Government of **Western Australia**
Department of **Health**

Enhanced Access Community Pharmacy Pilot

Oral health risk assessment and fluoride application

Clinical practice guideline

Service recommended for patients aged 18 months and over.

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

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Refer when

- The patient is aged below 18 months (does not preclude a patient from accessing usual pharmacy care)
- The patient is screened at high or moderate risk of tooth decay/poor oral health, but the application of fluoride varnish is contraindicated
- Immediate (same day) referral required:
  - recent orofacial trauma (not yet seen by a dental and/or medical practitioner)
  - facial swelling or fever from an oral infection
  - difficulty swallowing or breathing
  - a toothache that is worsening despite taking regular analgesia
- Urgent (within 3 days) referral required:
  - advanced decay (discolouration and cavitation)
  - a visible abscess
  - a toothache that is not impacting daily functioning and can be managed with over-the-counter analgesics.

Treat and concurrently refer

- The patient is screened at high or moderate risk of tooth decay/poor oral health
- The patient presents with white spot lesions or advancing decay (brown spot lesions – no cavitation evident)
- The patient has not seen a dental practitioner in the previous 12 months.

Key points

- Tooth decay (caries), one of the most prevalent chronic diseases, is caused by acid-producing bacteria (commonly Streptococcus mutans) present in the thin biofilm on teeth (plaque)[1,2]. Acidophilic and cariogenic bacteria grow in plaque and produce acid that demineralises the tooth, starting with the enamel[1].
- If left untreated, the demineralisation of the tooth structure will progress into the dentine layer until it reaches the nerve/pulp of the tooth to cause localised infection[1]. Cavitation (holes) in the outer surface of the tooth enamel may occur[3].
- An established body of evidence suggests that the application of fluoride varnish to teeth every 6 months can reduce dental decay and prevent progression of early-stage carious lesions[4-6].
- Patients may either be referred by a dental practitioner (an oral health therapist, dental therapist, oral hygienist, or dentist), or assessed by the pharmacist as at moderate or high risk of tooth decay or poor oral health and be eligible for fluoride varnish application.
- Fluoride varnish contains 22.6 mg/mL (22,600 ppm) fluoride ion suspended in an alcohol and resin base[5-7]. The only fluoride varnish currently registered in Australia to prevent caries is Duraphat® 5 per cent w/v sodium fluoride varnish[5,8].

Refer when

Refer the patient to an appropriate healthcare provider (including emergency services, if required) in the following situations:

- the patient is aged below 18 months (does not preclude a patient from accessing usual pharmacy care)
- the patient is screened at high or moderate risk of tooth decay/poor oral health but the application of fluoride varnish is contraindicated
- immediate (same day) referral required:
  - recent orofacial trauma (not yet seen by a dental and/or medical practitioner)
  - facial swelling or fever from an oral infection
  - difficulty swallowing or breathing
  - a toothache that is worsening despite taking regular analgesia.
- urgent (within 3 days) referral required:
  - advanced decay (discolouration and cavitation)
  - a visible abscess
  - a toothache that is not impacting daily functioning and can be managed with over-the-counter analgesia.

Treat (if clinically appropriate) and concurrently refer

Apply fluoride varnish and concurrently refer to an appropriate healthcare provider:

- if the patient is screened at high or moderate risk of tooth decay/poor oral health
- if the patient presents with white spot lesions or advancing decay (brown spot lesions – no cavitation evident)
- if the patient has not seen a dental practitioner in the previous 12 months.

Obtain patient history and complete assessment

To assess the patient's suitability for an application of fluoride varnish and/or whether a referral to a dental practitioner or another appropriate healthcare provider is required, an oral health risk assessment, patient history, and dental history must be undertaken by the pharmacist. Fluoride varnish should be considered for patients aged 18 months and over.

Appendix 2 provides descriptions and clinical photographs of common oral presentations.

Review for other signs and symptoms that may require the attention of another healthcare provider (see Refer when) and consider standard pharmacy treatment and referral where appropriate (e.g. for mouth ulcers).

Risk assessment and screening

Risk assessment

Refer to Appendix 1.

There is no arbitrary scoring system for risk status due to the variability of the interaction between risk factors and protective factors. Pharmacists must use their professional judgement to evaluate a child's risk status.

- A child with no obvious clinical signs of decay, only a few moderate level risk factors, and multiple protective factors may be deemed low risk.
- If the child has at least one high risk factor, regardless of the number of protective factors, they would be at least at moderate risk of tooth decay and poor oral health. Fluoride varnish application should be considered.
- For patients aged 6 years and over, a risk assessment questionnaire is completed with the patient, and/or parent/caregiver.

