PROCEDURE	
Oral health examination	
Scope (Staff):	Community health staff
Scope (Area):	CACH, WACHS

This document should be read in conjunction with this DISCLAIMER

Aim

To identify children at increased risk of oral disease and early identification of early childhood caries (ECC).

Risk

Failure to identify early childhood caries (ECC) can affect a child's quality of life and may lead to the development of chronic diseases such as cardiovascular disease, respiratory disease, kidney disease and mouth cancers later in life.[1]

Background

Oral health conditions are responsible for the highest number of acute hospital admissions in Western Australian children; therefore prevention of poor oral health is a significant public health measure.[2] Despite the fact that it is largely preventable, early childhood caries (ECC) remains one of the most common chronic diseases of early childhood.[3] Impacts include pain, irritability and disturbed sleeping habits, and cognitive development. The effects of poor oral health extend beyond the child, to the family, the community and the health care system.[4, 5]

ECC is a form of severe decay that affects the primary dentition in young children. It is a serious dental condition occurring in the first three years of life and can occur as soon as the first tooth erupts, and is commonly found on the upper front teeth but other teeth may also be affected. There are a number of genetic factors which increase the risk of dental caries, including family history of caries;[6] the shape of cusps, ridges, and grooves in teeth and elements of saliva such as pH[7] that can increase the likelihood of caries in fissures and pits.[6] While it is important to be aware of these. The focus of this guideline is on environmental and behavioral factors which are amenable to change.

ECC is associated with early intake of sugary foods, drinks and snacks. It may occur in young children who are given pacifying bottles of juice, milk, formula, soft drink or cordial to drink for prolonged periods during the day or overnight (inappropriate feeding methods). Multiple factors contribute to ECC, including socioeconomic, behavioural, and psycho-social influences. ECC is an active process of tooth destruction resulting from the interactions between teeth, food and bacteria. Children are not born with decay causing bacteria. While the disease is initiated by bacteria, the presence of bacteria alone will not result in decay. In children, oral hygiene is a good predictor of future caries.[2] The evidence strongly shows that ECC is one of few chronic diseases that, if preventive strategies are implemented, can be mostly avoided.[8]

The pain, psychological trauma, health risks and costs associated with restoration of carious teeth for children affected by early childhood caries can be substantial. If teeth are lost or need to be extracted in early life it can affect speech development and space for permanent teeth. [3, 4]

More than one-third of six year old children in Western Australian experience tooth decay. The prevalence of tooth decay is as much as 50% higher in children from low socioeconomic backgrounds and Aboriginal children.[8] [9] The average rates of tooth decay in Aboriginal children are twice as high as non-Aboriginal children and are rising, particularly in the baby teeth.[1]

The identification of children at risk of oral disease and the detection of ECC at an early age can prevent widespread destruction of the deciduous teeth and is critical to good oral health outcomes for children.[8] Current evidence suggests that potentially effective interventions should occur in the first 2 years of a child's life. There is evidence that nurses have embraced programs such 'Lift the lip', and that it is successful in screening those children who require priority dental care.[10]

Oral health inspections using the 'Lift the lip' program are recommended during the 12 month and two year contacts, and as a component of the School Entry Health Assessment, after receiving a completed CHS409-1. It may also be part of the 'general' health assessment or used at any other time where there is parent/caregiver or staff concern from the time the first tooth erupts. When children are already receiving specialist care for existing conditions such as cleft lip and palate, it is not necessary to complete the physical examination. Parent/caregivers should still receive the health education component and resources.

Key Points

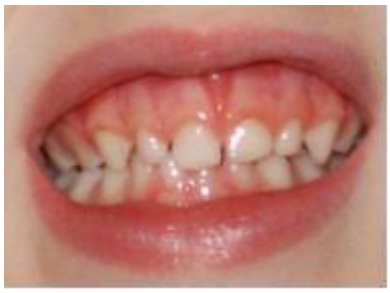
Before conducting a mouth examination, explain that:

- Baby teeth are important
- By maintaining a healthy mouth, parents can help prevent or reduce decay risk in themselves and their children
- Preventing tooth decay is easier and less costly than treating it
- The earlier that decay is detected the better the outcomes will be for the child
- It is important to conduct 'lift the lip' regularly at home to look for early signs of decay (at least once a month).

