Submission
No 183

# INQUIRY INTO DENTAL SERVICES IN NSW


**Organisation:** St Vincent's Hospital Sydney

**Name:** Dr Peter Foltyn

**Telephone:**



**Date Received:** 14/06/2005


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Due to privacy concerns, photographs included in appendices are not to be made available to the public or media.

**Summary**

ST VINCENT'S HOSPITAL SYDNEY LIMITED
A.B.N. 77 054 038 872
UNDER THE CARE OF THE SISTERS OF CHARITY

10 June 2005

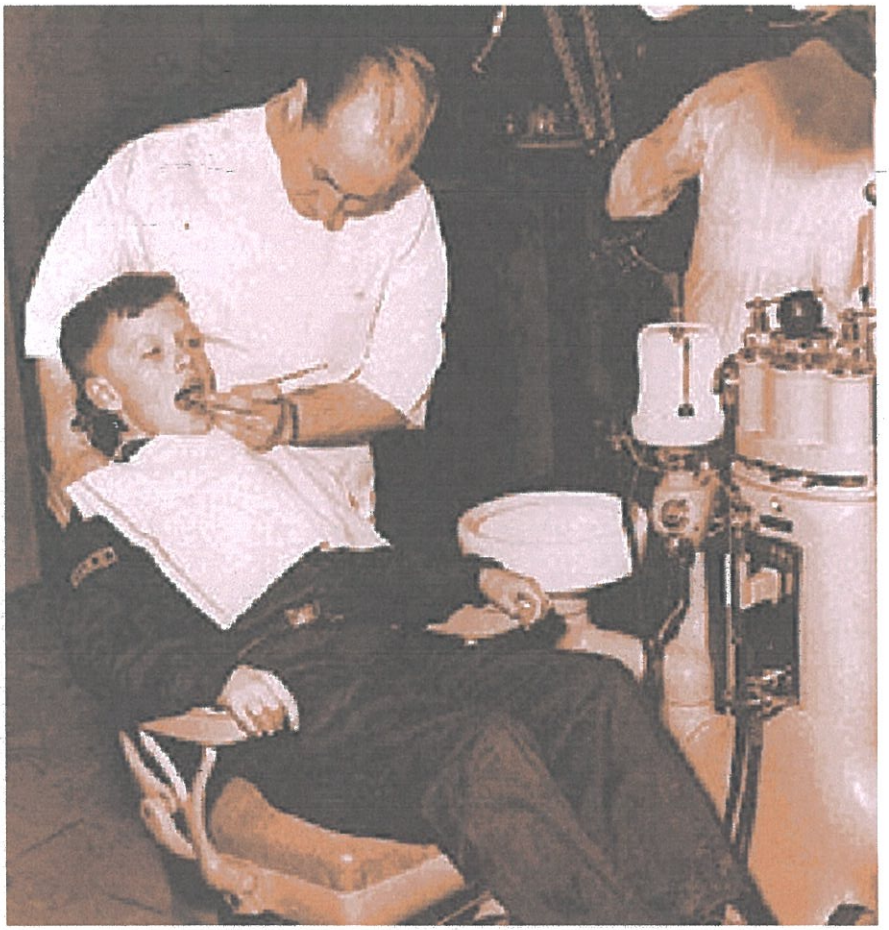
Director of Standing Committee on Social Issues
NSW Parliament
Macquarie Street
Sydney 2000

Please find to follow my submission to the 'Inquiry into Dental Services in NSW'.

Due to privacy concerns I would like to request that the photographs in the Appendices not be made available to the public or media.

Dr Peter Foltyn

Dental Department
St Vincent's Hospital



# Inquiry

# into Dental Services in NSW

Submission by:

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**Terms of Reference**

That the Standing Committee on Social Issues inquire into and report on dental services in New South Wales, and in particular:

(a) the quality of care received in dental services,
(b) the demand for dental services including issues relating to waiting times for treatment in public services,
(c) the funding and availability of dental services, including the impact of private health insurance,
(d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,
(e) the dental services workforce including issues relating to the training of dental clinicians and specialists,
(f) preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and
(g) any other relevant matter.

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*From early childhood we are told how important it is to get into the habit of cleaning and caring for teeth and gums. This habit is harder to maintain for the elderly or those suffering from dementia, receiving radiotherapy to the head and neck as part of cancer management or for those with medical problems which have associated oral health implications.*

*This submission is made mainly in respect of oral health care and dental services for persons who are medically compromised, in nursing homes, residential care facilities and hospitals.*

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## Introduction

I have been a consultant dentist at St Vincent's Hospital, Darlinghurst for over 27 years. My primary role is the care of a wide cross section of medically compromised patients. The nature of the patient mix at St Vincent's Hospital has meant significant exposure to oral health problems that the average dentist in private practice would only occasionally encounter. A submission was made to the Commonwealth Government Senate Inquiry on Dental Health in 1998 which also involved participation in the resulting public hearings. Reference to that submission and others can be found at the following web address and in Hansard. I believe the report of the 1998 Commonwealth Government Senate Inquiry on Dental Health has relevance to this inquiry.

http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1996-99/dental/report/c02.htm

## Role of St Vincent's Hospital Dental Department

St Vincent's Hospital is a schedule 3 teaching hospital and not under direct management by the local Area Health Service, in this instance South East Sydney and Illawarra Area Health Service (SES&IAHS).