Visual screening using the 'lift the lip' technique

Visual screening is recommended for patients aged 18 months to 5 years.

- Depending on age, the child may either sit or stand in front of the pharmacist or lay in the parent/caregiver's lap (see Figure 1).
- The parent/caregiver should lift the upper lip of the child in front of the pharmacist so that the front teeth and gums are clearly visible to look for signs of decay[4].
- A torch may be used to check around the mouth and back teeth if desired. A soft toothbrush with no toothpaste may be used to clean visible plaque and debris off teeth for better visibility[9]. Consider the use of plastic sunglasses to not expose the patient's eyes to excessive light.
- During the screening, the pharmacist should look for:
  - signs of tooth decay (white spot lesions, brown spot lesions, cavitation (holes))
  - facial trauma (loose or broken teeth, lacerations on gums)
  - oral infection, facial swelling/asymmetry due to spreading infection
  - gum disease (red, swollen gums)
  - other relevant findings including mouth ulcers and possible signs of fluorosis.
- Consider referring to a dental practitioner if the child is not able to co-operate with visual screening (e.g. unwilling/unable to show you their mouth or stay still enough for assessment).

Figure 1. Young child positioned sitting in parent/caregivers lap for lift the lip screening

Image source: Metro South Health[10].

Lift the lip may not be required as anterior caries are less common for patients aged 6 years and over, as signs of poor oral health may be easily observable, such as plaque accumulation, decay, abscess, trauma, gingivitis, or bad breath.

Patient history

Obtain sufficient information from the patient and/or their parent/caregiver to assess the safety and appropriateness of any recommendations.

Consider:

- age
- pregnancy and lactation status (if applicable)
- current medical conditions or special healthcare needs that may impact on oral health status and the safe use of fluoride varnish, e.g.:
  - asthma (severity and current level of symptom control)
  - history of hospitalisation for allergic reactions.
- current illness e.g. colds, influenza, current infection of herpes simplex virus (HSV)
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- drug allergies/adverse drug reactions
- hypersensitivity/allergic reaction to colophony (natural resin) e.g. sticking plasters or medical adhesives
- smoking status (including vaping).

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Dental history

Consider the following:

- does the patient have a dental practitioner that they visit routinely?
- when did the patient last see a dental practitioner? What was the reason e.g. emergency treatment, toothache, routine check-up?
- when was the last fluoride varnish application? Any previous adverse experiences with fluoride varnish?
- history of recent orofacial trauma (within the last 6 months), oral infections, toothaches, or other oral pain (including use of analgesics), soft tissue pathology in or around the mouth (ulcerative gingivitis, herpetic stomatitis, or aphthous ulcers), tooth discolouration
- impacts of oral health on quality of life including sleep and school attendance
- oral hygiene routines including type of toothbrush used, type of toothpaste (fluoride strength), toothbrushing frequency, use of fluoridated products (toothpaste, mouthwash), use of other oral hygiene aids (e.g. mouthwash, flossing)
- consumption of fluoridated water.

Confirm management is appropriate

Refer to the Queensland Health Guideline for Fluoride Varnish (QH-GDL-410:2013) and specific product information provided by the manufacturer to confirm the application of fluoride varnish is appropriate, including:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

General information only is provided within this guideline.

Where there is any doubt about the suitability of a patient, the pharmacist should not undertake the procedure and refer the patient to their preferred dental practitioner, closest public dental service, or Aboriginal and Torres Strait Islander Community Controlled dental clinic.

Explain treatment and apply fluoride varnish

Advise patients and/or parents/caregivers that fluoride varnish is a preventative treatment and cannot reverse advanced tooth decay (although it may halt further development), treat dental infections, or relieve dental pain.

Fluoride varnish is applied to at-risk tooth surfaces where it sets rapidly on contact with saliva to form a coating that is subsequently worn off over a 24 hour period through chewing and delayed tooth brushing. In the context of this guideline an 'at-risk' tooth surface is defined as:

- a tooth surface that has signs of early decay (white spot or brown spot lesions)
- a tooth surface directly abutting a decayed tooth surface (in between 2 teeth)
- the 4 front primary teeth in the upper jaw (present in children up to age of 6 to 7 years) (as per Figure 2) – apply to outside (front), inside (back), and biting surfaces[11]
- chewing (occlusal) surfaces and interproximal surfaces (in between) of molars and pre-molars (if present) (as per Figure 2).

