

The Salford Royal Oral Decontamination And Mouth Care Bundle

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- Large foundation trust – planned income of £275.7 million in 2008/9
- 45,200 inpatients
- 4,500 staff
- Intensive Care Unit – 16 soon to be 18 beds
- General / Neurological patient population
- Year on year increase in patient numbers
- 17 consultants & 150 nursing staff members
- Transient medical force

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Quality improvement strategy – to be the safest hospital in the country:

Reduce hospital mortality rate

Reduce harmful events by 50%

Reduce infection by 70%

Reduce average length of stay by 20%

Save 1000 lives over 3 years

ICU's problem

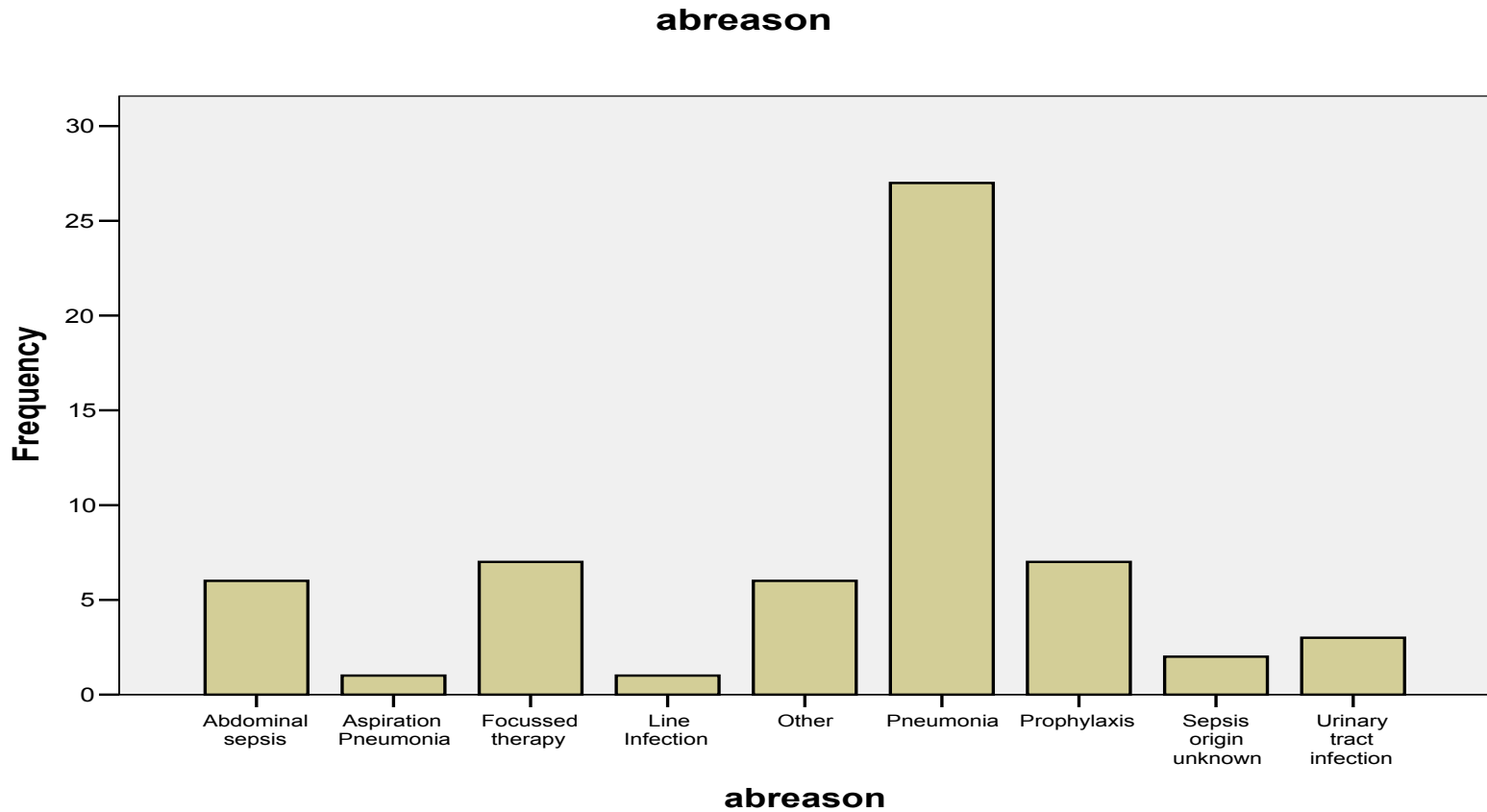
Ventilator Associated Pneumonia –

Defined as a hospital acquired pneumonia occurring after 48hrs of tracheal intubation and mechanical ventilation - affecting approximately 25% of the patient population and increasing patient morbidity and mortality

Factors in place to reduce VAP

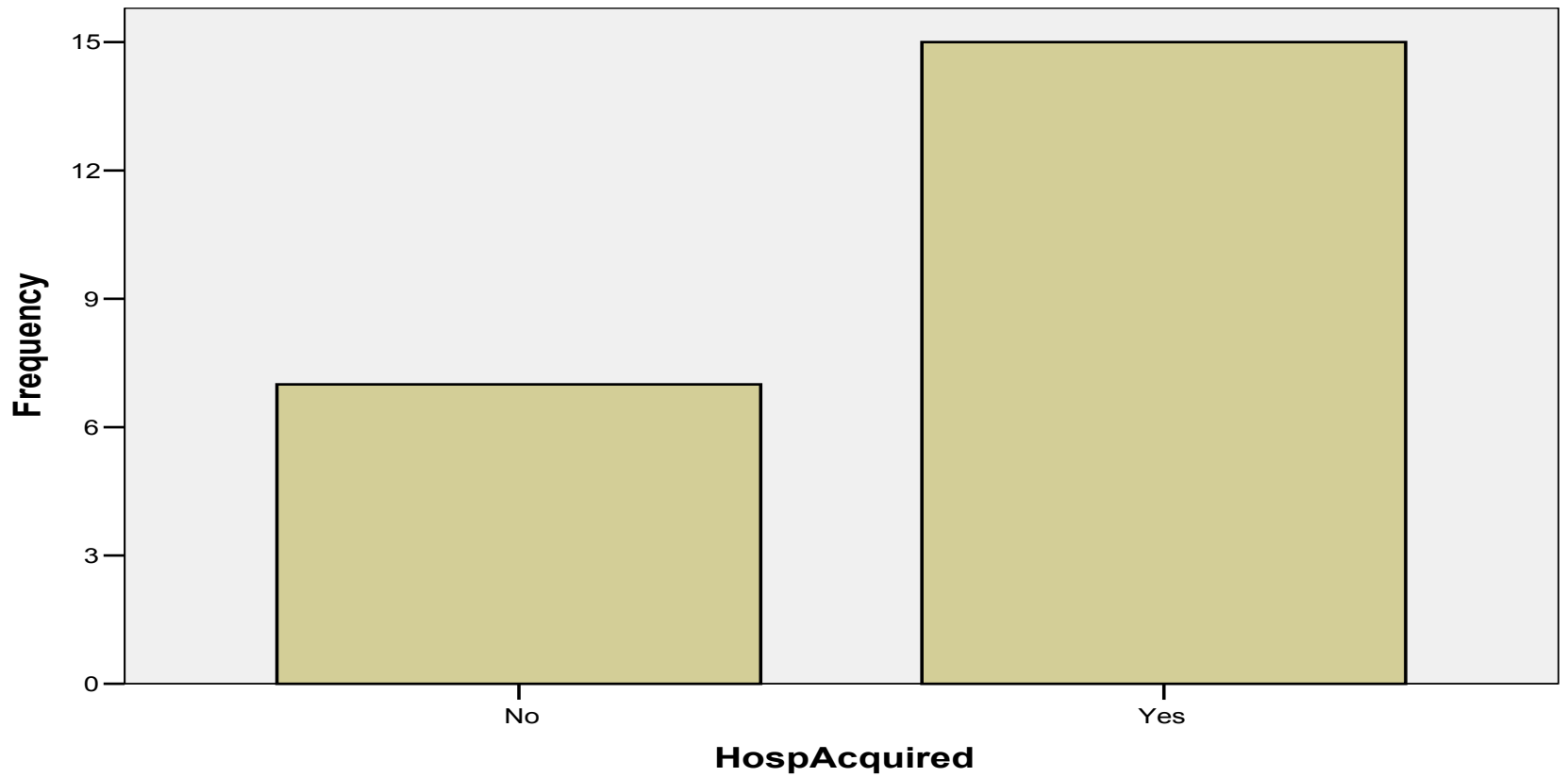
- Head elevation
- DVT prophylaxis
- Gastric ulceration prophylaxis
- Sedation holds
- Tubing management
- Use of aspiration ported ET and tracheotomy tubes
- HME

