### COLLEGE OF DENTAL HYGIENISTS OF ONTARIO ADVISORY

#### ADVISORY TITLE

Use of the dental hygiene interventions of scaling of teeth and root planing including curetting surrounding tissue, orthodontic and restorative practices, and other invasive interventions for persons\(^1\) with dementia.

#### ADVISORY STATUS

Cite as

*College of Dental Hygienists of Ontario, CDHO Advisory Dementia, 2015-06-30*

#### INTERVENTIONS AND PRACTICES CONSIDERED

Scaling of teeth and root planing including curetting surrounding tissue, orthodontic and restorative practices, and other invasive interventions (“the Procedures”).

#### SCOPE

### DISEASE/CONDITION(S)/PROCEDURE(S)

**Dementia**

#### INTENDED USERS

- Advanced practice nurses
- Dental assistants
- Dental hygienists
- Dentists
- Denturists
- Dieticians
- Health professional students
- Nurses
- Patients/clients
- Pharmacists
- Physicians
- Public health departments
- Regulatory bodies

#### ADVISORY OBJECTIVE(S)

To guide dental hygienists at the point of care relative to the use of the Procedures for persons who have dementia, chiefly as follows.

1. Understanding the medical condition.
2. Sourcing medications information.
3. Taking the medical and medications history.
4. Identifying and contacting the most appropriate healthcare provider(s) for medical advice.

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\(^1\) Persons includes young persons and children
5. Understanding and taking appropriate precautions prior to and during the Procedures proposed.
6. Deciding when and when not to proceed with the Procedures proposed.
7. Dealing with adverse events arising during the Procedures.
8. Keeping records.

TARGET POPULATION

Middle Age (45 to 64 years)
Aged (65 to 79 years)
Aged 80 and over
Male
Female

Parents, guardians, and family caregivers of children, young persons and adults with dementia.

MAJOR OUTCOMES CONSIDERED

For persons who have dementia: to maximize health benefits and minimize adverse effects by promoting the performance of the Procedures at the right time with the appropriate precautions, and by discouraging the performance of the Procedures at the wrong time or in the absence of appropriate precautions.

RECOMMENDATIONS

UNDERSTANDING THE MEDICAL CONDITION

Terminology used in this Advisory

Resources consulted

- Alzheimer’s disease: Alzheimer Society of Canada
- Vascular Dementia: Alzheimer Society Toronto
- Seniors and Dementia Disorders, including Alzheimer’s Disease: Canadian Mental Health Association

Dementia is a set of symptoms and signs associated with changes in particular parts of the brain, which

1. is characterized chiefly by
   a. loss of memory
   b. impairment of judgment and reasoning
   c. changes in thinking, mood, and behaviour
   d. loss of communication abilities.
2. occurs as disorders which manifest the symptoms of dementia, chiefly
   a. Alzheimer’s disease, the most common dementia-related condition, of two types
      i. sporadic Alzheimer’s disease
      ii. familial Alzheimer’s disease
   b. Creutzfeldt-Jakob disease
c. **frontotemporal dementia**

d. **Lewy body dementia**

e. **vascular dementia**, the second most common dementia-related condition.

**Overview of dementia**

**Resources consulted**

- **Alzheimer’s disease**: Alzheimer Society of Canada
- **Alzheimer’s disease**: PubMed Health
- **Approach to management of mild to moderate dementia, Canadian guidelines**: Canadian Medical Association Journal
- **Co-Morbidity and Dementia**: American Medical Association
- **Confusion**: PubMed Health
- **Dementia - home care**: PubMed Health
- **Dementia**: MedlinePlus
- **Dementia**: PubMed Health
- **Frontotemporal Lobe Dementia**: Medscape
- **Including Persons With Alzheimer Disease in Research on Comorbid Conditions**: Medscape (membership required, free)
- **Lewy body Dementia**: Alzheimer Society of Canada
- **Observing and talking about pain behaviors**: University of Alberta
- **Pick’s disease**: PubMed Health
- **Safeguarding vulnerable adults – a tool kit for general practitioners**: British Medical Association
- **Seniors and Dementia Disorders, including Alzheimer’s Disease**: Canadian Mental Health Association
- **Vascular Dementia**: Alzheimer Society Toronto

**Dementia**

1. describes a set of **signs and symptoms** arising from loss of brain function, that
   a. in most dementia-related conditions
      i. is nonreversible
      ii. cannot be cured or slowed in its progression
   b. most commonly is caused in elderly adults by **Lewy body disorder**
   c. may be a comorbidity, complication or associated condition of other brain disorders.

