

Best Practice Statement ~ *May 2005*

## **Working with Dependent Older People to achieve Good Oral Health**



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## **Introduction**

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. NHS QIS does this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

## **Background to Best Practice Statements**

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing, midwifery and allied health professional practice.

The development of best practice statements reflects the current emphasis on delivering care that is patient-centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

A series of best practice statements has been produced, designed to offer guidance on best practice relating to specific areas of practice and to encourage a consistent and cohesive approach to care.



## **Key Principles of Best Practice Statements**

A best practice statement describes best and achievable practice in a specific area of care. The term 'best practice' reflects the commitment of NHS QIS to sharing local excellence on a national level. Best practice statements are underpinned by a number of shared principles.

- Best practice statements are intended to guide practice and promote a consistent and cohesive approach to care.
- Best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may also contribute to multidisciplinary working and be of guidance to other members of the healthcare team.
- Statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary.
- Information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus.
- Statements are targeted at practitioners, using language that is accessible and meaningful.
- Consultation with relevant organisations and individuals is undertaken.
- Statements will be nationally reviewed and updated every 3 years.
- Responsibility for implementation of statements will rest at local level.
- Key sources of evidence and available resources are provided.

## **Use of Evidence in Best Practice Statements**

The need to embrace evidence in its broadest sense has been acknowledged by NHS QIS in the development of best practice statements. Best practice statements represent a unique synthesis of research evidence, evidence complemented by audit, patient surveys and inputs derived from expert opinion, professional consensus and patient/public experience.

The process for developing these statements adopts a rigorous, transparent and consistent 'bottom-up' approach to articulating best practice that involves professionals and patients, and is based on all types of available evidence.

## Key Stages in the Development of Gerontological Nursing Best Practice Statements

A unique feature of the Gerontological Nursing Demonstration Project best practice statements is that they are refined through evaluative research to enhance practice.

### Review Evidence

Research, major reports, national audits, existing care guidance, expert nursing opinion, evidence from older people.



### Draft Best Practice Statement

Identify nursing contribution, apply gerontological nursing values, identify level and type of evidence.



### Pilot within a Demonstration Site

Base-line audit, facilitate practice development and problem solve, involve users, pool expertise of gerontological community of practice, refine statement, follow-up audit. External consultation on the revised draft



### Disseminate and Update 3-yearly

Paper copies, on-line in PDF format, face-to-face seminars, e-based practice facilitation with gerontological nursing community of practice.

Promote networking between community of practice nurses, demonstration site staff and practitioners involved in progressing implementation.

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## **How Can the Statement be Used?**

The best practice statement on Working with Dependent Older People to achieve Good Oral Health is intended to serve primarily as a guide to good practice and promote a consistent and cohesive approach to care. The statement is intended to be realistic but stretching, and can be used in a variety of ways, including:

- as a basis for developing and improving the care that nurses give to older people
- to stimulate learning among teams of nurses
- to promote effective interdisciplinary teamworking
- to determine whether a quality service is being provided
- to stimulate ideas and priorities for nursing research.

## **Who was Involved in Developing the Statement?**

### **Steering Group**

Andy Lowndes,	Practice Development Fellow, EQUAL project, Glasgow Caledonian University
Marea Mulholland	Staff Nurse, Southern General Hospital, NHS Greater Glasgow
Tom Norton	Nursing Home Manager, Woodlands Nursing Home, West Lothian
Irene Schofield	Research Fellow in Gerontological Nursing, Glasgow Caledonian University
Petrina Sweeney	Senior Lecturer in Special Needs Dentistry, Glasgow Dental School
Debbie Tolson	Professor of Gerontological Nursing, Glasgow Caledonian University