Where did we stand?



Where did we stand?

HospAcquired



Insanity: doing the same thing over and over
again and expecting different results
Albert Einstein

Looking for other causes

The normal human mouth is colonised by 250 microbes and an accumulation of these microbes plays a major role in patient illnesses such as pneumonia, chronic lung disease, bacteraemia and endocarditis

VAP caused by:

- Reduction in salivary secretions
- Reduction in self cleaning of the oral cavity
- Increase in the oropharyngeal colonisation of bacteria
- Leakage of this bacteria around cuff leading to aspiration

Could reducing oral colonisation have an impact on the rates of VAP in ICU?

Practice vs. evidence available

A review of the literature found that defining then standardising oral decontamination and mouth care reduced VAP in patients and as a decontamination product chlorhexidine was most easily available and the most cost effective

Practice vs. evidence available

- No set standard/ guidelines for oral care in place
- No continual education for staff
- Varies methods for oral hygiene being used in the ICU
- Varied staff beliefs and knowledge

The standardisation of guidelines

- Chose the product
- Defined an assessment procedure
- Defined an oral hygiene procedure
- Defined an oral decontamination procedure
- Decided that the chlorhexidine should be prescribed by medical staff and introduced pre printed prescriptions
- Introduced educational package
- Removed the 'pink sponges' from practice

Assessment

Check the patients mouth using the BRUSHED assessment tool & document results

- B = bleeding? - Look @ gums, mucosa and coagulation status
- R = redness? - Gums, tongue, antibiotic stomatits
- U = ulceration? - Size, shape, infected?
- S = saliva? - Xerostomia, hyper salivation, characteristics
- H = halitosis? - Character, infected?
- E = external factors? - ET tapes, bite guard
- D = debris? - Visible plaque, particles

Oral hygiene procedure

- Place a pea sized amount of 'chlorhexadine dental gel' onto a soft tooth brush
- Brush teeth, gums and tongue
- Draw up 50 ml of sterile water and ready oral suction
- Rinse water around the mouth and suction out simultaneously until all toothpaste removed
- Dispose of used syringe immediately