Equipment

- Disposable latex free gloves (may be used in child health settings, not required in school settings)
- Penlight torch (may be used in child health settings)

Procedure

Steps	Additional Information
1. Position the child appropriately so that the 'Lift the lip' assessment can be performed. **a) In a child health setting:** Child sits on parent/caregiver's lap, facing the parent/caregiver. Parent/caregiver gently leans them back so their head is resting on the nurse's lap. With gloved hands, the nurse lifts the lip and checks the health of the teeth and surrounding soft tissues. Alternatively, the child sits on the parent/caregiver's lap, facing the nurse. Parent/caregiver leans the child back so their head is resting on their lap and lifts the child's lip so the nurse can look inside the mouth. No gloves are required for this method and it encourages the parent/caregiver to feel comfortable and confident about 'lifting the lip' at home. **b) In a school setting:** Nurse sits in a chair and with child in front, facing the nurse. • The child is asked to lift their lip to allow the nurse to check the health of the teeth and surrounding soft tissues.	 
2. Examine the upper front teeth and look for signs of tooth decay, e.g., white or brown spots that don't brush off, and existing cavities. A healthy mouth is : • Plaque-free • The teeth should have a whitish hue, be smooth and glossy, except for the biting surfaces of the back molar teeth, which will be grooved • Firm, moist gums- not puffy or bleeding • No ulcers, lumps or sores. Danger signs include: • Plaque – colourless film of bacteria that forms on the teeth daily	It may be necessary to use a small torch to illuminate the teeth. If there are signs of plaque on the teeth, the parent/caregiver should be informed, either in-person in a child-health setting, or using the CHS409-6A in a school setting.

Steps	Additional Information
• White spot lesions (that don't wipe off) • Brown and yellow spots (that don't brush off) • Cavities (decay) • Ulcers, lumps and sores.	
3. Provide anticipatory guidance to parent/caregivers regarding oral health: **a) In a child health setting:** • Begin mouth care early by wiping gums and clean teeth as soon as they appear • Provide tooth brushing advice for older children, including introducing low fluoride toothpaste at 18 months • Encouraging first dental visit no later than two years of age and then regular check-ups • Avoid bacterial transfer i.e. 'don't put anything in baby's mouth that has been in your mouth' • Explain results to parent/caregiver. **b) In a school health setting** • Encourage children to brush their teeth using a low-fluoride toothpaste morning and night with adult assistance. Spit out, don't rinse after brushing teeth. • Encourage children to choose water as their preferred drink. • Encourage healthy eating habits in children and young people. Reducing intakes sugar-sweetened beverages, juice, sweets and processed foods are all recommended. • Where concerns are noted, make contact with the parent.	Provide information on nutrition and child feeding practices such as : • Do not put baby to bed with a bottle. • Only give water or milk in a baby's bottle. Do not give fruit juice, cordial, soft drinks or flavoured milks. • If a child is using a dummy, do not dip the dummy in any substance. • From 6 months teach baby to drink from a cup. • For example, parents/caregivers should be discouraged from sucking on a dummy that has fallen on the floor. For referrals see below. Children aged 18 months to five years of age should use a pea sized amount of low fluoride toothpaste. Children should spit out, not swallow, and not rinse after brushing. The fluoride in toothpaste may protect against the development of plaque, so not rinsing toothpaste off allows the toothpaste to form a protective barrier on teeth even after brushing. Provide information on nutrition and oral health practices such as : • Promote water and avoid soft drinks, fruit juice, cordial, or flavoured milks. • Brush teeth twice per day. Recommend a dental review, see referral options below.

Steps	Additional Information
4. Provide parent/caregiver with 'Lift the lip' resources.	Provide routine child and/or school dental health resources (via HealthPoint and Dental Health Services.)
5. Document findings in appropriate written or electronic records.	Complete School Entry Health Assessment Results for parents (CHS409-6) and School Entry Health Assessment Results for staff (CHS409-2).

Referral pathway

If referral to dental health services is indicated, discuss with parents/caregivers to offer information and support. See Appendix A for referral options.