As a core hospital service we provide the following:

- Management of incidental dental problems for any hospital in-patient
- Dental assessment and selective management of all prospective heart/lung transplantation patients
- Dental assessment and selective management of all prospective heart valve replacement patients
- Dental assessment and selective management of all prospective head and neck cancer patients
- On call to the Emergency Department for management of oro-facial trauma/swelling/pain

- On call to the general operating theatres for management of dental injuries in theatres
- Dental assessment and management of HIV patients holding disability support pensions
- Dental assessment and selective management of patients with diabetes
- Dental assessment and selective management of patients undergoing bone marrow transplantation
- Dental assessment and selective management of patients undergoing chemotherapy
- Dental assessment and selective management of patients with autoimmune diseases
- Education of medical undergraduates in oral and dental health

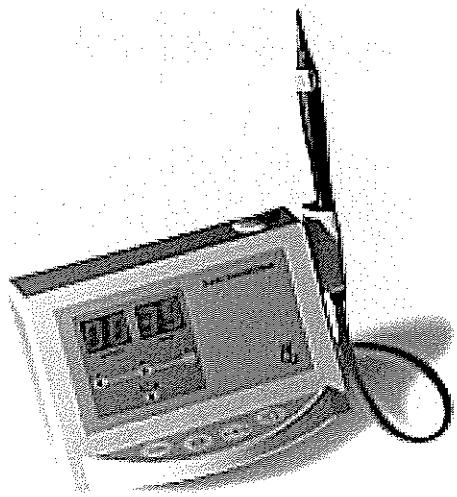
The Dental Department does not provide outpatient dental services for eligible local residents (health care card holders) in the immediate surrounding area as the funding and support it receives is limited to specific patient groups within the hospital.

**Evolution of dentistry**

Dentistry has seen significant changes over the years in both the scientific approaches to understanding and managing dental disease and in technological advancements of diagnosis, prevention and treatment. In Public Health dentistry, however, this has meant nought as the service struggles with stagnant funding in real dollar terms, whilst facing increased costs across the board and an ever growing demand for services. Waiting lists in many Area Health Service regions can be many years for routine dental care due to a chronic lack of adequate funding. Procedures now regarded as commonplace in private dental practice, eg molar endodontics, posterior crowns and bridges, metal based partial dentures, implants etc, are rarely, if ever offered.

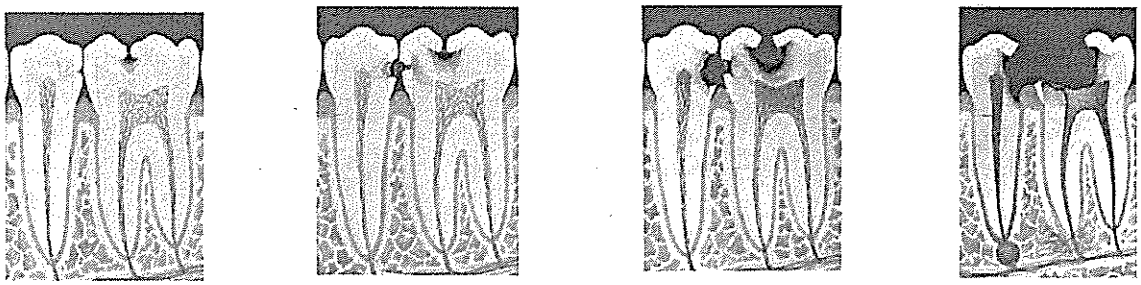
One example of many recent technological advancement in dentistry is in the early diagnosis of dental caries using the DIAGNOdent™ by KaVo. This is small laser caries detector, which is extremely accurate and reliable in detecting early dental decay.

A very informative Powerpoint presentation can be found at the following address.
http://www.kavo.com/En/downloads/diagnodent_milicich_en.pps



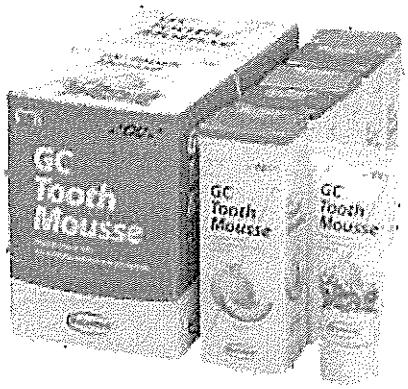
This presentation not only demonstrates the roles of the DIADGNOdent™ but also explains the technique of fissure sealing, a preventative strategy in limiting the progression of dental decay.

There are obvious and immediate benefits to the early detection of decay; however, in public health dentistry unless one is suffering from oro-facial trauma, swollen or currently under treatment, in some regions one will not even get on to a waiting list for routine dental care for many years. Sadly therefore, the dental budget of most facilities is spent being reactive rather than proactive. Dental dollars spent primarily treating the consequences of oral neglect provide little long-term solace and perpetuate maintenance of poor oral health and all its ramifications (Appendix 1).



Progression of tooth decay from small, incipient cavity to dental abscess formation and eventual extraction can be avoided with timely periodic dental examination and early dental restoration using modern dental materials.

An example of a newer preventative strategy is Tooth Mousse™, a water based, sugar-free cream containing amorphous calcium phosphate and is the result of Australian research and development. This topical paste provides extra protection for the patients' teeth. When applied to tooth surfaces, it binds to biofilms, plaque, bacteria,




demineralised tooth structure and surrounding soft tissue localising bio-available calcium and phosphate. Saliva will also enhance the effectiveness of the active ingredients and the flavour of the tooth mousse will help to stimulate saliva flow. The longer the active ingredients are maintained in the mouth, the more effective the result. There is a wide range of benefits for Tooth Mousse™. It can be used to provide protection for teeth and to help neutralise an acidic oral environment. In regions where the dental budget is limited to providing for people with swelling, trauma or pain, there is little opportunity for preventative strategies such fluoride trays (mouth guard like appliance for home fluoride application) or give aways of Tooth Mousse™, tooth brushes, interproximal brushes or dental floss.