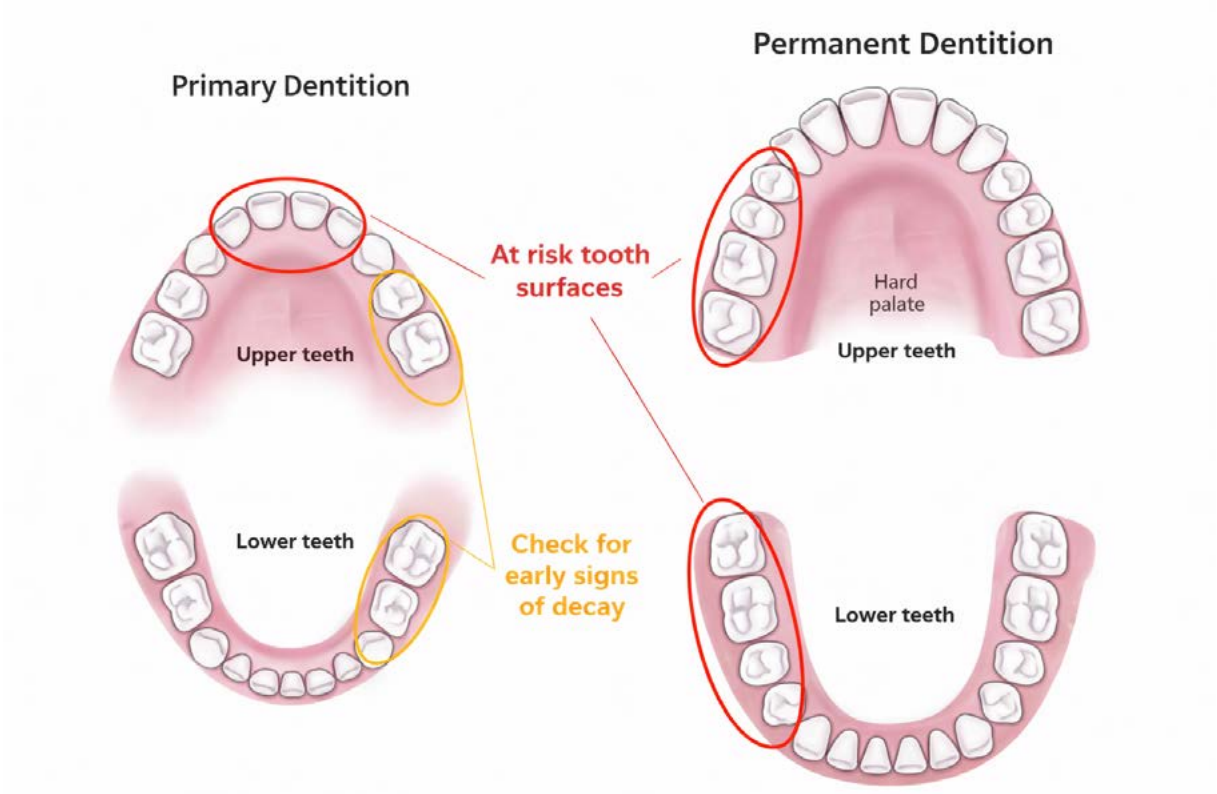
The recommended frequency of fluoride varnish application is twice per year. More frequent applications (up to 4 applications per year) are recommended for patients at higher risk of dental caries[5].

Advise patients and/or parents/caregivers that fluoride varnish is safe, easy to apply, and generally well tolerated, even in children[6]. In rare cases swelling of the oral mucosa, ulcerative gingivitis, and stomatitis has been observed in sensitive individuals and/or those with a tendency to allergic reactions. If necessary, the varnish layer can easily be removed from the mouth by brushing and rinsing[7]. Teeth may appear yellow for up to 24 hours due to the tint of the varnish, before it wears off and tooth colour returns to normal.

There is no published evidence that professional application of fluoride varnish is a risk factor for enamel fluorosis in children of any age[4].

Guidance regarding Duraphat® application is provided in Appendix 4.

Figure 2. Common areas of decay



Post application instructions

Provide patients and/or parents/caregiver with post-application instructions and advice before the procedure is undertaken.

The efficacy of fluoride varnish depends on the length of time it can remain undisturbed on the teeth surfaces. As such, patients and/or parents/caregivers should be advised:

- eating and drinking should be avoided for at least 30 minutes after application, after which time soft food and fluids can be consumed
- not to chew food (i.e. harder foods) for at least 4 hours after application (it is important that the varnish is left undisturbed for as long as possible)
- not to brush teeth for at least 4 hours after application[5].

