.
9. Identify and locate key information from the long-term care chart and employ appropriate documentation techniques.
10. Write appropriate long-term care orders.
11. Discuss dental team roles in the long-term care dental program and describe the long-term care liaison concept.
12. Describe the requirements and scope of practice for licensed dental hygienists and dental therapists working in long-term care under collaborative practice agreements with licensed dentists.
13. Discuss the significance of preventive dental care in long-term care and approaches to preventive treatment planning and care delivery.
14. Identify appropriate in-service educational materials and approaches for the long-term care staff.
15. Describe potential elements of a quality assurance plan for a long-term care dental program.

INTAKE PROTOCOL (for Nursing Homes)

Nursing Home Dental Services Policy & Procedures

Facility:	[NURSING HOME]	**Creation Date:**	8/27/08
Title:	Dental Services	**Revision Date:**	
Procedure Number:	12345	**Exec. Dir. Approval:**	
Procedure for Policy			

[NURSING HOME] must provide or obtain from an outside resource, dental services that meet the needs of each resident including routine, annual, and emergency dental services.

1. Admission - **at the time of admission the Social Worker shall have the resident or responsible person complete the** [DENTAL CLINIC] - Provider Selection Form **which indicates the resident's choice of providers.**

   A. **The** [DENTAL CLINIC] - Provider Selection Form **will be submitted to the unit's Health Unit Coordinator (HUC) who will review the information provided.**

   B. **When the resident/responsible person authorizes Walker Dental Clinic to provide services the HUC will:**

      - **complete the** Request for Dental Appointment Form **and submit this form along with the original** [DENTAL CLINIC] - Provider Selection Form **to the Walker Dental Clinic.**

      - **maintain the yellow copy of the [DENTAL CLINIC] - Provider Selection Form in the resident's medical record.**

   C. **When the resident chooses another provider the HUC makes the necessary appointment(s) as determined with the resident and / or responsible person.**

   D. **The Dental Clinic Coordinator, on receipt of the [DENTAL CLINIC] - Provider Selection Form and the Request for Dental Appointment Form enters the resident into the system and schedules the resident according to availability.**

2. Routine or Annual Appointments - **the RAI Coordinator will submit a Request for Dental Appointment Form to the unit HUC when the resident will be seen at the [DENTAL CLINIC] and will use form for external Dental Providers.**

3. **The unit's HUC e-mails the [DENTAL CLINIC] Coordinator to schedule an appointment. The unit's HUC calls external Dental Providers to schedule an appointment.**

4. **The scheduled appointment is noted in the scheduling book and the HUC documents in the HUC Progress notes that a request for an appointment has been made.**

5. **The week prior to scheduled appointments the Dental Clinic Coordinator notifies each unit.**

6. **The unit's HUC notifies the Nurses and Nursing Assistants of the days/weeks scheduled dental appointments.**

7. **At the time of the scheduled appointment the resident, along with their medical record, is assisted to the clinic. (As with external appointments, resident's should arrive on time).**

8. **Following the completed dental care the resident's medical record is returned to the unit with the resident's medical record, post op form, and shingled progress notes.**

   A. **A licensed nurse transcribes any new orders to the MAR and/or TAR.**
   B. **The licensed nurse notifies the NAR of any changes in oral care related to the treatment received.**

9. **Recall Guidelines:**
   - **When the resident has natural teeth - recall will be every 6 months (unless otherwise noted).**
   - **Full upper and lower dentures - recall is annual**

10. ***Note: Per state and federal regulations residents are required to receive an annual dental check up unless they or their responsible party refuses care. This refusal must to be documented in the resident's medical record including the care plan.***

ORAL CARE DVD INFORMATION

Introducing a New Resource for Dental and Long-term Care Professionals. . .