**The Medically Compromised Patient**

13% of the present population of Australia is over the age of 65. By the year 2010, when the first of our post-war baby boomers reaches this age, this figure will have risen to over 22%. One implication of living longer will be a greater reliance on modern medicines and newer surgical procedures. As there are significant oral health implications in medical management of patients, a greater understanding of oral health is essential amongst the medical profession and conversely a better understanding of medical matters by dentists.

The foreword by Dr Sol Silverman to the 6th edition of Dental Management of the Medically Compromised Patient by Little et al is included here as part of this submission. (Appendix 2)

Many medically compromised patients are affected to such an extent by their illness that they are unable to continue working, necessitating reliance on a health care card which provides an entitlement to access public dental services. For those in rural and remote locations, however, there is often inadequate provision of public dental facilities within a reasonable distance, if at all. In larger cities the public facilities are burdened with long waiting lists for planned treatment. Some facilities have 2-4 year waiting lists whilst others have closed their waiting lists all together, citing inadequate resources and only provide relief from pain and are unable to provide preventative dental care or a meaningful treatment plan for patients requiring more extensive management.

Routine oral examinations are carried out as part of the medical and/or surgical management of many patients. On many occasions considerable dental treatment is required before a patient can proceed with organ transplantation or heart valve replacement surgery, or radiotherapy to the head and neck for cancer management. Often these patients are unable to access the appropriate treatment in the public sector or have it expedited to enable the planned medical/surgical procedure to proceed as scheduled. On countless occasions we have had patients who have had

their heart surgery or head and neck radiation therapy delayed as their teeth had not been extracted in time as they were unable to access public dental services in their region.

Patients with HIV infection and other immune deficiencies must limit oral infection and often require biopsies of oral lesions and management of xerostomia (dry mouth). HIV infection in particular requires an understanding of many of the early and often subtle clinical presentations of the disease, as these may occur in and around the mouth before anywhere else. Dentists are the most appropriate health care workers to treat the oral manifestations of HIV infection. Failure to provide treatment may further compromise the immune system and have a direct impact on the individual's general health.

All prospective candidates for heart valve replacement surgery at St Vincent's Hospital are sent the enclosed letter (Appendix 3) several weeks before their planned admission. Many of these patients are not seen for pre-surgery assessment at St Vincent's Hospital (hence not seen at our Dental Department) as they may be managed by cardiac physicians outside of Sydney and referred to St Vincent's Hospital for their surgery only. The pro-forma letter outlines the dental implications and asks the patient's dentist to attend to any necessary treatment. Patients who are seen within the Dental Department are provided with reports for their doctors and proposed dental treatment for their dentist.

Our experience over the past five years is that it is becoming extremely difficult for many rural and remote area patients with health care card entitlements to access immediate dental care in the public sector. For example the Northern Rivers and Richmond Area Health Services of far northern NSW have all but closed their dental facilities and can offer an appointment only if the person is swollen or has sustained a traumatic injury to the teeth but no elective dental procedures or even relief of pain. We have had patients from this region and other parts of rural NSW who have been unable to complete dental procedures required as part of their medical management.

Most patients are reviewed on admission to the hospital prior to their surgery or treatment. If the proposed dental procedures have not been completed, the operation may be cancelled or, in the case of radiotherapy to the head and neck, postponed until completed. In many instances this has led to unnecessary and costly (to Medicare for public patients) additional bed days in hospital, or premature discharge until the prescribed procedures have been completed. For some this delay can be life threatening (Appendix 4).

**Aged Care**

The following comments refer to persons in nursing homes, residential care facilities, hospitals and people with disabilities.

There is a lifetime association between oral health, nutrition and disease. An interdisciplinary, co-ordinated approach between dentists, other health care providers and dieticians is essential for the elderly and disabled. Poor oral health is linked to weight loss and a greater dependence on more medications (including laxatives and antireflux agents) for a greater frequency of gastrointestinal disorders. The links between oral health and nutrition can be demonstrated. Infectious diseases of the mouth as well as oral manifestations of systemic diseases affect diet and nutrition but on the other hand good diet and nutrition may limit the progression of diseases of the oral cavity.

The importance of oral health care needs to be acknowledged and seen as a priority by the medical profession and government. Many doctors have a limited knowledge of oral and dental anatomy and the close relationship between oral health and general health. We now see many of our 'baby boomers' retiring. Some will shortly be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns, bridges and implants, unlike the average 60-70 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the

needs of the most dentally vulnerable members of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled.

**Equity and Access**

There is no doubt that the flow-on effect from the reconfiguration of the state Area Health Services that took place early in 2005 has the potential to deliver equity and access to services for rural, remote and necessitous regions. In the dental setting, however, it will mean that the dental budget will be spread over a larger area and although, for example, those in the Shoalhaven region of SES&IAHS will not have to wait 7 years for dental care, the corollary is that those living in the northern sector will now struggle for any dental service at all. The northern sector has a disproportionate number of older residents compared to other regions and is likely to lose the domiciliary service that the Sydney Dental Hospital provided for nursing homes and for people in residential care. As the northern sector has no stand alone adult dental services within its boundaries and no proposed replacement for the domiciliary service provided by the Sydney Dental Hospital this region will suffer greatly.