### **Demonstration Site Staff**

Linda Bruce	Clinical Care Manager, Middleton Hall, Ashbourne Healthcare
Mary Macgee	General Manager, Ashbourne Healthcare
Maureen Pearson	Clinical Nurse Manager, Directorate of Elderly Medicine, NHS Greater Glasgow
Cath McFarlane	Divisional Nurse, Acute & Specialist Medical Services, NHS Greater Glasgow
Anne Simpson	General Manager, Middleton Hall, Ashbourne Healthcare
Karin Hulston	Staff nurse, Ward 19, Glasgow Royal Infirmary, NHS Greater Glasgow
Jane Warren	Ward Manager, Ward 19, Glasgow Royal Infirmary NHS Greater Glasgow

### **Nurse Reference Group**

Scottish Gerontological Nursing Community of Practice (see Appendix 4)



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## **Best Practice Statement: Working with dependent older people to achieve good oral health.**

This best practice statement has been produced by NHS QIS in conjunction with the Gerontological Nursing Demonstration Project research team (Glasgow Caledonian University), the Scottish Gerontological Nursing Community of Practice (Appendix 4), the staff of Middleton Hall, Glasgow, Ashbourne Healthcare, and Ward 19, Glasgow Royal Infirmary, NHS Greater Glasgow. Its purpose is to offer evidence-based nursing guidance for oral health care. In particular, the care of dependent older people admitted to hospital or living in a care home will be informed by this best practice statement.

Good oral health is crucial to meeting fundamental human needs such as comfort, nutrition, communication and acceptable personal appearance. It is recognised however, that provision of oral care is a neglected area of practice. For example, there are few assessment tools that focus on the specific oral health needs of dependent older people. The Scottish Executive has funded a project to develop and pilot a mucosal assessment form for adults which can be used by a range of professionals. It is anticipated that this form will be available in the future through National Health Service Education for Scotland (NES). In developing this best practice statement the expert and project team brought together the existing evidence to underpin daily and continuing care of the mouth and teeth for dependent older people.

### **The Gerontological Nursing Demonstration Project**

This practice innovation research project involves the development of best practice statements, which are informed by a review of existing evidence and refined through testing and user involvement in a demonstration site. The presentation of the statement reflects the emerging definition of gerontological nursing, and an agreed set of values developed by the Scottish Gerontological Nursing Community of Practice. The statement reflects the beliefs of nurses and has been demonstrated to be achievable within practice areas similar to the demonstration site. To see the definition and list of values refer to Appendix 5; alternatively you may wish to find out more about the project by visiting the website at <http://www.geronurse.com>

## Section 1: Raising nurses' awareness of the need to promote good oral health

### Key Points ~

- 1 Nurses have a key role in promoting good oral health.<sup>1,2</sup>
- 2 A healthy mouth is essential for the maintenance of general health and nutritional status.<sup>1</sup> [Refer to Best Practice Statement on Nutrition for Physically Frail Older People, Nursing and Midwifery Practice Development Unit, 2002]
- 3 A person's well being and quality of life are enhanced by a healthy, comfortable mouth.<sup>1</sup>

[The numbers in the text correspond to the sources of evidence in Appendix 2]

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Nursing and care staff are knowledgeable about the importance of promoting effective oral health care for older people. <sup>1,2</sup>	A healthy mouth is central to good nutrition, effective communication, comfort and acceptable personal appearance. <sup>1,3</sup>	There are evidence-based local guidelines/protocols detailing the nursing and care staff's role in providing oral health care.
Nurses are aware that poor oral health can influence the older person's mood, dietary intake and general health. <sup>1</sup>	It is recognised that the provision of oral health care by nurses may not be based on sound evidence. <sup>4,5</sup>	Guidelines are made known to nursing and care staff at local induction.
An older person's need for oral health care is influenced by their general health and functional ability. <sup>1</sup>	Oral health may be compromised by the effects of ageing, some medical conditions and their treatments.	There is a range of legible and clear information in a variety of formats, for staff, older people and carers about the importance of good oral health and the services that can be accessed to promote oral health. Individual care plans are in place to address specific oral health care needs.