2. occurs in
   a. 8 percent of Canadians over the age of 65 years
   b. 35 percent of seniors aged 85 years and over.

3. results from particular causes or is associated with risk factors that
   a. include
      i. amyotrophic lateral sclerosis (**CDHO Advisory**)
      ii. Huntington’s disease
      iii. infections of the brain, such as
         1. HIV/AIDS (**CDHO Advisory**)
         2. Lyme disease
      iv. many small strokes
      v. multiple sclerosis (**CDHO Advisory**)

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vi. Parkinson’s disease (*CDHO Advisory*)

vii. frontotemporal dementia (Pick’s disease)

viii. progressive supranuclear palsy

b. also include causes that may be stopped or reversed if they are found soon enough, such as

i. anemia (*CDHO Advisory*)

ii. brain tumours (*CDHO Advisory*)

iii. chronic alcohol abuse (*CDHO Advisory*)

iv. depression (*CDHO Advisory*)

v. low vitamin B12 levels (*CDHO Advisory*)

vi. medication side effects

vii. metabolic causes

viii. normal-pressure hydrocephalus

c. age, because

i. the risk of dementia rises with age

ii. dementia is rare under age 60.

4. presents signs and symptoms that include

a. difficulty with mental functions, including

i. cognitive skills, such as

1. abstract thinking

2. calculation

3. judgment

ii. emotion

iii. behaviour

iv. expression of personality

v. language

vi. memory

vii. perception

b. pain, which may be directly related to *comorbidities, complications and associated conditions*, which

i. may not be recognized, assessed or treated effectively

1. because elderly persons with dementia differ from elderly persons without dementia in the ways they

   a. perceive or experience pain

   b. describe, express or signal pain which persons with dementia may through behaviours

      i. such as rocking or striking out

      ii. which may be wrongly attributed to dementia

2. which may result in common, painful conditions, such as mouth ulcers, remaining undetected

ii. requires professional service providers, such as dental hygienists, and family caregivers to understand

1. when an elderly person is experiencing pain

2. when treatment is required

iii. requires for the patient/clients

1. necessary investigation and care regardless of mental status

2. coordination of medications used for pain management

c. mild cognitive impairment as the initial appearance, which
i. is the stage between normal forgetfulness due to aging and the development of dementia
ii. is characterized by mild problems with thinking and memory that
   1. do not interfere with everyday activities
   2. are apparent to the person
iii. does not invariably develop into a dementia-related condition
d. difficulties manifested as
i. general categories of challenges, such as
   1. difficulty in performing more than one task at a time
   2. difficulty in solving problems
   3. forgetting of recent events or conversations
   4. requiring extra time in performing somewhat complex mental activities
ii. specific problems, such as
   1. difficulty in naming familiar objects
   2. misplacing things
   3. getting lost on familiar routes
   4. impairment of social skills
   5. undergoing personality changes
   6. losing interest in things previously enjoyed
   7. flat mood
   8. difficulty performing tasks such as
      a. balancing a checkbook
      b. playing card games
      c. learning new information or routines
e. increasing interference with life and self-care through
i. forgetfulness of
   1. details of current events
   2. events in the person’s own life history
ii. social withdrawal
iii. loss of self-awareness
iv. nocturnal wakefulness
v. major difficulty reading or writing
vi. impairment of
   1. judgment
   2. ability to recognize danger
vii. word confusion, pronunciation difficulty, muddle in spoken sentences
viii. hallucinations, argumentativeness, threatening and violent behaviour
ix. delusions, depression, and agitation
x. difficulty with basic tasks, such as preparing meals, choosing proper clothing, and driving
f. late-stage loss of ability to
i. understand language
ii. recognize family members
iii. perform basic activities of daily living, such as eating, dressing, and bathing
g. physical manifestations, such as
i. incontinence
ii. swallowing difficulties.