**Workforce and changing face of dentistry**

In the post World War II halcyon days of graduations from the Dental Faculty at the University of Sydney we had some years of 200+ graduates in the 50's with close to 100 each year throughout the 60's. The attrition rate amongst these dentists is now naturally high with many deceased and the remainder no longer in practice. Although the population of Australia and in particular that of NSW has grown dramatically over the past 30-40 years present graduation numbers are less than 50 per year from the University of Sydney with a proportionate drop in numbers at other Australian institutions.

Through the combined efforts of a then pro fluoridation state government, the Australian Dental Association, dental education which leant towards prevention and a public which took on board the oral health message of the day, we found marked improvements in the level of decayed, missing and filled teeth. Slowly we had children, then teenagers and then young adults with negligible need for traditional dental services.

The expectation of improvements in dental health had been realised and the profession was starting to question itself about the prospect of doing too good a job and putting itself out of business. Unfortunately no one involved in dental health planning had predicted the unparalleled rise in consumerism and with it an insatiable desire by many in the community for straighter and whiter teeth. Orthodontics and cosmetic dental procedures have never been more popular. Prior to the 80's the average general practitioner dentist would spend much of his/her working day replacing small amalgam fillings with even bigger ones and providing a large number of extractions and dentures. This was the era known as "blood and acrylic" dentistry. In the 50's through to the early 80's it would not be uncommon for each dentist in a busy private dental practice to see 30+ patients per day. It was also not uncommon for rural women to have all their teeth removed before they were married so they wouldn't be a burden on their husbands.

Today, however, a dentist would regard him or herself extremely busy if they were seeing 15 patients per day. We therefore have a situation in which the number of dentists has significantly declined and at the same time dentists are finding treating fewer patients is financially more rewarding and less stressful. The "blood and acrylic" days of yesteryear have been replaced by a consumer driven demand for looking and feeling good about appearance – the era of Cosmetic Dentistry. Another issue impacting on the delivery of dental care is medical negligence. Before, many dentists would just dive in and do what was needed with little discussion with the patient. Today most dental procedures require "valid consent". Dentists spend considerable time preparing treatment plans and discussing the benefits and side effects and

complications of treatment and ensuring that the patient understands what is being discussed. This takes time and in the end the patient pays a higher fee.

Dental hygienists were a welcome addition to the dental workforce in the late 80's. Initially only overseas trained hygienists, who passed NSW or other state Board examinations, were able to practice. Since then, training facilities have sprung up around Australia; however, NSW was slow to accept the need to establish a hygiene school. Hygienists are well accepted by patients and provide dentists with the opportunity to divest themselves of scaling, cleaning and oral health education for which a lower pro rata remuneration is available compared to providing crown and bridge, implants and other cosmetic procedures for patients. It is a happy marriage by providing a higher level of oral care and education within the practice whilst allowing the dentist to concentrate on the more remunerative aspects of dental care. The chronic shortage of hygienists in NSW has meant that a hygienist can get a starting salary of $45+ per hour. This hourly rate is about the same as a Grade V Dental Officer (dentist) can earn in the Public sector. The NSW Public Hospital's Industrial Code has the hourly rate for dental hygienists at about $18 per hour, which is less than what an untrained dental assistant can earn and has changed little since the 80's. Due to the hourly rate in private practice being so high the Dental Hygienists Association has all but given up in trying to improve hourly rates in the public sector. As there is a directive by NSW Health regarding payment of above award wages it is not possible for public dental facilities to engage NSW Dental Board registered dental hygienists, even though many would be prepared to work a couple of 1/2 days with professionally challenging patients, such as those with head and neck cancer, HIV infection, diabetes etc at a lower hourly rate but not at $18 per hour.

Dental Therapists have been trained in NSW for many years; however, by law they can not treat adults. They can give injections, provide fillings and extract deciduous teeth. Dental therapists in NSW however are unable to work in private dental practice and generally are limited to treating children in school dental clinics or community dental centres.

There has been a large influx of immigrants in NSW from parts of the world that do not have the same level of oral health awareness and water fluoridation as we do. In many instances this has meant that these migrants have teeth which are at much higher risk of dental decay compared to Australian born children and adults exposed to water fluoridation and oral health education through school, home and media. As a result, public sector dentistry in metropolitan areas has a disproportionate number of migrant adults and children as patients. Allied to managing patients with inadequate English is the need to rely on interpreters on a regular basis, which naturally slows down the process of delivery of dental care.

Dental neglect or apathy is a new phenomenon. For some in the community their first contact with a dentist is in late teenage years when wisdom teeth start to cause problems. For others never having been to a dentist has meant that they may have active periodontal infection. Consumption of highly sugared soft drinks and sports drinks over the last decade has meant that the benefit of fluoridation has been negated by a persistent acidic environment in the mouth (Appendix 5). When this is coupled with increasing levels of diabetes and other health issues and medication use which impacts on salivary flow, there are real concerns for unprecedented levels of root caries being the dominant form of new dental cavity in the future.

With private dental practice offering attractive salaries, associateships, partnerships, assistantship positions etc, working in public health dentistry with its lower wage structure, limited funding and facilities and negligible exposure to contemporary dental procedures and techniques, there is little incentive for new graduates to consider a career or even part-time employment in the public sector. Government must give serious consideration to making the first year following graduation compulsory for new dental graduates to work in public hospitals or for Area Health Services. Although this would require some supervision it would go some way in addressing the manpower shortage in the public sector; however, it would only be a worthwhile exercise if additional funding were made available to employ these new graduates.