"Growing Old with a Smile: Oral Care for Older Adults in Long-Term Care"

- **New DVD and Workbook for use by both long-term care facilities and dental providers to help train direct care staff about how to provide appropriate oral care**
- **Developed and produced by the Minnesota Department of Health's Licensing and Certification Program and University of Minnesota School of Dentistry's Oral Health Services for Older Adults Program**
- **Distribution supported by the Minnesota Dental Association**

DVD Menu	Workbook

• Introduction
• Oral Cares:
  ➢ General Hygiene
  ➢ Checking the Resident's Mouth
  ➢ Routine for Natural Teeth (Brushing)
  ➢ Flossing
  ➢ Brushing Full or Partial Dentures
  ➢ Use of Denture Adhesives
  ➢ Managing Difficult Situations
  ➢ Unconscious or Bedridden Patients
• Summary
	• PDF file on DVD can be printed & duplicated as needed
	• Review of all video materials
	• Glossary of Terms
	• Oral Health Quiz & Answer Key
	• Additional Resource List

Ordering Information

For Long-term Care Professionals:	For Dental Professionals:
Minnesota Department of Health Division of Compliance Monitoring Phone: 651-201-4101 E-mail: health.fpc-web@state.mn.us	Minnesota Dental Association Phone: 800-950-DENT (3368) E-mail: info@mndental.org ($5.00 shipping & handling)

LONG-TERM CARE FORMS

DENTAL PROVIDER SELECTION FORM

WALKER DENTAL CLINIC
3737 Bryant Avenue, S.
Minneapolis, MN 55409
Phone: 612-827-8310 Fax: 612-827-8408

DENTAL PROVIDER SELECTION FOR: _____
(Name of Client)

- **RESIDENCE OR PROGRAM:** [ ] Walker Methodist Health Center [ ] Walker Place
  [ ] Walker Care Suites [ ] Walker Senior Club [ ] Ebenezer Care Center
  [ ] Other: _____
- **ROOM NUMBER:** _____

To ensure that oral health problems can be promptly identified and treated, the Walker Dental Clinic is available to provide dental services for residents of Walker Methodist Health Center and other community long-term care facilities, as well as for older adults in the community. The Walker Dental Clinic is uniquely qualified to provide such care since it is staffed by the University's Oral Health Services for Older Adults Program, which has many years of experience and is nationally recognized for its work in geriatric dentistry. Our clinic is open on a regular weekly schedule to ensure that treatment can be provided promptly as needed.

Because of its specially trained staff, convenient location and experience in caring for older adults, the Walker Dental Clinic is a good choice for clients of Walker Methodist and other older adults in the community. Of course, you are also welcome to make arrangements for dental care with another dental provider if you choose to do so.

PLEASE CHOOSE AN ORAL HEALTH PLAN FROM THE FOLLOWING:

[ ] I hereby authorize the Walker Dental Clinic to provide an initial exam and periodic dental check-ups, x-rays, and cleanings every 6 to 12 months or as needed. Following each check-up, I understand that I will be provided with a treatment plan containing the dentists' recommended treatment which will **NOT** be started without further consent. To assist us in arranging appropriate care, please provide the following information if available:

- Previous dentist's name: _____
- Date of last dental visit: _____ Were x-rays taken? [ ] Yes [ ] No [ ] Don't know

[ ] I will make alternative arrangements with Dr. _____ to provide dental care.

[ ] I choose not to have any dental services at this time. (I understand this may lead to the development of a dental emergency.)

_____ _____
Signature of Resident/Responsible Person **Date**

Comments: _____

White copy: Dental Clinic *Yellow Copy: Facility Chart*

WALKER DENTAL CLINIC

REQUEST FOR DENTAL APPOINTMENT

To improve communication and efficiency in patient care, please provide the following Information and FAX this form to us at 612-827-8408. Our staff will then phone you to schedule an appointment. Only acute dental emergencies should be phoned in to 612-827-8310 for immediate scheduling consideration.