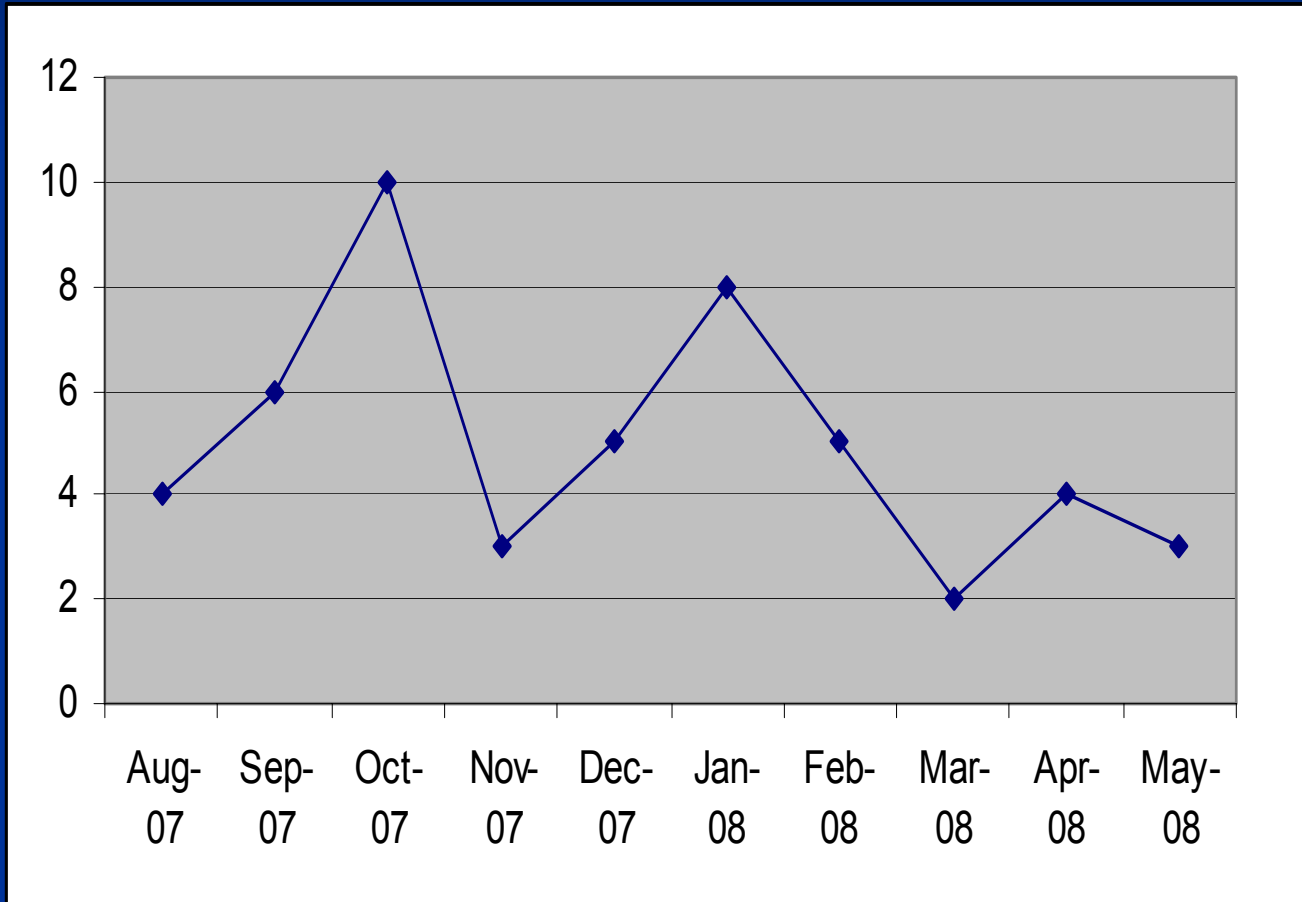
Oral decontamination procedure

- Draw up 20ml of corsodyl from a single patient use bottle & attach kwill to syringe
- Rinse around patient mouth – ensuring good coverage of teeth, gums, and back of mouth, pharynx
- Suction residual out with yanker

And finally

- Dispose of used syringe & kwill immediately
- Replace ET ties if damp
- Apply yellow paraffin to lips
- Aspirate subglottic suction port & dispose of waste immediately

Has it made a difference?



Future plans

- Improve the documentation
- Continue to observe for new & improved products
- Continue to audit practice and results
- Continue to educate staff

Any questions?



Thank You For Listening

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References

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