**Looming Problems**

We have several looming problems in SES&IAHS. The director of Dental Services at Sydney Dental Hospital has confirmed that discussions are presently (May/June 2005) taking place with NSW Health regarding Sydney Dental Hospital's divestment of dental services for the Northern sector of SES&IAHS. This is the region bounded by Sydney Harbour, Woollahra, Waverley, Randwick, Maroubra, La Perouse, Botany, Hillsdale etc. My understanding is that Sydney Dental Hospital, now that it is situated in the Eastern Zone of the newly formed Sydney South West Area Health Service (SSWAHS), is expecting to significantly increase the services it provides to residents in the Liverpool/Campbelltown areas now that they can access Sydney Dental Hospital through SSWAHS. Sydney Dental Hospital has limited manpower and funding and intends to focus its resources on this group and intends to return responsibility for the northern sector of SES&IAHS to this Area. Unfortunately the northern sector has no adult services within its boundaries, meaning anyone requiring public dental services living in Bondi/Coogee/Maroubra may have to travel 1.5-2 hours on public transport to get to the only adult dental services in the region at Sutherland or St George Hospitals.

The proposed cessation of dental services by Sydney Dental Hospital to this region is going to inevitably lead to an increase in the need for both the St Vincent's and Prince of Wales Hospital's Emergency Department (ED) to triage and admit patients with dental problems. In a two-week period in May 2005 the St Vincent's Hospital ED triaged 5 and admitted 4 patients with dental pain/swelling. Although Sydney Dental Hospital states it will still triage out of Area patients who present with trauma/swelling, they do not anticipate providing out of Area continuing care for these patients or for those who present with pain only. Inevitably this will lead to significantly increased ED presentations at St Vincent's Hospital for dental problems clogging up a valuable and expensive resource and **PUSHING THE HOSPITAL INTO CODE RED** situations with greater frequency (Appendix 6).

**Summary and recommendations**

1. Oral Health is an integral part of primary health care. Although dental fillings, extractions and dentures are regarded as traditional dental procedures, the removal of unsound teeth and the elimination of periodontal disease for a person who is about to have a mitral valve replacement or extensive radiotherapy to the head and neck must be regarded as part of the overall management of the underlying medical condition. There must be sufficient flexibility in the Public Dental Health system so that dental services for all medically compromised patients can be expedited so that no patient is at risk of having life saving surgical or medical procedures delayed.

2. Although conducting a comprehensive dental service for children in NSW is admirable the reality is that dental disease is preventable. Parents should accept greater responsibility for their child's dental health.

- More education is needed on the role of dietary sugars and dental health
- More money spent on adult dental services

3. The Enhanced Primary Care Program, introduced by the Commonwealth Government, provides dental care by referral from a medical GP under Medicare; however, this scheme is extremely limited.

- In liaison with the Commonwealth or on its own NSW Health must provide greater access to dental care by medically compromised patients either through extension of the EPS scheme or through a voucher system.

4. Medical graduates all serve internships as part of their training which benefits the graduate and provides a valuable resource for the public hospital system.

- In the same way, new dentists should have to serve their first 12 months after graduation in public health facilities.

5. As NSW is now providing training for dental hygienists they should also have to serve their first 12 months after graduation in public health facilities.

- The hourly rate for dental hygienists under the NSW Health Industrial Code must be reviewed as a matter of urgency.
- If review of the NSW Health Industrial Code for dental hygienists can not be undertaken immediately Public Health facilities wanting to engage hygienists for special needs patients must be given exemption to pay outside the guidelines.

6. Dental therapists at present are unable to provide any adult services in NSW.

- Dental therapists should be permitted to provide dental assessment and limited dental care in nursing homes, residential care facilities, hospitals etc.

7. As there are no stand alone adult dental services in the northern sector of SES&IAHS the Sydney Dental Hospital should be provided with sufficient funding to maintain the traditional services it has always provided for this region.

Dr Peter Foltyn

Appendix

# Foreword

Dental management of medically compromised patients has assumed great importance in oral healthcare delivery. An important reason for that is the relationship between disease and aging; almost 14% of Americans are over age 65, a percentage expected to grow to 20% by the year 2020. With extended longevity, an increase in diseases and disabilities will demand larger responsibilities and challenges from healthcare providers. Ever increasing identification of abnormalities is occurring through a greater use of diagnostic techniques, recognition and popularity for prevention, and the widespread use of drugs. As a consequence, a growing number of individuals will be seeking oral healthcare, leading to a concomitant expansion of patients with health risks that may complicate dental-oral diseases and treatments.

A multitude of diseases have an impact on oral healthcare services. Cancer is an age-related disease that serves as an example. More than 1.3 million new cancers are diagnosed each year in the United States that in turn account for almost 25% of all deaths. Because of the ever-increasing number of new malignancies and the complications caused by aggressive therapy, dental services and knowledge in this area take on significant importance. Other examples that commonly affect dental-oral care are cardiovascular disease, the number-one killer of Americans, and diabetes, which affects 16 million Americans. The list could go on endlessly. This underscores the need for current, reliable, and practical information to minimize or prevent potential problems related to general health and ongoing oral health-dental care.

Interrelationships between oral and general health involve most organ systems. A most dramatic example of medical-dental interaction relates to infectious diseases that strike both the young and the elderly. This includes HIV infection, hepatitis, tuberculosis, sexually transmitted diseases, and many other bacterial, viral, and fungal infections. The problem involves recognition and management of oral manifestations, control of blood-borne pathogens, and avoidance of complications when providing dental treatment. Again, to meet this challenge, updated information in a concise and understandable format is required.