Related internal policies, procedures and guidelines
The following documents can be accessed in the Community Health Manual via the HealthPoint link or the Internet link
Universal contact 12 months
Universal contact 2 years
Universal contact 4 years (School Entry Health Assessment)

Related internal resources and forms
The following resources and forms can be accessed from the HealthPoint CACH Intranet link
Clinical handover referral form (CHS 663 – CACH only)
Give your child's teeth a healthy start (Child Health)
Kindy and Pre-primary School Children – Lift the lip (School Health)
Lift the Lip Referral Options (Child Health and School Health)
Personal Health Record (CHS 800)
School Entry Health Assessment parent questionnaire (CHS409-1)
School Entry Health Assessment results for parents (CHS409-6)
School Entry Health Assessment results for staff (CHS 409-2)

Related resources and forms
Clinical handover/referral form (CHS 663)
WACHS Electronic Community Health Nursing Clinical handover form

Useful external resources
The Commonwealth provides assistance for 2-17 year olds through the Child Dental Benefits Schedule (CDBS). The CDBS provides individual benefits for a range of services including examinations, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. Benefits are not available for orthodontic or cosmetic dental work and cannot be paid for any services provided in a hospital
Dental health promotion material from Dental Health Services
Derbarl Yerrigan dental health service offers walk-in appointments for young Aboriginal people aged 16 to 18 accompanied by a parent or guardian.

Appendix A: Lift the Lip Referral Options

Tooth decay can start as soon as the first tooth appears in the mouth. Early signs to look for:

- White lines along the gum line
  - decay process can be reversed by the use of fluoride
    - ➢ make a dental appointment
- Brown or yellow spots that don't brush off
  - advanced decay which will become a 'hole' that will need to be filled
    - ➢ make an urgent dental appointment

Public Dental Health Services

- Children from 0-4 years can receive subsidised dental care at Public Dental Clinics if they, or their parent or carer has a Health Care or Pensioner Concession Card
- All school children are eligible for dental care through the School Dental Service from the year they turn five until the end of Year 11 or the attainment of 17 years of age whichever comes first
- Perth Children's Hospital provides emergency dental services (e.g. trauma or infection) but does not provide preventative or restorative services

Private settings

Private dentists may or may not:

- Provide services to children of any age
- Participate in the **Child Dental Benefits Schedule**
- Offer a bulk-billing for their services via the Child Dental Benefits Schedule
- Provide services to children at the Private Health Insurance rebate amount only.

The Child Dental Benefits Schedule

- Is a dental benefits program governed by the Commonwealth via the Department of Human Services for **eligible children** aged 2-17 years
- Eligible children:
  - Children aged between 2 –17 years on any one day of the calendar year whose family, or carer receives Family Tax Benefit Part A for at least part of the calendar year
  - The Department of Human Services has written to all eligible families to confirm eligibility.
- Provides up to $1,000 in benefits to the child for **basic dental services** over two consecutive calendar years.
- Private dental practices are able to provide services under the Child Dental Benefits Schedule that are either Bulked Billed (no gap to be paid) or Non Bulk Billed (gap to be paid).
- Public Dental Clinics are not participating in the Child Dental Benefits Schedule.
- **Basic dental services:**
  - Examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures (the services required may exceed the $1,000 benefit).
  - Benefits are not available for orthodontic or cosmetic dental work and cannot be paid for any services provided in a hospital.

Aboriginal services

Aboriginal children can receive free dental care at Aboriginal Medical Services which contain a dental clinic. These include:

East Perth	Derby	Kalgoorlie	Roebourne
Broome	Geraldton	Kununurra	Warburton
Carnarvon	Halls Creek	Port Hedland	Wiluna

For further information please call Dental Health Services on 9313 0555 or the Australian Dental Association on 9211 5600. (Revised June 2018)

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This document can be made available in alternative formats on request for a person with a disability.

Document Owner:	Director Clinical Services Community Health		
Reviewer / Team:	Clinical Nursing Policy Team		
Date First Issued:	2010	Scheduled Review Date:	23 February 2021
Last Reviewed:	February 2015 (amendments October 2016; May 2017, February 2018, January 2019, November 2020)		
Approved by:	Community Health Clinical Nursing Policy Governance Group		
Endorsed by:	Executive Director CACH	Date:	23 February 2018
Standards	NSQHS Standards: 1.7.1, 1.8.1		
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