5. is clinically investigated by tests
   a. of mental status
   b. for causes that can be arrested.

6. is treated with regimens that
   a. aim to control symptoms
   b. focus on the causal condition if one can be recognized
   c. may involve short or long-term residential or institutional care
   d. require caution in altering medications, because some changes may increase confusion
   e. involve mental stimulation and attention to quality of life of the person and of family caregiver
   f. address comorbid conditions, complications and associated conditions which adversely affect mental function, such as
      i. anemia (CDHO Advisory)
      ii. decreased oxygenation of the blood
      iii. depression (CDHO Advisory)
      iv. heart failure (CDHO Advisory)
      v. infections
      vi. nutritional disorders (CDHO Advisory)
      vii. thyroid disorders (CDHO Advisory), (CDHO Advisory)
   g. use medications
   h. include regular checks of
      i. vision
      ii. hearing
   i. increasingly involve communal and inclusive activities, such as
      i. dancing
      ii. familiar activities appealing to the person
   j. do not normally involve psychotherapy or group therapy because these may increase rather than decrease confusion.

7. can be prevented only to a limited extent
   a. chiefly through life-style changes to prevent vascular dementia
   b. because most types of dementia are not preventable.

8. offers a variable prognosis because dementia
   a. may not always develop from mild cognitive impairment
   b. when it does develop, it usually
      i. progresses
      ii. diminishes the quality of life
      iii. decreases lifespan.

9. generates complex social considerations which
   a. become pressing when
      i. dementia develops
      ii. a sudden change in mental status occurs
      iii. the mental condition of a person worsens
      iv. the family caregiver is unable to care for the person at home
   b. raise difficult ethical questions, such as the patient/client’s
      i. decision-making capacity for giving consent for
         1. the Procedures
2. disclosure of personal health information (CDHO Clinical Information Practice Standard for Dental Hygiene)

ii. vulnerability socially, mentally, physically and financially

c. often require involvement of support groups, such as in

i. Canada
- I have Alzheimer’s Disease: Alzheimer Society of Canada
- On Memory: In conjunction with the Alzheimer Society of Canada
- Seniors’ Info: Government of Ontario

ii. US
- Alzheimer’s Association
- Alzheimer’s Disease Education and Referral Center
- Alzheimer’s Disease Research.

10. occurs chiefly as the following disorders
    a. Alzheimer’s disease

    i. was first identified in 1906 by Dr Alois Alzheimer, who described
        1. numerous dense microscopic deposits, plaques, scattered throughout the brain which when excessive harm brain cells
        2. tangles, which interfere with the brain’s physiological processes and eventually choke off the living cells

    ii. is the most common dementia-related condition

    iii. is of two types

    1. sporadic Alzheimer’s disease, which
        a. accounts for more than 90 percent of diagnoses of Alzheimer’s disease
        b. may affect adult men and women of all ages though mostly occurs in persons over the age of 65 years
        c. may take up to 20 years to develop

    2. familial Alzheimer’s disease, which
        a. account for fewer than 10 percent of diagnoses of Alzheimer’s disease
        b. is caused by a genetic mutation
        c. begins in the age range of 40 to 50 years

    iv. accounts for about 64 percent of all dementia-related conditions diagnosed in Canada

    v. is a progressive, degenerative disease of the brain
        1. characterized by deterioration of thinking ability and memory
        2. caused by progressive death of brain cells

    vi. is marked by shrinking of some parts of the brain following degeneration and death of brain cells

    vii. is associated with Down syndrome (CDHO Advisory) which, as aging progresses, leads to the types of changes in the brain observed in Alzheimer’s disease, though not all persons with Down syndrome develop it

    viii. presents as
        1. gradual onset and continuing decline of memory
        2. changes in judgment and reasoning
        3. loss of ability to perform familiar tasks

    ix. affects all aspects of a person’s life: thinking, feeling and acting
x. varies widely in its impact on individuals, making unpredictable the
   1. effects experienced
   2. order in which the effects appear
   3. rate of progression