- DATE: _____ FACILITY NAME: _____
- PATIENT NAME: _____
- REASON FOR REQUESTING DENTAL SERVICES: _____

  _____
- DEFINE PATIENT'S DENTAL STATUS – PLEASE CHECK ALL THAT APPLY:

  [ ] All natural teeth (no dentures) [ ] Some natural teeth [ ] No natural teeth

  ---

  [ ] Complete Upper Denture [ ] Partial Upper Denture

  [ ] Complete Lower Denture [ ] Lower Partial Denture [ ] No Dentures

  Please Note: All existing dentures must accompany patient to the dental visit.
- DOES THE PATIENT SPEAK ENGLISH? [ ] Yes [ ] No

  IF NOT, WHAT IS THEIR PREFERRED LANGUAGE? _____
- FOR THE SAFETY OF BOTH PATIENT AND OUR DENTAL PROVIDERS, ARE THERE ANY BEHAVIOR MANAGEMENT ISSUES WE SHOULD BE AWARE OF IN PROVIDING CARE?

  _____
- HOW DOES THIS PATIENT TRANSFER TO THE DENTAL CHAIR?

  _____
- WEIGHT-BEARING STATUS: _____
- WHAT METHOD OF TRANSPORTATION DOES THIS PATIENT USE?

  _____
- IF PATIENT IS TRANSPORTED BY FAMILY, PLEASE IDENTIFY

  PERSON DRIVING: PHONE # _____
- IS THERE A FAMILY MEMBER WHO CAN ACCOMPANY PATIENT TO THEIR FIRST

  VISIT? IF SO, WHOM? _____ PHONE #:_____
- YOUR NAME: _____ PHONE #:_____

PLEASE FAX COMPLETED FORM TO 612-827-8408 AND OUR STAFF WILL CONTACT YOU AT THE NUMBER ABOVE TO ARRANGE THE APPOINTMENT. YOU SHOULD BE CONTACTED WITHIN THREE WORKING DAYS OF YOUR REQUEST. INCOMPLETE FORMS MAY BE RETURNED FOR FURTHER INFORMATION. *THANK YOU FOR HELPING US SERVE YOU BETTER!*

[DENTAL CLINIC NAME]

PREVENTIVE ORAL CARE INSTRUCTIONS

CLIENT NAME: _____ **FACILITY** _____

ROOM # _____

❖ ASSESSMENT OF ASSISTANCE LEVEL NEEDED

[ ] Self-sufficient [ ] Supervision [ ] Assistance [ ] Cooperation problems

❖ CARE RECOMMENDATIONS

[ ] **TOOTH BRUSHING** -- Brush natural teeth in the morning and before bed for at least 3 minutes using soft toothbrush and fluoride toothpaste. Brush all sides of the teeth. Pay special attention to brushing at the gum line by holding the toothbrush at a slight angle toward the gumline and using a gentle circular motion. If there are problems brushing, contact dental office.

[ ] **FLOSSING** -- Use a thin, waxed floss and slide it gently between each tooth. Then slide it gently up and down to remove food and plaque between teeth. If normal floss tears or shreds, try Glide™ Dental Floss. Contact dental office if problems occur.

[ ] **DENTURE CARE** --

1. Brush full/partial dentures q.d. with soft denture brush and mild soap/water. Soak after brushing if desired.
2. With dentures out, brush the gums, palate, and tongue daily with a soft toothbrush to remove plaque.
3. Remove dentures 6 to 8 hrs/day; keep dentures in denture cup with plain water.

[ ] **FLUORIDE MOUTHWASH** -- ACT™ or FLUORIGARD™ mouthwash (over-the-counter) x _____ days/months: rinse with 2-3 tsp. for one full minute, then spit out. Use b.i.d., AM and h.s. Avoid eating, drinking for 30 minutes after use. For dental caries prevention.

[ ] **PRESCRIPTION FLUORIDE** -- 1.1% NEUTRAL SODIUM FLUORIDE CREAM (Prevident 5000 or generic equivalent) x _____ days/months: Brush onto teeth b.i.d., AM and h.s. and spit out excess. Avoid eating, drinking for 30 minutes. May be left in resident's room at discretion of nursing staff. For dental caries prevention.