Provide general and preventative advice

Patients and/or parents/caregivers should be reminded of the importance of regular check-ups with a dental practitioner and provided with appropriate information to enable effective home care. The application of fluoride varnish should be documented and communicated to the patient's dental practitioner to avoid duplication of treatment. Anticipatory guidance should include instruction on toothbrushing, flossing, and the use of other oral hygiene aids tailored to the patient's age.

Children aged 18 months to 5 years

- Teeth should be cleaned twice daily by a parent/caregiver with a pea sized amount of toothpaste (containing 500 to 550 ppm fluoride) using a small, soft bristled toothbrush.
- The child should be instructed to spit out, and not swallow the toothpaste, and not to rinse after brushing[6,12].

People aged ≥6 years

- Teeth should be cleaned twice daily (or more frequently) with a soft bristled toothbrush and a toothpaste containing 1000 to 1500 ppm fluoride (a standard toothpaste readily available at supermarkets or the pharmacy).
- Toothpaste should not be swallowed, and the patient should avoid rinsing after brushing[6,12]. Floss should be used to clean in between teeth.
- Plaque disclosing tablets may be used to demonstrate effective methods of plaque removal.

Patient resources

- HealthyWA:
  - Tooth decay and gum disease
  - Fluoridated drinking water
  - Fluoride and protecting your teeth from tooth decay
  - Fluoride facts for Western Australia
- Find a Clinic, Dental Health Services, Government of Western Australia
- Dental Health, Derbarl Yerrigan, Aboriginal Medical Health Service
- Dental Clinic, St Patrick's Community Support Centre
- The Oral Health Centre of Western Australia, The University of Western Australia
- National Institute of Dental and Craniofacial Research:
  - The Tooth Decay Process: How to Reverse it and Avoid a Cavity
  - Tooth Decay
- Brushing Teeth, Australian Dental Association
- Resources for Aboriginal and Torres Strait Islander People, NSW Health.

Pharmacist resources

- WA Health Resources:
  - Dental Health Services publications, Government of Western Australia
  - Smiling Starts
  - Fluoridation
  - Fluoride use for oral health in WA
- Pharmacy and Oral Health, Australian Centre for Integration of Oral Health
- Healthy mouths, healthy lives, Australia's National Oral Health Plan 2015–2024, Australian Government, Department of Health, Disability and Ageing
- Queensland Health Guidelines:
  - Fluoride Varnish (QH-GDL-410:2013)
  - Fluoride – Prevention of Dental Caries and Maintenance of Oral Health (QH-GDL-411:2013)
  - Lift the Lip, Metro North Health
- Clinical Procedures Manual, Remote Primary Health Care Manual
- Primary Clinical Care Manual 12th edition 2022, Queensland Health and Royal Flying Doctors Service (Queensland branch)
- Healthy Smiles: Oral Health and Fluoride Varnish Information for Health Professionals, Northern Territory Department of Health
- Healthy Mouths Healthy Living, NSW Health
- Duraphat, MIMS Online
- Water fluoridation and human health in Australia: questions and answers, NHRMC.

Appendix 1 – Risk assessment tool (18 months to 5 years)

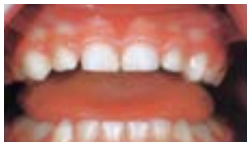
Risk assessment and screening process – children aged 18 months to 5 years
(Adapted from Metro North Health[13] and CAMBRA risk assessment[14])

Risk factors	**Risk level**
Individual or family history of decay (including parents/caregivers and siblings with fillings, teeth extracted, or active untreated decay). Routine referral to a dental practitioner (including public dental clinic) is required if the child has not had a dental check-up (not just emergency treatment) in the past 12 months.	**Moderate to high**
Child has a bottle or sippy cup with a fluid other than water, plain milk, or plain formula during the day.	**Moderate**
Child takes a bottle or sippy cup to bed with fluid other than water, including on-demand breastfeeding. Routine referral to a dental practitioner (including public dental clinic) is required.	**High**
Snacking between meals, especially high sugar and carbohydrate intake, e.g. lollies, chips, biscuits, muesli bars, flavoured milk, juice, soft-drinks, cordial, jams etc. Consider frequency of snacking and child's diet as a whole.	**Moderate to high**
Special healthcare needs and/or regular medications that have a high sugar content or may cause dry mouth. Routine referral to a dental practitioner (including public dental clinic) is highly recommended.	**Moderate**
Clinical signs	**Risk level**
White spot lesions visible on any teeth or obvious decay (brown spots, holes/cavitation) (see Appendix 2). Routine referral to a dental practitioner (including public dental clinic) is highly recommended.	**High**
Visible plaque accumulation. Routine referral to a dental practitioner (including public dental clinic) is highly recommended.	**Moderate**
Gingivitis (bleeding, swollen, or red (as opposed to pink) gums). Routine referral to a dental practitioner (including public dental clinic) is highly recommended.	**Moderate**
Toothache, recent trauma (not yet seen by a dental practitioner), facial swelling from infection, or visible abscess (see Appendix 2). Immediate referral to the nearest dental practitioner or a medical practitioner/emergency department is required.	**High**
Protective factors that reduce risk of poor oral health and caries	
• Child drinks fluoridated water (tap water in communities with fluoridated water supply). • Child/primary caregiver has a usual dental practitioner. • Child has seen a dental practitioner for a check-up (not just emergency care) in the past 12 months. • Fluoride varnish has been applied in previous 6 to 12 months. • Parents/caregiver brushes the child's teeth twice daily with an appropriate fluoride toothpaste.	