Because the majority of medically compromised patients need or want oral healthcare, a working knowledge of the multitude of compromised conditions is essential for dental professionals. This knowledge will support high standards for dental-oral healthcare delivery, which include understanding medical conditions and compromised states, preventing adverse side effects from procedures and drugs used in dentistry, and formulating treatment plans that are compatible with a patient's medical status.

Treating the compromised patient is a complex part of dentistry, requiring competent practitioners with many attributes: sound technical skills, insight into medicine, familiarity with pharmacotherapeutics, and the capability of analyzing findings from patient histories and signs and symptoms. Therefore the usefulness of this text as a reference at all levels of dentistry, for the student and the practitioner, is evident.

Care of the medically compromised patient often is complicated, requiring specialists. However, occurrence of compromised patients is so common that practitioners and students must know how to recognize and prevent problems associated with dental management, and to use consultations and referrals appropriately. This updated, revised, and expanded text recognizes and supplies this type of information with practical and organized overviews of diagnosis and management. This is accomplished by comprehensively covering, in 26 well-organized and revised chapters, conditions that lead to compromised states that affect a person's well-being. The material is supported by summary tables for easy access to information, some figures to supplement text, and appendices that allow the reader to recognize disease states, be aware of potential complications, and select an approach to drug management. Although the main focus is on the management of compromised patients during dental procedures, the text effectively includes causation, medical treatment, pathophysiology, and prognosis. In its present format, it serves as both a quick reference and a somewhat in-depth resource for this critical interface of medicine and dentistry. It will help ensure high standards of care and reduce the occurrence of adverse reactions by improving knowledge and encouraging judgment in the management of at-risk patients.

**Sol Silverman, Jr.**
Professor of Oral Medicine
University of California, San Francisco

# St. Vincent's Hospital Sydney Limited

A.C.N. 074 083 872

UNDER THE CARE OF THE SISTERS OF CHARITY

## DENTIST LETTER

As you are being considered for cardiac surgery it is essential that you visit a dentist for a thorough evaluation of your oral health. It is important that your mouth, in particular the gums, have no infections. Your teeth may have cavities, which could cause complications prior to your surgery or during the recovery period. Early attention to oral health will limit inconvenience and discomfort during this time.

Please ask your dentist to sign this letter after he or she has made a review of your oral health, and **bring it with you with all your x-rays when you come to the hospital.**

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Dear Dentist,

The bearer of this letter is scheduled for admission to St. Vincent's Hospital for cardiac surgery and requires an oral health evaluation. Please ensure your patient is thoroughly examined both clinically and radiographically, with **full O.P.G.**, if possible. Please give the x-rays to the patient. There should be no active dental cavities, periodontal disease or other oral infection present. Antibiotic prophylaxis when required should be given in accordance with:

*Antibiotics Guidelines,* *10th Edition, January 1999*
*Victorian Medical Postgraduate Foundation*
*(Endorsed by ADA Inc).*

(Copies of this publication are obtained from Therapeutic Guidelines Ltd.
Level 3, 55 Flemington Road,
North Melbourne,
Victoria, 3051)

A patient with advanced periodontal disease, dental abscess formation or extensive dental cavities should be encouraged to have involved teeth removed and dentures constructed, if required, well before admission to hospital. Those with good oral health to follow strict oral hygiene guidelines before and after surgery.

All patients are re-evaluated on admission to hospital and active oral infections may result in the postponement of operations. If you have any inquiries, please contact either Dr. Foltyn, on (02) 8382 3129 or the Cardiothoracic Surgical Registrar on (02) 8382 1111.

Dr. Phillip Spratt
Director Cardiothoracic Surgery
Clinical Chief, Heart/Lung Vascular Institute
Director, Heart/Lung Transplant Program

Dr. Peter Foltyn. Dr. Lydia Barold.
Dental Department,
St. Vincent's Hospital (02) 8382 3129
Fax: (02) 8382 2607

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Name of Dentist: _____ Telephone: _____
Address: _____
_____ Post Code _____

Mr/Mrs/Ms/Dr_____ is free of active periodontal disease, dental carries or other infection.

Signature_____ Date _____

# Inquiry

# into Dental Services in NSW

## Addendum

The attached document formed part of my 1998 submission to the Commonwealth Senate Inquiry on Public Dental Health. At the time I lodged my submission to this Inquiry I was unable to locate a copy the 1998 submission.

This section of the guideline was primarily produced to assist Nursing Homes and Residential Care Facilities better understand oral health issues and is relevant to this inquiry. It should be read in conjunction with the section on **Aged Care** on page 9.

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Appendix L

# St. Vincent's Hospital Sydney Limited

A.C.N. 054 038 872

UNDER THE CARE OF THE SISTERS OF CHARITY

# Nursing Homes, Residential Care Facilities, Persons with Disability and Oral Health❖

No matter what one's age, good oral health is important and forms an essential part of primary health care. Unfortunately for some, ageing, illness, temporary or permanent disability and functional dependence brings with it impaired manual dexterity, limiting an individual's ability to effectively clean teeth and maintain an appropriate level of oral care. Due to these circumstances special consideration must be taken when accessing oral health care. In addition to the obvious benefits, an oral health program will be a component of quality improvement/assurance and form part of accreditation requirements.

The following are many of the issues which need to be understood and taken into account in any discussion on oral health care. It is not intended to imply that every person will require extensive and frequent dental treatment but to bring relevant aspects of oral health to the attention of those involved with the care and management the aged and unwell. For people who will spend many years in a facility, their general health and comfort can be greatly enhanced by all staff understanding oral health issues.