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nurses are aware of the following issues specific to caring for a dependent older person:</p> <ul style="list-style-type: none"> <li>• Fungal infections and <i>Staphylococcus aureus</i> can lead to aspiration pneumonia.<sup>5</sup></li> <li>• There is increased incidence of fungal infection.<sup>9</sup></li> <li>• There is increased incidence of dry mouth known as <i>xerostomia</i> as a side effect of medications.<sup>10</sup></li> </ul>	<p>Poor oral hygiene leads to changes in normal oral flora.<sup>7,8</sup></p> <p><i>Candida albicans</i> (thrush) can cause discomfort, affecting ability to swallow and decreasing nutritional intake.</p> <p>Some single medications and polypharmacy have the potential to exacerbate the problem of dry mouth. Pharmacists will provide information and advice on this issue.</p> <p>Reduced salivary flow impairs removal of debris, increases the risk of tissue ulceration and the speedy development of dental caries. The older person may require artificial saliva to remedy reduced salivary flow and high dose fluoride toothpaste to prevent dental caries.</p>	<p>Advice sheets on products used to combat the sensation of oral dryness are available for patients, residents, and nursing and care staff.</p>
<p>Nursing staff are aware of the incidence, presentation and effects of oral cancer. A person with a history of smoking and heavy alcohol use is particularly at risk.<sup>1,1,2</sup></p>	<p>Oral cancer is more common in people over 50 years of age.</p>	<p>Information and advice sheets on oral cancer are available for patients, residents, nursing and care staff.</p>

### Key Challenges ~

- 1 Acknowledging that nursing staff may perceive that caring for a person's mouth is difficult, distressing and intrusive, and then overcoming these barriers to provide effective care!
- 2 Raising nurses' awareness of the link between oral infection and pneumonia.<sup>13</sup>
- 3 Raising nurses' awareness about oral cancer in older people.
- 4 Raising awareness of the link between poor oral health, the inability to eat and malnutrition.

## Section 2: Assessment

### Key Points ~

- 1 A registered nurse carries out an initial screening of the lips, oral soft tissues and teeth.<sup>1,4,5</sup>
- 2 Assessment includes the older person's attitudes and feelings about oral health.
- 3 The achievement of oral health requires interdisciplinary working.<sup>1,6</sup>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
A registered nurse makes an initial assessment of an older person's physical and mental ability to carry out their own oral care.	To facilitate provision of oral care	Care documentation provides evidence that a person-centred assessment has been completed within 48 hours of admission.
A registered nurse makes an inspection of the lips, mouth and teeth in a good light eg using a hand held pen torch, as part of initial and ongoing assessment.	Regular examination is essential in order to assess the condition of the oral mucosa, lips and teeth, and the need for routine oral care. <sup>1</sup>	Reassessment takes place monthly and sooner if the person's condition changes.
A registered nurse uses a screening tool to make a simple assessment of the mouth. <sup>1,4,5,7,8</sup> The following are noted in particular: <ul style="list-style-type: none"> <li>• presence or absence of saliva</li> <li>• presence or absence of teeth</li> <li>• fit, condition, type and cleanliness of dentures</li> <li>• general condition.</li> </ul>	To form a baseline for routine care and to facilitate appropriate referral to a dentist or other allied health professionals. A patient in hospital for a short stay needs referral to a dentist if they have a dry mouth or if other dental problems are diagnosed. A person whose stay is longer than 1 month needs referral for dental support. A permanent care home resident who has not received dental care in the past 6-12 months requires to be referred to the dentist within 1 week of admission to the home.	A screening tool is in use and there is evidence that findings from the initial screening are documented and inform subsequent collaborative care planning. Criteria for referral to a dentist are in place and documentation shows that appropriate therapeutic support has been provided or referrals have been made, and what action has been taken. There is evidence of interdisciplinary care planning.
Assessment includes the person's attitude and feelings about their own mouth and teeth. <sup>1</sup>	To ensure that the person receives optimum care that complies with their wishes.	There is evidence that the older person's wishes have been respected, or care is in the best interest of the older person with cognitive impairment.

