Mouth care case study – Stroke

Patient background

- Admitted to an acute hospital with a left middle cerebral artery stroke resulting in severe apraxia of speech, expressive aphasia and severe pharyngeal dysphagia resulting in an inconsistent ability to trigger swallows. The patient was nil by mouth when admitted to a rehabilitation unit.
- He was previously independent with his activities of daily living and enjoyed driving, visiting friends and going to an Irish day centre. He had an ex-partner who called the ward daily at 4pm and spoke to him on the phone (he was unable to speak back but would listen and make sounds).
- He had upper dentures and several lower teeth. He had a dense hemiplegia and needed a hoist to transfer from bed to chair. He required a tilt in space wheelchair and could sit out for up to 2 hours. He had chronic obstructive pulmonary disease (COPD).

Speech and language therapy input into patient's mouth care

- A Mouthcare Matters oral assessment was completed by nursing staff on arrival. Dry mouth was observed but no oral infections or teeth problems.
- The speech and language therapist (SLT) procured non-foaming toothpaste and dry mouth gel to use in mouthcare due to his dysphagia. His dentures were cleaned using hand soap and water and were left in a labelled denture pot overnight. His teeth/gums were brushed gently with toothpaste and gauze soaked in water was wrapped around his toothbrush and used to remove secretions.
- The SLT observed that he breathed through his mouth and had a dry mouth with dried secretions and cracks on his tongue. He always consented to mouthcare and requested it at times.
- The SLT recommended mouthcare every 3-4 hours during the day and set up a record form for staff to complete.
- A capacity assessment was completed regarding oral intake. The patient presented with capacity to make a decision about oral intake. The SLT completed a risk feeding passport with the medical team, the patient and his next of kin.
- He communicated that he was distressed by his dry mouth. He chose to have up to 4 teaspoons of cold water after mouthcare when it was explained to him that water after mouthcare would present the least risk of developing aspiration pneumonia compared to other liquids. He swallowed best from a teaspoon which limited the bolus size.

Outcomes

- The patient's mouth tended to be pink and hydrated with fewer incidences of dry mouth/dried secretions.
- He was able to say several words to his ex-partner when they visited the ward (after COVID-19 restrictions were lifted). He received mouth care before the visits meaning that he had his dentures in place and no dried secretions or halitosis.
- He remained on his risk feeding guidelines on discharge. Due to his breathing difficulties, medical frailty and inability to consistently trigger swallows/hyolaryngeal elevation he did not have any ongoing swallowing rehab goals.

Learnings

- The case highlights the importance of mouthcare for dignity/quality of life.
- A multidisciplinary (MDT) approach prevented the patient's mouth from deteriorating.
- This case highlighted the importance of mouth care for dysphagic patients in preventing aspiration pneumonia and other medical complications.
- SLTs have a role supporting risk feeding/capacity assessments regarding having small amounts of water for oral hydration/quality of life.
- SLTs have an important role giving mouth care advice for patients with dysphagia and educating staff on how mouth care can reduce the risks of developing aspiration pneumonia.
- Mouth care can be an activity in speech and language therapy sessions/joint sessions when working on communication or swallowing.