| PROCEDURE | |
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| **Oral Health Assessment** | |
| **Scope (Staff):** | Community health staff |
| **Scope (Area):** | CAHS-CH, WACHS |

**Child Safe Organisation Statement of Commitment**

The Child and Adolescent Health Service (CAHS) commits to being a child safe organisation by meeting the National Child Safe Principles and National Child Safe Standards. This is a commitment to a strong culture supported by robust policy documents to ensure the safety and wellbeing of children at CAHS.

**This document should be read in conjunction with this DISCLAIMER**

## Aim

To identify children at increased risk of oral disease, to identification of early childhood caries (ECC), and to educate parents /carers to maintain and monitor their child's oral health.

## Risk

Failure to identify (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

Early childhood caries (ECC) is defined as dental caries in children younger than 72 months. It is one of the most common chronic childhood diseases and it is almost entirely preventable.[2] ECC occurs mainly in disadvantaged populations, and is a multifactorial disease, with socioeconomic, behavioural and psycho-social components.[2] In WA, acute oral health conditions are the leading potentially preventable reason for admission to hospital.[3]

Consequences of ECC include pain, infections, abscesses, malnutrition, gastrointestinal disease, irritability and disturbed sleeping habits, and impaired cognitive development.[2] If children require dental clearance for severe ECC, the resulting pain, pain, psychological trauma, health risks and costs associated with restoration of carious teeth for affected children 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.[4,5] Severe ECC is a risk factor for decay in permanent teeth.[6]

ECC is an active process of tooth destruction resulting from the interactions between teeth, food and bacteria. It 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. Dental caries result from complex interactions among acid-producing members of the biofilm, fermentable carbohydrates, and many host factors, including susceptible tooth surfaces and saliva.[7]

It is caused when the dental plaque is not removed regularly. A diet that commonly includes monosaccharides (simple sugars) contributes to ECC. Many oral bacteria can metabolise the monosaccharides, leading to increased production of acids that demineralise the enamel.[8] Enamel on deciduous teeth is thinner and has a less organised microstructure, so acids are able to demineralise deciduous enamel faster than permanent teeth.[8]

ECC is associated with early intake of sugary foods, drinks and snacks. and can be prevented by good oral hygiene and a nutritious diet low in sugary drinks and foods.[1] It may occur in young children who are exposed to inappropriate feeding methods, such as receiving bottles of juice, milk, formula, soft drink or cordial to drink for prolonged periods during the day or overnight.

## Risk factors

- Family history of caries; especially maternal
- Child's gender as males are at higher risk
- Increasing age
- Lack of fluoride exposure
- Oral health behaviours
- Unhealthy lifestyle such as use of sugar-sweetened beverages and energy-dense low-nutritious food
- Low socio-economic status
- Maternal extraction history.

## Key Points

- Oral health inspections using the 'Lift the lip' technique 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 be part of the 'general' health assessment or used at any other time where there is a 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 compete the oral examination. Parents/ caregivers should still receive the health education component and resources.
- Health education messages should be delivered using the common risk approach, so discuss relationship between nutrition and oral health wherever possible.
- Promote good oral health practices for the whole family.
- Community health nurses must follow the organisation's overarching infection control policies and perform hand hygiene in accordance with WA Health guidelines at all appropriate stages of the procedure.

## 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 |
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| **1. Before conducting a mouth examination**<br><br>Discuss:<br>• By maintaining a healthy mouth, parents can help prevent or reduce decay risk in themselves and their children<br>• Baby teeth are important<br>• Preventing tooth decay is easier and less costly than treating it<br>• The earlier that decay is detected the better the outcomes will be for the child<br>• It is important to conduct 'lift the lip' regularly at home to look for early signs of decay (at least once a month). | |
| **2. Position the child appropriately so that the 'Lift the lip' assessment can be performed.**<br><br>**In a child health setting:**<br>**a)** 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.<br>**Or**<br>**b)** The 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. |  |