[ ] **ANTIMICROBIAL MOUTHWASH** -- Chlorhexidine gluconate 0.12% mouthwash x _____ days/months as follows: rinse or brush onto teeth one capful (1/2 oz) for 30 seconds, then spit out. Use b.i.d., AM and h.s. Avoid eating, drinking for 30 minutes after use. For soft tissue infections.

[ ] **ADDITIONAL RECOMMENDATIONS:**

_____

_____

_____

_____

[ ] **HOW TO REACH US** -- Call dental office at [phone number] during regular office hours if questions.

DATE: _____ **SIGNATURE:** _____

TITLE/POSITION: _____

P. Simonson
4/08

Walker Senior Dental Program
3737 Bryant Avenue South
Minneapolis, MN 55409

Phone: 612-827-8310

Preventive Oral Health Plan for: _____ **Date:** _____

A careful oral examination and review of health history reveals the following preventive concerns:

[ ] Dry Mouth [ ] Difficulty Brushing Teeth [ ] Gum Disease

[ ] Tooth Decay [ ] Build-up of Hard Deposits [ ] Other: _____

Because of these conditions, more disease of the teeth, gums, and oral soft tissues is likely to occur. To help prevent additional disease and keep the mouth and remaining teeth healthy, we recommend the personal preventive oral health plan outlined below. Estimated costs are also included. If you have any questions please call our office at the number listed above.

Service	Frequency	Unit Price	Total Cost
[ ] Periodic Examination	_____ time(s) per year	$_____	$ _____
[ ] Periodic Cleaning	_____ time(s) per year	$_____	$ _____
[ ] Fluoride Application	_____ time(s) per year	$_____	$ _____
[ ] Clean Upper/Lower Denture	_____ time(s) per year	$_____	$ _____
[ ] Cavity-detecting X-rays [ ] Two [ ] Four	_____ time(s) per year	$_____ for 2 $_____ for 4	$ _____
[ ] Other: _____	_____ time(s)/ _____	$_____	$ _____

The estimated **yearly** total cost of the preventive care plan is: $ _____

The estimated financial support from Medical Assistance and/or Insurance is: $ _____*

The estimated **yearly** cost to be paid by the Patient/Responsible Party is: $ _____

[ ] In addition to a fluoride toothpaste, we also recommend the following for oral hygiene at home:

[ ] Home Fluoride Mouthwash (such as ACT™) to be purchased over the counter at any drug store.

[ ] Prescription Germ-killing Mouthwash

[ ] Prescription Home Fluoride Gel:

[ ] Other: _____

**For those eligible, Medical Assistance pays for two exams and dental cleanings per year; and one oral hygiene instruction per year. Medical Assistance does not cover denture cleanings at this time.*

I hereby authorize the Walker Senior Dental Program to begin the preventive oral health plan outlined and I agree to pay any fees which are my responsibility.

_____ _____

Signature of Resident/Responsible Person Date

10-06

White Copy: Return to Walker Dental Yellow Copy: Retained by Patient/Family/Responsible Party Pink Copy: Chart

WALKER DENTAL CLINIC *612-827-8310*

CLIENT NAME:

POST-OPERATIVE ORDERS: NEW OR RELINED DENTURES

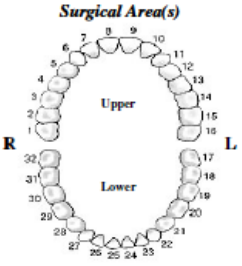
- ☐ **SORE SPOTS – Sore spots are expected as dentures settle into the soft tissues of the mouth. If the mouth is sore, the following steps can be taken:**
  1. **Take dentures out and replace the next day.**
  2. **Rinse gently with warm salt water (1/2 tsp salt in 8 oz. warm water) q 4 h x 2 to 3 days.**
  3. **Apply an over-the-counter ointment (Benzodent or Orabase with Benzocaine) to sore spots q.i.d. x 3 days.**
  4. **If sore spots persist for more than 3 days and patient does not already have a scheduled appointment, please call our office to schedule. Please try to insert dentures 24 hours before the adjustment appointment so dentist can see where sore spots are occurring.**
- ☐ **DIET – Choose softer foods for the first week. Gradually introduce new foods as patient gets more comfortable with denture(s). Fibrous, stringy foods such as raw vegetables, many fruits, and steak can be difficult to chew with dentures.**
- ☐ **CLEANING – Dentures should be brushed thoroughly at least once per day with a soft denture brush and a mild soap and water.**
- ☐ **SOFT LINERS – A soft denture liner (clear or white) may be placed to condition the soft tissues or temporarily improve fit. Be careful not to remove it. To clean dentures with soft liners, simply rinse under warm water. DO NOT USE DENTURE CLEANERS.**
- ☐ **EXCESS SALIVA – New dentures may cause extra saliva to be produced. This decreases as the mouth adapts to the new denture(s).**
- ☐ **LOOSENESS – Dentures may feel loose at first. They may move during chewing or speaking until the patient has learned to control them with the muscles of the lips, cheeks and tongue. Looseness can also mean that further adjustment is needed, so please call our office if looseness persists.**
- ☐ **BULKINESS – No matter how thin dentures are, they may feel bulky at first. Time is needed to get used to this feeling.**
- ☐ **MENTALLY IMPAIRED PATIENTS – Patients with mental impairments (e.g., dementia) may have difficulty wearing dentures and may remove them, break them, or lose them. Please call our office if such problems are noted.**
- ☐ **HOW TO REACH US – If there are questions or concerns with new or relined dentures from our office, please call us at 612-827-8310 during normal clinic hours.** **SIGNATURE:** _____

DATE: *POST-OPERATIVE ORDERS: NEW/RELINED DENTURES*

WALKER DENTAL CLINIC **612-827-8310**

CLIENT NAME:

POST-OPERATIVE ORDERS: ORAL SURGERY



- ☐ **GAUZE PACK** – Gauze has been placed over the surgical site(s). Please remove at _____ AM PM.
- ☐ **DO NOT RINSE MOUTH FOR 24 HOURS** to avoid disturbing blood clots. After 24 hours, patient may rinse gently with warm salt water (1/2 tsp salt in 8 oz. warm water) q 4 h x 2 days.
- ☐ **SUTURES** – Silk sutures must be removed by dental staff in 7-14 days. Dissolving sutures will fall out in 5-7 days.
- ☐ **BLEEDING** – Following extractions or other oral surgery some bleeding is normal. If bright red bleeding occurs:
  1. Place folded gauze pads over the area and have patient bite down firmly for 20 minutes. Repeat x 3 prn.
  2. Have patient bite down firmly on a wet teabag for 20 minutes. (Tea contains natural hemostatic agents.)
  3. If bright red bleeding still persists after these measures, please call our office or the on-call dentist.
- ☐ **SWELLING** – Apply ice pack to the face over the surgical area – 20 minutes on and 10 minutes off for one hour.
- ☐ **PAIN** – For mild pain, Tylenol may be administered prn per current facility standing orders x 3 days. Call us if pain is not relieved.
- ☐ **FOOD & DRINK** – Eat a light/soft diet for 24 hours. Avoid very hot or very cold foods/drinks and use of straws for 24 hours.
- ☐ **OTHER PROBLEMS:**
  1. Hematoma can occur after some extractions and will fade after 1 or 2 weeks.
  2. Small, sharp bone chips may work their way up through the gums during healing. Call our office if these are noted.
- ☐ **SMOKING** – Smoking should be avoided or reduced as much as possible during the first 2-3 days after oral surgery to help healing.
- ☐ **ORAL HYGIENE** – Do not brush surgical area for 24 hours. After 24 hours, please resume gentle toothbrushing to keep area clean.
- ☐ **HOW TO REACH US** – To report severe pain, bleeding or unusual symptoms, please call our office at 612-827-8310 during the clinic day. After clinic hours, please contact the dentist on call.

DATE: *POST-OPERATIVE ORDERS: ORAL SURGERY*

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