xi. involves impairment of
   1. mental abilities
      a. to understand, think, remember and communicate
      b. to make decisions; simple tasks performed for years become more difficult or are forgotten
      c. to find the right words and follow a conversation
      d. to recall recent events and ultimately events in the distant past, reflective of memory loss and confusion
   2. emotions and moods, revealed as
      a. uninterested, apathetic and withdrawn demeanour
      b. diminished expressiveness
      c. loss of interest in hobbies and activities previously enjoyed
      d. loss of ability to control mood and emotion, though it seems that even in the later stages of the disease the person may continue to experience joy, anger, fear, love, and sadness
   3. behaviour, in the form of
      a. changes observed in the person’s reactions to surroundings
      b. actions that seem out of character
      c. repetitiveness of
         i. actions or words, statements and questions
         ii. hiding of possessions
         iii. physical outbursts and restlessness
   4. physical abilities manifested as
      a. loss of physical co-ordination and mobility, leading to gradual physical decline
      b. deterioration in the performance of day-to-day tasks of self-care such as eating, bathing, getting dressed and oral hygiene.

b. Creutzfeldt-Jakob disease
   i. is a rare, rapidly fatal disease of the type spongiform encephalopathy believed to be caused by transmissible abnormal proteins called prions
   ii. occurs in animals, for example in cattle as bovine spongiform encephalopathy known also as “Mad Cow” disease.

c. Lewy body dementia
   i. is characterized by abnormal deposits of a protein, called Lewy bodies, that form inside the nerve cells of the brain
   ii. chiefly affects the areas of the brain involved in thinking and movement
   iii. is of unknown cause
   iv. accounts for 15 to 20 percent of all dementias diagnosed
   v. occurs alone or in conjunction with
      1. Alzheimer’s disease
2. Parkinson’s disease *(CDHO Advisory)*.

d. **Frontotemporal dementia**
   
i. is also known as Pick’s disease
   
ii. comprises a group of rare disorders primarily affecting the frontal and temporal lobes of the brain, the areas generally associated with personality and behaviour
   
iii. include types in which brain cells
   
   1. in the areas shrink or die
   
   2. enlarge and contain round *Pick’s bodies*
   
iv. accounts for some 2 percent of dementia-related conditions.

e. **Vascular dementia**, the second most common type of dementia-related condition, which
   
i. occurs when the cells in the brain die because they are deprived of oxygen
   
ii. is commonly caused by many small strokes
   
iii. occurs less commonly as *Binswanger’s disease*, which is
   
   1. caused by atherosclerosis in the brain’s white matter
   
   2. associated with hypertension.

**Multimedia and images**

*Alzheimer’s disease*

*Alzheimer’s disease, video*

**Comorbidity, complications and associated conditions**

Comorbid conditions are those which co-exist with dementia but which are not believed to be caused by it. Complications and associated conditions are those that may have some link with it. Distinguishing among comorbid conditions, complications and associated conditions may be difficult in clinical practice.

Comorbidities, complications and associated conditions of dementia include the following categories.

1. Antecedents
   
a. alcoholism
   
b. brain injury
   
c. drug abuse
   
d. side effects of certain medications
   
e. thyroid function abnormalities
   
f. vitamin B12 deficiency.

2. Circumstances
   
a. abuse by a caregiver
   
b. malnutrition because of
   
   i. the person’s confusion
   
   ii. inadequacy of care for the person
   
c. infection because of inadequate care or self-care
   
d. side-effects of treatments including
i. medications
ii. inappropriate care
e. constipation.

3. Consequences
   a. loss of ability to
      i. function unaided
      ii. care for self
      iii. to interact with family, friends and caregivers
   b. impairment of the quality of life of the person with dementia, the family and the family caregiver, associated with the person’s
      i. apathy
      ii. depression
      iii. anxiety
   c. physical injury, such as hip fracture
   d. pain, dyspnea, agitation, depression, and other symptoms which could be associated with a comorbidity, complications and associated conditions of dementia rather than the dementia itself
   e. development of chronic conditions requiring medical care, and which contribute more to mortality than the dementia itself such as
      i. cardiovascular disease
         1. congestive heart failure
         2. coronary artery disease
         3. ischemic heart disease
      ii. chronic obstructive pulmonary disease
      iii. diabetes
      iv. genitourinary disorders
   f. in the late stages, requirement for palliative, hospice or residential care
   g. reduced lifespan.