| Steps | Additional Information |
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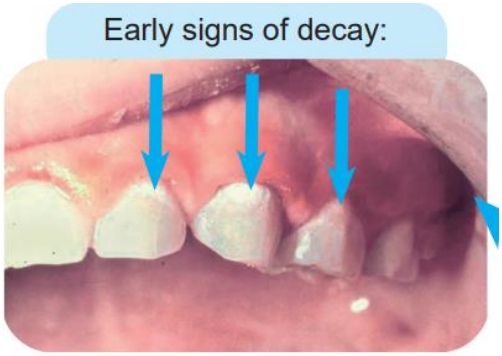
| **In a school setting:**<br>Nurse sits in a chair and with child in front, facing the nurse.<br>• The child is asked to lift their lip to allow the nurse to check the health of the teeth and surrounding soft tissues.<br>• If there are any concerns during the Lift the Lip assessment, nurse to assess further by asking the child to open their mouth so that nurse can look in the oral cavity and observe for any other concerns. | |
| **2. Examine the upper front teeth and look for signs of tooth decay.**<br>Observe for white or brown spots that don't brush off, and existing cavities.<br>A healthy mouth is:<br>• Plaque-free<br>• The teeth should have a whitish hue, be smooth and glossy, except for the biting surfaces of the molar teeth, which will be grooved<br>• Firm, moist gums- not puffy or bleeding<br>• Free of ulcers, lumps or sores.<br>Danger signs include:<br>• Plaque – colourless film of bacteria that forms on the teeth daily<br>• White spot lesions (that don't wipe off)<br>• Brown and yellow spots (that don't brush off)<br>• Cavities (decay)<br>• Ulcers, lumps and sores.<br>If there are signs of plaque on the teeth, the parent/caregiver should be informed, usually in-person in a child-health setting. In a school setting, parents may be informed by using the CHS409-6A Results for Parents form in or by telephone. |  <br>  <br>  <br>It may be necessary to use a small torch to illuminate the teeth. |

| Steps | Additional Information |
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| **3. Provide anticipatory guidance to parent/caregivers regarding oral health**<br><br>**In a child health setting:**<br><br>• Begin mouth care early by wiping gums and clean teeth as soon as they appear.<br><br>• Provide tooth brushing advice for older children, including introducing low fluoride toothpaste at 18 months<br><br>• Encouraging first dental visit no later than two years of age and then regular check-ups<br><br>• Avoid bacterial transfer i.e. 'don't put anything in baby's mouth that has been in your mouth'.<br><br>• Explain results to parent/caregiver<br><br>• If concerns are noted, provide referral and/or information as appropriate.<br><br>**In a school health setting:**<br><br>• 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.<br>• 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.<br><br>• Encourage children to choose water as their preferred drink.<br><br>• Encourage healthy eating habits in children and young people. Reducing intake of sugar- sweetened beverages, juice, sweets and processed foods are all recommended<br><br>Where concerns are noted, make contact with the parent. | Provide information on nutrition and child feeding practices such as:<br><br>• Do not put baby to bed with a bottle.<br>• Only give water or milk in a baby's bottle. Do not give fruit juice, cordial, soft drinks or flavoured milks.<br>• If a child is using a dummy, do not dip the dummy in any substance.<br>• From 6 months teach baby to drink from a cup.<br>• Parents/caregivers should be discouraged from sucking on a dummy that has fallen on the floor.<br><br>**For children aged under 18 months,** when the infant has a few teeth, toothpaste is not required.<br><br>**For children aged 18 months to 6 years,** use a pea sized amount of children's low fluoride toothpaste.<br><br>**For children aged over 6 years,** use a small amount of adult toothpaste.<br><br>**Children under 8 years** need supervision and help to brush their teeth.<br><br>Other key messages:<br><br>• Everyone in the family should have their own toothbrush.<br>• Replace toothbrushes every 3 to 4 months, or earlier if bristles are frayed.<br>• Everyone should brush their teeth or have their teeth brushed twice a day.<br>• Make toothbrushing positive by being a role model and having a fun time together.<br>• Don't routinely recommend electric toothbrushes, but if parents/ caregivers enquire, inform them that it is not recommended to use an electric toothbrush with children under 3 years of age.<br>• Young children using electric toothbrushes require supervision to ensure correct technique.<br>• Check for signs of decay every month.<br>• Recommend a dental review, see referral options below. |

| Steps | Additional Information |
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| **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. Refer children to dentists or dental services as appropriate.** | Check child/family eligibility for dental benefits.<br>Refer to Appendix A for dental referral information. |

## Documentation

Nurses maintain accurate, comprehensive and contemporaneous documentation of assessments, planning, decision making and evaluations according to CAHS-CH and WACHS processes.