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Family/other carers are present to provide support whilst the nurse assesses the mouth and teeth of a person who has cognitive impairment. <sup>19</sup>		
In the event of a person collecting food in the mouth and drooling, a registered nurse with specific training in this procedure carries out a simple screen of swallowing ability, and when appropriate makes a referral to a speech and language therapist. <sup>20</sup>	To achieve prompt screening of a person's swallowing ability.	There is evidence in the care documentation that screening/referral for swallowing difficulties has taken place.

**Key Challenges ~**

- 1 *Facilitating family/other carer participation.*
- 2 *Locating dental services and liaising with community dentists and dental hygienists.*
- 3 *Developing a valid screening tool.*

### Section 3: Care of the mouth and teeth

#### Key Points ~

- 1 *Nursing staff provide assistance for the older person who is unable to meet their own oral health care needs.<sup>1</sup>*
- 2 *Appropriate use is made of equipment, cleansing agents and oral care techniques.<sup>21</sup>*
- 3 *Family/other carers are involved in supportive care.*
- 4 *An optimum level of care is achieved with minimum upset and stress for the older person.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Nursing and care staff assist the older person in the use of aids to maintain independence where appropriate, or carry out care on behalf of the dependent person according to their wishes [See Appendix 1 for protocol on routine oral care].	To enable the older person to remain independent in carrying out oral care.	There is evidence of the need for assistance and level of care in the care documentation.
Nursing staff encourage and assist the older person to drink at least 1.5 litres of fluid per day. <sup>8</sup>	Adequate hydration is necessary to maintaining a healthy mouth.	Fluid charts are completed for older people who are at risk of dehydration.
An older person who is receiving their nutritional requirements through a percutaneous endoscopic gastrostomy (PEG) requires regular oral care throughout the day (3-4 hourly or more frequently as required). <sup>22</sup>	Acutely ill people receiving PEG feeding are at increased risk of oral infection and <i>xerostomia</i> .	There is regular documentation that oral care is being carried out to a satisfactory level.
With the permission of the older person family members/other carer may participate in the provision of oral care.	To encourage the older person to take responsibility for and participate in oral care procedures, and to facilitate the involvement of family members.	There is evidence in the care documentation that family/other carer are involved in care if this is what the older person and family/other carer want.
An older person with cognitive impairment who needs urgent attention to an oral health problem, and who is thought likely to be reluctant to accept care is accompanied and supported by family or carer during treatment. <sup>19</sup>	To provide urgent care with minimum upset and stress for the older person and their family/other carer.	There is evidence in the care documentation of liaison between family members/other carers, and care staff.

#### Key Challenges ~

- 1 *Challenging oral care that is based on outmoded custom and practice and which is not evidence-based.*
- 2 *Influencing those who order supplies to obtain the appropriate cleansing agents and equipment.*
- 3 *Influencing the hospital shop and/or suppliers to supply small soft toothbrushes for adult patients, denture fixative and cleansing agents.*
- 4 *Accepting that some people may wish to continue wearing their dentures overnight, even though this is not recommended.*

## Section 4: Education and training

### Key Points ~

- 1 Oral care training programmes are up to date and evidence-based.<sup>4,23</sup>
- 2 Training programmes are delivered by those trained in the scientific basis of oral health.
- 3 Training programmes include guidance on effective record keeping

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Staff education and training programmes for nursing and care staff are in place and consist of:</p> <ul style="list-style-type: none"> <li>• recognition of a healthy mouth for young and old, and the importance of good oral health</li> <li>• the effects of medications on oral health</li> <li>• person-centred assessment of the mouth and teeth</li> <li>• caring skills in oral health</li> <li>• nursing care of the oral mucosa, lips, natural teeth, and dentures</li> <li>• nursing care of the person with an oral infection</li> <li>• nursing care of the person with dry mouth</li> <li>• interdisciplinary working to promote oral health</li> <li>• simple screening of ability to swallow.</li> </ul> <p>Nursing staff access the education and training package "Making Sense of the Mouth" which consists of a CD, book and video.<sup>23,24</sup></p>	<p>To ensure a full understanding of the scientific basis of oral health and disease and the practice of oral care.</p> <p>To provide evidence based training for all members of the nursing team.</p> <p>As endorsed by the Scottish Centre for Research in Education (SCRE).</p>	<p>There is evidence from staff records that training in oral health care has taken place at regular intervals.</p> <p>There is evidence from patient/resident feedback and audit that staff are effective in providing oral health care.</p>