Oral health considerations

Resources consulted

- Approach to management of mild to moderate dementia, Canadian guidelines: Canadian Medical Association Journal
- Dental care and dementia: Alzheimer’s Society
- Dental Care in Dementia: About.com
- Dental surgery attendance amongst patients with moderately advanced dementia attending a day unit: a survey of carers’ views: British Dental Journal
- Personal Care: Alzheimer Society of Canada

The dental hygienist is an important service provider in the care of persons with dementia because appropriate oral healthcare
1. is necessary in light of findings that poor oral hygiene is more common in dementia compared with age-matched controls, a gap in health status which is attributed to
   a. deterioration in self-care
   b. diminished ability to adapt to changes such as new dentures.
2. is important to prevent tooth decay and gum disease, which may diminish the patient/client’s ability and willingness to eat.
3. calls for oral assessment
   a. early in the development of dementia
   b. focused on retention of natural teeth.
4. requires consideration of the role of the family caregiver because
   a. for the care of persons with mild-to-moderate dementia, Canadian healthcare
      policy seeks to change the existing model of chronic disease management from
      reliance on self-management by the person to greater involvement of the family
      caregiver, a change which
      i. aligns with Aging at Home, a strategy widely favoured in Canada by
         government and public
      ii. increases the care load and associated burdens of responsibility for
          family caregivers
   b. the care load and associated burdens on families and family caregivers may
      actually increase when the person is transferred to facility-based care
   c. family or other caregivers may be reluctant to accompany a dementia
      patient/client for oral healthcare because of
      1. anxiety that he or she may be uncooperative
      2. concerns that he or she may become upset
         a. en route to the oral healthcare office
         b. by the presence of an oral healthcare professional in
            his/her home or place of residence
      3. inadequate preparation for the oral healthcare visit, for
         example by omission of reassurances that even patient/clients
         with advanced dementia may be able to co-operate with oral
         healthcare because appropriate behaviours learned in
         childhood may be retained
      4. of concerns that oral healthcare may not be sufficiently
         beneficial to justify risk of provoking behavioural problems.
5. requires communication with the family caregiver because the patient/client may be
   unable to
   a. recall important aspects of his or her medical history
   b. describe symptoms accurately
   c. remember appointments.
6. should be closely integrated with the person’s care generally because
   a. in the early stages of dementia the patient/client may be capable of oral self-
      care but nevertheless may
      i. need reminding, supervision or help
      ii. be assisted with an electric toothbrush or a toothbrush with a grip-
          enhancing adaptation
   b. in the later stages of dementia, when self-care skills and interest in most
      aspects of self-care diminishes, the patient/client may
      i. lose the ability for cleaning teeth
      ii. lose interest in oral self-care
      iii. need family or other care providers to take over, who themselves
          require guidance on technique
      iv. may require adequate sedation for the Procedures.
7. requires mouth checks as the person/client’s ability to describe or report oral
   symptoms, including pain, diminishes with progression of dementia; such checks should
   include
a. inspection for
   i. injury from biting and other trauma
   ii. signs of oral cancer
b. enquiry of family caregiver for signs such as
   i. rubbing or touching the cheek or jaw
   ii. moaning or shouting
   iii. head rolling or nodding
   iv. flinching when washing the face or being shaved
   v. refusing hot or cold food or drinks
   vi. restlessness, poor sleep, increased irritation or aggression
   vii. refusal or reluctance to use dentures not previously a problem.
8. involves review of the oral side effects of medications taken by the patient/client.

MEDICATIONS SUMMARY

Sourcing medications information

1. Adverse effect database
   ▪ Health Canada’s Marketed Health Products Directorate
toll-free 1-866-234-2345
   ▪ Health Canada’s Drug Product Database

2. Specialized organizations
   ▪ US National Library of Medicine and the National Institutes of Health Medline Plus Drug Information
   ▪ WebMD

3. Medications considerations
   All medications have potential side effects whether taken alone or in combination with other prescription medications, or as over-the-counter (OTC) or herbal medications.