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❖ *For purposes of this guideline the comments refer to persons in nursing homes, residential care facilities and hospitals and people with disabilities.*

### *Dry mouth 'xerostomia'*

One of the most significant oral problems facing many nursing home residents and those in residential care is 'xerostomia' or dry mouth. Saliva is needed to lubricate the mouth, allowing easy passage of food and to neutralize food acids and bacteria. Ageing, medical conditions affecting the immune system like arthritis, Sjogrens Syndrome and HIV/AIDS, radiotherapy to the head and neck or chemotherapy as part of cancer management plus many medicines may affect salivary glands and lead to complete cessation of salivary flow.

The visible part of a tooth is protected by enamel which is the hardest part of the body; however, the normal ageing process, changes in the quantity and quality of saliva and a resultant change in the type of microorganisms present in the mouth may lead to gum recession and periodontal (gum) disease. The tooth root surfaces, which are relatively soft, become exposed and susceptible to decay. Without adequate saliva to bathe teeth, wash away food debris and dilute food acids, rapid dental decay, especially around exposed tooth root margins, takes place. The onset of xerostomia may be sudden with a dramatic impact on oral health and therefore general health. The resultant oral diseases, coupled with poor nutrition, discomfort and loss of teeth may be devastating for the individual and compound psychosocial problems. As appearance, function and comfort suffers, so may self-esteem.

Xerostomia is also important for denture wearers. Lack of saliva contributes to greater denture discomfort and irritation, poor retention and increased oral candidiasis or thrush.

### *Oral Cancer*

More than 90% of oral cancers occur in persons over the age of 40 with the average age being about 63. Significantly the population growth rate in over 60's is greater than for any other age group and must therefore inevitably lead to a greatly increased prevalence of oral cancer. In Australia over 2000 new cases of head and neck cancer are diagnosed annually, with many of these occurring in the mouth.

Of additional concern is a recent audit of the Heart/Lung Transplant Unit at St Vincent's Hospital in which the results of over 700 transplants were reviewed. Of those who have survived ten years or more following transplantation there was an alarming increase in the incidence of cancers and lymphomas, in particular lip cancers. This report is consistent with the global literature which links the immune suppression of solid organ transplant recipients and the variety of drugs they take to the increased incidence of cancer.

As many nursing home residents and those in residential care may have had organ transplantation or are also immune suppressed due to another cause there is an added reason for regular, thorough oral examination to identify an early cancerous change. Oral cancers commonly occur on the tongue, cheek and gums but can appear on any area within the mouth. The cancer may appear as a white or red patch, a change in texture of oral tissues, ulceration or swelling. Any sudden unexplained speech patterns, difficulty in swallowing, excessive bleeding from gum margins of teeth or any oral site must be explored as this may be an early sign or symptom of oral cancer. As most ulcerations, swellings and colour changes in the mouth are **NOT** cancer and may be caused by a variety of local factors or are manifestations of other illnesses, a biopsy or other investigation should be considered, especially if the ulceration, swelling or discoloration has been present for 14 days or more.

A study reported by the Centers for Disease Control in the United States indicated that the five year survival rate for oral cancer is only 53% (closer to 40% in Australia) which suggests that oral cancer is being diagnosed at an advanced stage. Early identification followed by appropriate medical management can elevate the rate of cure to nearly 80% significantly improving quality of life, whereas late diagnosis is associated with extensive, invasive and often debilitating combinations of surgery, radiotherapy and chemotherapy and increased morbidity and reduced longevity.

### *Dementia*

Dementia is an illness that affects the brain and may result in judgment, orientation, emotions, memory and thinking being impaired. It is common for people with dementia to forget or lose interest in bathing, changing their clothes or looking after their natural or artificial teeth. Although this may be extremely frustrating for health care workers, a clean and healthy mouth will be both rewarding and satisfying for the carer and patient alike.

Allow plenty of time, explain in simple terms what it is you are trying to do, endeavor to keep to the same routine, make a note of any areas of discomfort to be avoided and give plenty of encouragement. A painful and uncomfortable mouth is going to lessen the patient's ability to maintain an adequate diet with the associated deleterious consequences. Any concerns should be noted in the patient's progress notes and a dentist contacted.

### *Oral Health and Nutrition*

There is a lifetime association between oral health, nutrition and disease. An interdisciplinary, coordinated approach between dentists, other health care providers and dietitians is essential for the elderly and disabled. Poor oral health is linked to weight loss and a greater dependence on more medications (including laxatives and antireflux agents) for a greater frequency of gastrointestinal disorders. The links between oral health and nutrition can be pronounced. Infectious diseases of the mouth as well as oral manifestations of systemic diseases affect diet and nutrition but on the other hand good diet and nutrition may limit the progression of diseases of the oral cavity.

### *Dental problems hazardous to health*

Loose teeth or crowns, bridges and dentures may be aspirated (inhaled). Sharp or rough edges on teeth, fillings, dentures, crowns or bridges and broken roots may cause ulceration of oral tissues, especially if the mouth is dry. Traumatic ulcers have also been known to progress to oral cancers. Acute and chronic infections in the mouth can be an impediment to basic oral health and function causing major bite discrepancies, preventing jaw closure or mastication and have life-threatening systemic consequences.