### Key Challenges ~

- 1 Accessing training in an area that tends to be neglected.
- 2 Providing and sustaining training materials/courses.
- 3 Determining the effectiveness of training

## Appendix 1

### Evidence-Based Protocol for Daily Oral Care

Nursing and care staff can assist the older person or carry out care on behalf of the dependent older person as follows:

Care	Rationale for care
<p>Care of lips<sup>33,24</sup></p> <ul style="list-style-type: none"> <li>• clean with water-moistened gauze and protect with a lubricant (eg. Oralbalance gel)</li> </ul>	<p>To minimise the risk of dry, cracked, uncomfortable lips</p>
<p>Care of the person who is edentulous (no natural teeth) with dentures</p> <ul style="list-style-type: none"> <li>• ensure that dentures are marked with the person's name (eg "Identure" Denture Marking System, Geri Incorporated)</li> <li>• leave dentures out at night if acceptable to the individual</li> <li>• soak plastic dentures in dilute sodium hypochlorite (eg 1 part Milton to 80 parts water) or chlorhexidine solution (eg. Corsodyl 0.2%wv) for dentures with metal parts</li> <li>• clean dentures with individual brush under running water</li> <li>• rinse dentures after meals</li> <li>• use small quantity of cream/powder fixative if required. Clean off and replace before meals and clean off last thing at night</li> </ul>	<p>To enable continued comfortable wearing of dentures and maintain mucosal and denture cleanliness.</p>
<p>Care of natural teeth<sup>24</sup></p> <ul style="list-style-type: none"> <li>• clean twice daily and after meals with fluoridated toothpaste and soft toothbrush,<sup>21</sup></li> <li>• provide additional plaque control<sup>25</sup> if required using Corsodyl mouthwash or spray or gel</li> <li>• enable patients/residents who use a powered toothbrush to continue with it<sup>26,27</sup></li> </ul> <p>[Appropriate training is essential prior to staff using powered tooth brushes for others]</p>	<p>To prevent dental decay and gum disease</p> <p>To maintain oral comfort</p> <p>To reduce risk of damage to gums and oral mucosa</p>



Care	Rationale for care
<p>Care of oral mucosa<sup>24</sup></p> <ul style="list-style-type: none"> <li>• inspect in a good light</li> <li>• report any unusual appearances</li> <li>• clean with water-moistened gauzed fingers, water-moistened sponge sticks, TePe special care toothbrush or baby toothbrush</li> </ul>	<p>To provide a moist, comfortable, fresh environment and reduce the risk of infection</p>
<p>Care of the person with <i>xerostomia</i> (dry mouth) <sup>28</sup></p> <ul style="list-style-type: none"> <li>• Provide oral lubrication in the form of sips of water or spray or use mucin-based artificial saliva and use high dose fluoride toothpaste supplied by dental services</li> </ul>	<p>To ensure regular removal of debris and moistening of the oral soft tissues</p> <p>To prevent rapid development of dental caries</p>

## Appendix 2

### Sources of Evidence

[The numbers in square brackets relate to the SIGN guidelines levels of evidence contained in Appendix 3]