4. Information on herbals and supplements
   ▪ US National Library of Medicine and the National Institutes of Health Medline Plus Drug Information All Herbs and Supplements

5. Complementary and alternative medicine
   ▪ National Center for Complementary and Alternative Medicine

Types of medications

Medications
1. cannot halt or reverse brain damage in dementia generally or Alzheimer’s disease specifically.
2. are used to
   a. relieve symptoms and possibly delay their appearance
   b. control behaviour problems caused by a loss of judgment, increased impulsivity, and confusion
   c. slow the rate at which symptoms worsen.
3. are supplemented by medication treatments for comorbidities, complications and associated conditions.
4. include
   a. antipsychotics
      - haloperidol (no brand name products)
      - olanzapine (Zyprexa®)
      - risperidone (Risperdal®)
   b. mood stabilizers
      - citalopram (Celexa®)
      - fluoxetine (Prozac®, Rapiflux®, Sarafem®, Selfemra®)
      - imipramine (Tofranil®)
   c. anti-anxiety and anti-depression medications
      - buspirone (BuSpar®)
      - trazodone (no brand name products)
   d. tranquilizers
      - alprazolam (Alprazolam Intensol, Xanax®)
      - diazepam (Valium®)
   e. stimulants
      - methylphenidate (Concerta®, Methylrin®, Metadate®, Ritalin®)
   f. cholinesterase inhibitors, which increase the levels of or enhance the effectiveness of acetylcholine, a chemical messenger in the brain
      - donepezil (Aricept®)
      - galantamine (Razadyne®, formerly called Reminyl®)
      - rivastigmine (Exelon®)
   g. medication which may be used in conjunction with cholinesterase inhibitors
      - memantine (Ebixa®, Namenda®).

Side effects of medications

See the links above to the specific medications.

THE MEDICAL AND MEDICATIONS HISTORY

The dental hygienist in taking the medical and medications history-taking should
1. focus on screening the patient/client prior to treatment decision relative to
   a. key symptoms
   b. medications considerations
   c. contraindications
   d. complications
   e. comorbidities
   f. associated conditions.
2. explore the need for advice from the primary or specialized care provider(s).
3. inquire about
   a. the patient/client’s understanding and acceptance of the need for oral healthcare
   b. symptoms indicative of inadequate emotional moods and behavioural changes likely to adversely affect oral healthcare
   c. medications considerations, including over-the-counter medications, herbals and supplements
d. problems with previous dental/dental hygiene care  
e. problems with infections generally and specifically associated with dental/dental hygiene care  
f. the patient/client’s current state of health  
g. how the patient/client’s current symptoms relate to  
   i. oral health  
   ii. health generally  
   iii. recent changes in the patient/client’s condition.

IDENTIFYING AND CONTACTING THE MOST APPROPRIATE HEALTHCARE PROVIDER(S) FOR ADVICE

Identifying and contacting the most appropriate healthcare provider(s) from whom to obtain medical or other advice pertinent to a particular patient/client

The dental hygienist should
1. record the name of the physician/primary care provider most closely associated with the patient/client’s healthcare, and the telephone number  
2. obtain from the patient/client or parent/guardian written, informed consent to contact the identified physician/primary healthcare provider  
3. use a consent/medical consultation form, and be prepared to fax the form to the provider  
4. include on the form a standardized statement of the Procedures proposed, with a request for advice on proceeding or not at the particular time, and any precautions to be observed.

UNDERSTANDING AND TAKING APPROPRIATE PRECAUTIONS

Infection Control

Dental hygienists are required to keep their practices current with infection control policies and procedures, especially in relation to
1. the CDHO’s Infection Prevention and Control Guidelines (2019)  
2. relevant occupational health and safety legislative requirements  
3. relevant public health legislative requirements  
4. best practices or other protocols specific to the medical condition of the patient/client.

DECIDING WHEN AND WHEN NOT TO INITIATE THE PROCEDURES PROPOSED

1. There is usually no contraindication to the Procedures.  
2. With an otherwise healthy patient/client whose symptoms are under control and whose treatment is proceeding normally, the dental hygienist should implement the Procedures, though these may be postponed pending medical advice, which is likely to be required if the patient/client has
   a. symptoms or signs of
      i. behavioural or other dementia-related problems likely to cause difficulties before or during the Procedures
      ii. comorbidity, complication or an associated condition of dementia
      iii. not recently or ever sought and received medical advice relative to oral healthcare procedures
iv. recently changed significant medications, under medical advice or otherwise
v. recently experienced changes in his/her medical condition such as medication or other side effects of treatment
vi. is deeply concerned about any aspect of his or her medical condition.