### *Assessment*

All new residents must be provided with an oral assessment on entering a nursing home or residential care facility followed by a complete examination conducted by a dentist within 21 days. There is also an obligation on the part of any hospital or facility involved in the initial admission of a patient where it can be reasonably anticipated that the patient's stay may exceed 30 consecutive days at their facility ( or in combination with a second or subsequent facility) to arrange an oral assessment. This provides a baseline of oral health on which future treatment may be planned. Because breakdown of oral and dental structures is often rapid in the elderly or disabled a complete examination conducted by a dentist should be repeated for each resident every six months.

### *Care Plan*

A resident's care plan must also address oral health, including cleaning of natural teeth (by a dentist, hygienist or therapist), gum (periodontal) treatment, restoration or removal of teeth, nerve treatment (endodontic therapy) and fabrication or repair of dentures. To avoid an oral focus of infection special attention should be given to any person giving a history of infective endocarditis, prosthetic heart valves, prosthetic joints and pins, plates or screws which are

used in repairing fractured bones. As certain medications have been associated with gingival overgrowth and could lead to an unmanageable form of periodontal disease if left unchecked, some patients may need to be reviewed more frequently.

### *Carers and Family Members*

Caregivers or family members should recognize the importance of regular oral examinations and ongoing oral health care although there may be competing needs for funds required to provide other services. Staff who are well educated in oral health care are generally able to impress upon carers and family members the importance or urgency of treatment proposals.

### *Dentures*

Complete or partial dentures are worn by many in the community. Ageing and ill-health often cause weight loss which affects the fit and comfort of dentures. Rough spots, tight or loose retentive clasps and well worn dentures lead to a variety of oral problems. Optimal daily care and maintenance of dentures will reduce fungal and other infections in the mouth which could compromise general health.

### *Infection Control*

All oral care procedures must be carried out in accordance with an individual State's Infection Control Policy. In the absence of an official Infection Control Policy or guideline the key reference documents to be referred to should include:

- Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases. NHMRC/ANCA April 1996

- Code of practice for cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care settings. Standards Australian AS4187 - 1994

- State and Commonwealth WorkCover Authority and Worksafe Australia guidelines re: blood-borne pathogens in the workplace and any State Occupational Health and Safety Act.

### *Palliative Care*

Choice of dental materials, techniques and procedures should be considered for the terminally ill patient as it may not be possible to provide ideal oral care or within a given period of time. In such circumstances reducing the discomfort or severity of symptoms

without curing or eliminating the underlying cause may be reasonable and appropriate management.

### *Informed Consent*

Every treatment or procedure, regardless of how minor, involves some risk. Nursing home or residential care facility staff and the treating dentist must advise the patient, or if the patient lacks decision-making capability a recognised carer or family member, of these risks as well as benefits of treatment. There must be sufficient information provided so an informed decision concerning treatment options can be made. Signed consent is not necessary for minor dental procedures; however, documentation must be made in the patient's records. Signed consent must be obtained for any procedure under sedation or general anaesthesia or when significant discomfort might be anticipated as a consequence of the treatment.

### *Records*

All oral health service records should be part of a resident's general records and readily available to all nursing and medical staff and family members. It should include a customised daily oral health care plan and other proposed treatment. Each procedure should be checked and dated when completed.

### *Transportation*

Should the facility or attending dentist not be able to provide specific oral care services on the premises or the family are unable to assist in providing transportation a plan should be established to expedite treatment at an outside setting.

### *Continuing Education*

As ongoing oral and dental care is generally provided by registered nurses, aides, volunteers and family members, an understanding of oral and dental anatomy, oral hygiene techniques and basic dental procedures by those involved benefits the resident and the facility. A training program should be established for all involved in patient care, repeated annually or as required due to staff turnover.

### *Oral Health Standards*

Compliance with oral health requires close assessment of the following:

1. Does the facility have a protocol for enabling access to oral health services?

2. Are residents or their families able to access the dental practitioner of choice?

3. Do oral health records form part of medical records?

4. Is a baseline oral health status recorded for each new resident?

5. Are the care goals consistent with the patient's baseline oral health status?

6. Are the care goals consistent with the patient's general medical condition?

7. Are the care goals likely to be of benefit to the patient?

8. When existing oral or dental disease is identified:

   (a) if symptomatic, is appropriate treatment instigated?
   (b) if asymptomatic, is the patient's oral health status monitored as frequently as the condition requires?

9. If potentially life-threatening conditions are identified are they treated promptly and appropriately?

10. Does the care provided conform to standards endorsed by dental professionals?

11. Is there a specific policy on the care and maintenance of dentures? Does the facility have a mechanism to expedite the repair or replacement of a broken denture?

12. Would an independent audit of a patient's oral health indicate that it is optimal?

13. Has the facility a staff training program in Oral Health?

14. Does Oral Health form part of the facility's quality improvement program?

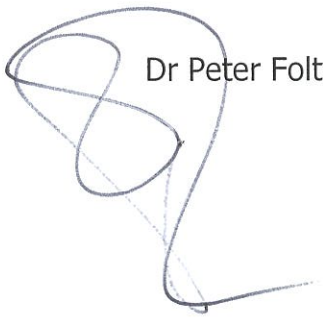
ST VINCENT'S HOSPITAL SYDNEY LIMITED
A.B.N. 77 054 038 872
UNDER THE CARE OF THE SISTERS OF CHARITY

15 June 2005

Director of Standing Committee on Social Issues
NSW Parliament
Macquarie Street
Sydney 2000

Please find to follow an addendum to my submission to the 'Inquiry into Dental Services in NSW'.

Appendix L was part of my 1998 submission to the Commonwealth Senate Inquiry into Public Dental Services, which I had intended to include n this submission but had mislaid and thought it lost.



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