- 1 Fiske J, Griffiths J, Jamieson R, Manger D. (2000) *Oral care for long-stay patients and residents. Guidelines and recommendations.* British Society for Disability and Oral Health. Available from: <http://www.bsdh.org.uk/guidelines/longstay.pdf> [Accessed 24 Jan 2005]. [3]
- 2 Clarke G. (1993) Mouth care and the hospitalised patient. *British Journal of Nursing* 2: 284-292. [3]
- 3 Jones CV. (1998) The importance of oral hygiene in nutritional support. *British Journal of Nursing* 7 Number 2: 74-83. [3]
- 4 Matear D. (1998) Why do we need education in geriatric dentistry? *Journal of the Canadian Dental Association* 64: 736-8. [4]
- 5 Rak OS, Warren K. (1990) An assessment of the level of dental and mouth care knowledge among nurses working with elderly patients. *Community Dental Health* 7: 295-301. [3]
- 6 Yoneyama T, Yoshida M, Ohrui T, et al (2002) Oral care reduces pneumonia in older patients in nursing homes. *Journal of the American Geriatrics Society*, 50: 430-433. [3]
- 7 Sweeney MP, Shaw A, Yip B, Bagg J. (1995) *Oral health in elderly patients.* *British Journal of Nursing* 4: 1204-8. [3]
- 8 Bagg J, Sweeney MP, Harvey Wood K, Wiggins A. (1995) Possible role of *Staphylococcus Aureus* in severe oral mucositis among elderly dehydrated patients. *Microbial Ecology in Health and Disease* 8: 51-56. [3]
- 9 Wray D and Bagg J. (1997) *Pocket reference to oral candidosis.* Science Press, London. [4]
- 10 Seebny LM, Schwartz SS. (1997) A Reference guide to drugs and dry mouth - 2<sup>nd</sup> edition. *Gerodontology*, 14: 33-47. [3]

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- 11 Griffiths J, Boyle S. (1993) *Colour Guide to Holistic oral Care. A Practical Approach*. London: Mosby - Year Book Europe. [4]
  - 12 Salisbury PL. (1997) Diagnosis and patient management of oral cancer. *Dental Clinics of North America*, 41: 891-914. [4]
  - 13 Langmore SE, Terpenning MD, Schork A, Yinmiao Chen MS, Murray J, Lopatin D, Loesche DMD. (1998) Predictors of aspiration pneumonia: How important is dysphagia? *Dysphagia* 13: 69-81. [2]
  - 14 Holmes S, Mountain E. (1993) Assessment of oral status: evaluation of three oral assessment guides. *Journal of Clinical Nursing* 2: 35-40. [3]
  - 15 White R. (2000) Nurse assessment of oral health: a review of practice and education. *British Journal of Nursing* 9: 260-266. [3]
  - 16 Adachi M, Ishihara K, Abe S, Okuda K, Ishikawa T. (2002) Effect of professional oral health care on the elderly living in nursing homes. *Oral Surgery Oral Medicine Oral Pathology*, 94 Number 2: 191-195. [2+]
  - 17 Eilers J, Berger AM, Petersen MC. (1988) Development, testing and application of the oral assessment guide. *Oncology Nurse Forum* 15: 325-330. [3]
  - 18 Roberts J. (2000) Developing an oral assessment and intervention tool for older people: 3. *British Journal of Nursing* 9 Number 19: 2073-2078. [3]
  - 19 British Society for Disability and Oral Health (2004) *Principles on intervention for people unable to comply with routine dental care*. Available from: <http://www.bsdh.org.uk/guidelines/PIDocument/pdf> [Accessed 10 Feb 2005]. [4]
  - 20 Scottish Intercollegiate Guidelines Network. (2004) *Management of patients with stroke: Identification and management of dysphagia, Annex 1 Example swallow screening procedure*. Edinburgh, SIGN. [4]
  - 21 Pearson LS, Hutton JL. (2002) A controlled trial to compare the ability of foam swabs and toothbrushes to remove dental plaque. *Journal of Advanced Nursing* 39: 480-489. [2]
  - 22 Scottish Intercollegiate Guidelines Network. (2004) *Management of patients with stroke: Identification and management of dysphagia, Annex 5 Example Oral Care Protocol*. Edinburgh, SIGN. [4]