DEALING WITH ANY ADVERSE EVENTS ARISING DURING THE PROCEDURES

Dental hygienists are required to initiate emergency protocols as required by the College of Dental Hygienists of Ontario’s Standards of Practice, and as appropriate for the condition of the patient/client.

First-aid provisions and responses as required for current certification in first aid.

RECORD KEEPING

Subject to Ontario Regulation 9/08 Part III.1, Records, in particular S 12.1 (1) and (2) for a patient/client with a history of dementia, the dental hygienist should specifically record
1. a summary of the medical and medications history
2. any advice received from the physician/primary care provider relative to the patient/client’s condition
3. the decision made by the dental hygienist, with reasons
4. compliance with the precautions required
5. all Procedure(s) used
6. any advice given to the patient/client.

ADVISING THE PATIENT/CLIENT

The dental hygienists should
1. urge the patient/client or the caregiver to alert any healthcare professional who proposes any intervention or test of
   a. the history of dementia
   b. the medications he or she is taking.
2. should discuss, as appropriate
   a. the importance of
      i. checking of the mouth regularly for new signs or symptoms
      ii. reporting to the appropriate healthcare provider any changes in the mouth
   b. the need for regular oral health examinations and preventive oral healthcare
   c. oral self-care or assisted care and provide as required information about
      i. choice of toothpaste
      ii. tooth-brushing techniques and related devices
      iii. dental flossing
      iv. mouth rinses
      v. management of a dry mouth
      vi. the importance of an appropriate diet in the maintenance of oral health
      vii. special considerations for persons at an advanced stage of a disease or debilitation
   d. regimens for oral hygiene as a component of supportive care and palliative care
e. the role of the family caregiver, with emphasis on maintaining an infection-free environment through hand-washing and, if appropriate, wearing gloves
f. scheduling and duration of appointments to minimize stress and fatigue
g. comfort level while reclining, and stress and anxiety related to the Procedures
h. medication side effects such as dry mouth, and recommend treatment
i. mouth ulcers and other conditions of the mouth relating to dementia, comorbidities, complications or associated conditions, medications or diet
j. pain management.

BENEFITS/HARMS OF IMPLEMENTING THE RECOMMENDATIONS

POTENTIAL BENEFITS

1. Promoting health through oral hygiene for persons who have dementia.
2. Reducing the adverse effects, such as stress and fear by
   a. appropriately interpreting the person’s history as it pertains to dementia
   b. generally increasing the comfort level of persons in the course of dental hygiene interventions
   c. using appropriate techniques of communication
   d. providing advice on scheduling and duration of appointments.
3. Reducing the risk that oral health needs are unmet.

POTENTIAL HARMS

1. Causing adverse emotional, moods and behavioural changes.
2. Performing the Procedures at an inappropriate time, such as
   a. when the dementia patient/client
      i. is likely to be alarmed or destabilized by the prospect of or application of the Procedures
      ii. is affected or debilitated by comorbidities
   b. in the presence of complications for which prior medical advice is required
   c. in the presence of acute oral infection without prior medical advice.
3. Disturbing the normal dietary and medications routine of a person with dementia.
4. Inappropriate management of pain or medication.

CONTRAINDICATIONS

CONTRAINDICATIONS IN REGULATIONS

Identified in the Dental Hygiene Act, 1991 – O. Reg. 218/94 Part III

DATE OF LAST REVIEW

2015-06-30

ADVISORY DEVELOPER(S)

College of Dental Hygienists of Ontario, regulatory body
Greyhead Associates, medical information service specialists
<table>
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<th><strong>SOURCE(S) OF FUNDING</strong></th>
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<th><strong>COMPOSITION OF GROUP THAT AUTHORED THE ADVISORY</strong></th>
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<th><strong>ACKNOWLEDGEMENTS</strong></th>
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<td>The College of Dental Hygienists of Ontario gratefully acknowledges the Template of Guideline Attributes, on which this advisory is modelled, of The National Guideline Clearinghouse™ (NGC), sponsored by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services.</td>
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<td>Final layout and proofreading</td>
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