Community health nurses working in child or school health settings will document relevant findings in the electronic record

Complete School Entry Health Assessment Results for parents (CHS409-6) and School Entry Health Assessment Results for staff (CHS409-2), as relevant.

## Referral

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

## References


1. National Advisory Committee on Oral Health, Community Care and Population Health Principal Committee, Australian Health Ministers' Advisory Council, COAG Health Council. Healthy mouths, healthy lives: Australia's national oral health plan 2015-2024. COAG Health Council; 2016.
2. Anil,S, Anand, P. Early childhood caries: prevalence, risk factors and prevention. Frontiers in Pediatrics. 2017 (5). https://www.frontiersin.org/articles/10.3389/fped.2017.00157/full
3. WA Department of Health. State Oral Health Plan 2016–2020. Perth: Office of the Chief Dental Officer, Clinical Services and Research, Department of Health; 2016.
4. Gussy MG, Ashbolt R, Carpenter L, Virgo-Milton M, Calache H, Dashper S, et al. Natural history of dental caries in very young Australian children. Int J Padiatr Dent. 2016;26(3):173-83
5. Sheiham A. Dental caries affects body weight, growth, and quality of life in pre-school children. Br Dent J. 2006;201(10):625-6.
6. Dhamo B, Elezi B, Kragt,l Wolvius E, Ongkosuwito E. Does dent all caries affect dental development in children and adolescents? Bosn J basic Med Sci 2018;18(2). 198-205
7. Ballentine,JL, Carlson,JC , Ferreria Zandona AG, Agler, C, Zeldon, Rozirer RG, et al. Exploring the genomic basis of early childhood caries: a pilot study. Int J Padiatr Dent. 2018; 28(2)217-25.
8. Meyer F, Enax J. Early childhood caries: Epidemiology, aetiology and prevention. .Int J Dent.2018: doi: 10.1155/2018/1415873


## Related policies, procedures and guidelines

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| The following documents can be accessed in the **Clinical Nursing Manual** via the HealthPoint link, Internet link or for WACHS staff in the WACHS Policy link |
| Universal contact 12 months |
| Universal contact 2 years |
| Universal contact 4 years (School Entry Health Assessment) |
| The following documents can be accessed in the CAHS-CH Operational Manual |
| Infection control Policy Manual |
| The following documents can be accessed in the CAHS Policy Manual |
| Nutrition for children – 1 to 11 years |
| The following documents can be accessed in the Department of Health Policy Frameworks |

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| Clinical Handover Policy (MP0095) |
| Clinical Incident Management Policy (MP 0122/19) |

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

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| 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 |

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

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| Document Owner: | Nurse Co-Director, Community Health | | |
| Reviewer / Team: | Clinical Nursing Policy Team | | |
| Date First Issued: | 2010 | Last Reviewed: | April 2021 |
| Amendment Dates: | October 2016; May 2017, February 2018, January 2019, November 2020, August 2021 | Next Review Date: | April 2024 |
| Approved by: | Community Health Clinical Nursing Policy Governance Group | Date: | 26 March 2021 |
| Endorsed by: | Executive Director of Nursing and Executive Lead Community Health | Date: | 12 April 2021 |
| Standards Applicable: | NSQHS Standards:  Child Safe Standards: 2, 3, 4, ,10 | | |

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Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

## Appendix A: Dental Referral Options

### 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 to the age of 17 years, 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 dentists

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.

### Child Dental Benefits Schedule

- The Child dental Benefits Schedule is a Commonwealth via the Department of Human Services program for eligible children aged 2-17 years.
- Eligible children are those 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 writes to all eligible families to confirm eligibility.
- The Schedule provides up to $1,000 for each child for basic dental services over two consecutive calendar years.
- Private dental practices may 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 do not participate in the Child Dental Benefits Schedule.
- The Schedule covers examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures.
- The Schedule does not cover 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:

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| 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.**