- 23 Sweeney MP, Bagg J, Kirkland G, Farmer TA. (2000) Development and evaluation of a multi-media resource pack for oral health training of medical and nursing staff. *Special Care in Dentistry* 20: 182-186. [3]
- 24 *Making Sense of the Mouth* training pack. Available from Dr. Petrina Sweeney, Senior Lecturer in Special Needs Dentistry, Glasgow Dental School, 378 Sauchiehall Street, Glasgow G2 3JZ. [4]
- 25 Loe H, Schiott CR. (1970) The effect of mouthrinses and topical application of chlorhexidine on the development of dental plaque and gingivitis in man. *Journal of Periodontal Research* 5 (2): 79-84. [2]
- 26 Hickman J, Millett DT, Sander L, Brown E, Love J. (2002) Powered versus manual toothbrushing in fixed appliance patients : a short term randomised clinical trial. *Angle Orthodontics* 72: 135-140. [1]
- 27 Heanue M, Deacon SA, Deery C, Robinson PG, Walmsley AD, Worthington HV, Shaw WC. (2003) *Manual Versus Powered Toothbrushing for Oral Health* (Cochrane Review). The Cochrane Library; Issue 1. Oxford: Update Software. [1]
- 28 Sjogren's Syndrome ( 2003). *A concise guide to diagnosis and management for health professionals*. The British Sjogren's Syndrome Association. Available from: [www.bssa.uk.net/](http://www.bssa.uk.net/) [Accessed 21 September, 2004] [3]

## Appendix 3

### Revised SIGN grading system

#### *Levels of evidence*

- 1++ High quality meta analyses, systematic reviews of Randomised Controlled Trials (RCT)s, or RCTs with a very low risk of bias
  - 1+ Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
  - 1- Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
- 
- 2++ High quality systematic reviews of case-control or cohort or studies  
High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
  - 2+ Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
  - 2- Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal
- 
- 3 Non-analytic studies, e.g. case reports, case series
  - 4 Expert opinion

#### *Grades of recommendation*

- A** At least one meta analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or  
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
- B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or  
Extrapolated evidence from studies rated as 1++ or 1+
- C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or  
Extrapolated evidence from studies rated as 2++
- D** Evidence level 3 or 4; or  
Extrapolated evidence from studies rated as 2+

On occasion, guideline development groups find that there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as Good Practice Points. It must be emphasised that these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.



## Appendix 4

### Scottish Gerontological Nursing Community of Practice

Sheila Bannon	Sister, Manor Parc Nursing Home, Glasgow
Linda Bruce	Clinical Care Manager, Ashbourne Healthcare, West Lothian
Sandra Cameron	Senior Nurse, St Johns Hospital, Livingstone
Linda Campbell	Stroke Co-ordinator, Raigmore House, Inverness
Duncan Clarkson	Director of Nursing, Whim Hall Nursing Home, Peebleshire
Valerie Cranston	Sister, Eastwood Court Nursing Home, East Renfrewshire
Mary Creed	Assistant Matron, Pittendreich Nursing Home, Midlothian
Jean Donaldson	Care Home Liaison Nurse, Strathclyde Hospital, Motherwell
Muriel Douglas	Senior Sister, Borders General Hospital, Roxburghshire
Morag Francis	Sister, Braeside House Nursing Home for the Elderly Blind, Edinburgh
Sue Gardiner	Clinical Nurse Practitioner, Royal Victoria Hospital, Edinburgh
Amanda Garrity	Senior Sister, Braemount Nursing Home, Paisley
Nancy Hamilton	Compliance & Monitoring Officer, Salvation Army, Glasgow
Helen Harkins	Staff Nurse, Moorburn Manor, Largs
Liz Hotchkiss	Deputy Manager, Eastwood Court Nursing Home, East Renfrewshire
Shona Hunter	Clinical Nurse Manager, Whim Hall Nursing Home, Peebleshire

Claire Jamieson	Sister, Eastwood Court Nursing Home, East Renfrewshire
Eveline Kearney	Manager, Millview, Barrhead
Mary Kelly	Matron, Manor Parc Nursing Home, Glasgow
Mary Kenyon	Matron, Whitefield Lodge Care Home, Glasgow
Fiona Lundie	Care Home Liaison Nurse, Strathclyde Hospital, Motherwell
Mary Macgee	General Manager, Ashbourne Homes, Glasgow
Fiona Mann	Matron/Manager, Buchanan Lodge, Bearsden
Freda Matheson	Registered Nurse, Isle View Nursing Home, Wester Ross
Louise Millar	Deputy Manager, Westminster South Grange Nursing Home, Dundee
Donna Morrison	Specialist Practitioner, Royal Dundee Liff Hospital, Dundee
Mae Munro	Manager, Southern Cross Healthcare, Inverness
Tom Norton	Nursing Home Manager, Woodlands Nursing Home, West Lothian
Nanette Paterson	Registered Nurse/Matron, Morningside Care Home, Wishaw
Lyndsey Redden	Staff Nurse, Moorburn Manor, Largs
Nancy Reid	Practice Development Nurse, Ravenscraig Hospital, Greenock
Liz Steven	Sister, Braeside House Nursing Home for the Elderly Blind, Edinburgh
Ria Tocher	Clinical Development Nurse, Astley Ainslie Hospital, Edinburgh
Christine Tonge	Health Visitor for the Elderly, Lerwick Health Centre, Shetland



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## **Appendix 5**

### **Definition and Principles of Gerontological Nursing**

Gerontological nursing contributes to and often leads the interdisciplinary and multi-agency care of older people. It may be practiced in a variety of settings, although it is most likely to be developed within services dedicated to the care of older people. It is a person-centred approach to promoting healthy ageing and the achievement of well being, enabling the person and their carers to adapt to health and life changes and to face ongoing health challenges.

To achieve this, in-depth gerontological nursing knowledge and skills are required alongside a commitment to an explicit value base. The virtual practice development community of link nurses has developed a set of principles, which reflects its beliefs about gerontological nursing:

#### **1 Commitment to person-centred care**

Understanding and acknowledging the needs and wishes of the older person and ensuring that these underpin the planning and delivery of care. Promoting continuity of care that values the older person's unique past, present and future individuality and recognising and respecting the person's role and contribution to family and wider society.

#### **2 Commitment to an enabling model of care**

Recognising the uniqueness of each older person, and building on positive lifelong coping skills and strategies. Negotiating and reviewing care goals in partnership with the older person and family, according to the individual's needs and wishes.

#### **3 Promotion of an enabling environment**

Promoting positive staff attitudes together with a supportive physical and organisational environment in order to create an enabling living, or care environment that conveys a sense of hope and achievement for the older person.

#### **4 Respect for a person's rights and choice**

Respecting and promoting the rights of each older person as a consenting adult to make independent choices and care decisions, according to the person's wishes, and recognising when it is necessary to draw on patient advocacy services.

#### **5 Promoting dignity**

Promoting dignity in day to day care to include consideration for the older person's privacy and confidentiality.

**6 Establishing equity of access**

Acting as champion and striving to secure on behalf of all older people the same access to services as other age groups.

**7 Maximising therapeutic interventions**

Developing attitudes, knowledge, and skills in order to turn a caring event into a therapeutic opportunity for the older person and, where appropriate, her/his family.

**8 Commitment to developing innovative practice**

Adopting strategies to promote evidence based gerontological nursing practice and advancing knowledge, skills and competencies of staff through continued education and research.

**9 Commitment to an explicit and shared set of values**

Developing an agreed care philosophy that seeks to maintain the uniqueness of the older person, reflecting their needs and identifying the standards of care which they can expect.

**10 Commitment to interdisciplinary working and partnership**

Working as part of a team of experts who recognise, seek out and respect each other's contribution to the care of the older person. Directing the collective effort towards the realisation of goals negotiated with the older person and their family, according to their needs and wishes.



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