Appendix 2 – Clinical photographs

Clinical photographs to assist with visual screening[15]

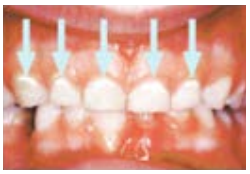
Healthy teeth and gums

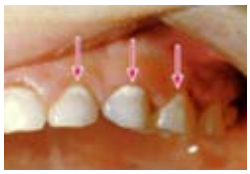


- No (or minimal) plaque on teeth and gums.
- Gums are pink with no evidence of swelling or bleeding.

White spot lesions

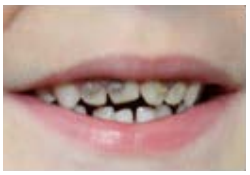
White, chalky/frosty lines/spots, usually along the gumline (this differentiates white spot lesions from similar presentations such as dental fluorosis).

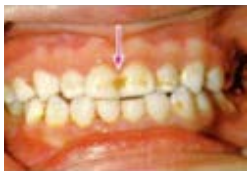




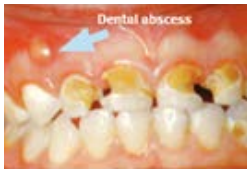
Advancing decay

Yellow or brown spots on teeth (possibly in combination with white spots) that don't wipe off, sometimes with visible cavitation.





Abscess



- Tooth decay that has progressed to the nerve causing periapical infection (at the root tip).
- Presents as a lump on the gums (usually seen in the presence of decay).
- May be pus-filled and painful, or draining (usually without pain).
- Can usually be differentiated from mouth ulcers and other mucosal conditions by location (ulcers are more likely to occur on the inner lip, cheek, or tongue).

Gingivitis

Reversible gum inflammation, often observed in the presence of plaque and as red 'puffy' gums, particularly on the gum/tooth line that may bleed when touched/during brushing.

Mouth ulcers

- Painful sores, often with a yellow or white centre, surrounded by a red border/halo on oral mucosal surfaces and tongue (occasionally palate and gums), usually as a result of minor trauma (accidental biting, scratching, or poking at gums with sharp objects e.g. fingernails).
- Recurrent severe or multiple ulcers may require a medical or dental referral to investigate the possibility of herpes simplex virus (HSV) or other infections[16].

Dental fluorosis

- The observable effect of higher fluoride intake in early childhood as teeth are developing (before age of 8 years). There is usually no effect on dental or enamel function[17].

Image source: American Academy of Pediatrics[19]

Appendix 3 – Risk assessment and screening tool ≥6 years

Risk assessment and screening process – patients aged ≥6 years[13,20]

Risk factors/disease indicators – Routine referral to a dental practitioner/ public dental clinic is highly recommended	**Risk level**
Patient comes from a low socio-economic background or has low health literacy.	**High**
Patient has had dental restorations placed (e.g. fillings, implants, crowns, bridges) in the last 3 years.	**High**
Frequent snacking and consumption of sugar-containing snacks or drinks in-between meals (>3 times a day).	**High**
Patient is a recent immigrant.	**Moderate**
Patient has special healthcare needs and/or uses medications that may cause dry mouth.	**Moderate**
Patient has orthodontic or other oral/dental appliances (may make cleaning teeth difficult).	**Moderate**
Clinical signs	**Risk level**
Visible decay (e.g. white spot lesions, brown spot lesions, holes/cavitation) (see Appendix 2). Routine referral to a dental practitioner/public dental clinic is required.	**High**
Visible plaque accumulation. Routine referral to a dental practitioner/public dental clinic is highly recommended.	**High**
Patient has low saliva production/flow Routine referral to a dental practitioner/public dental clinic is highly recommended.	**High**
Gingivitis (bleeding, swollen, or red (as opposed to pink) gums)[14]. Routine referral to a dental practitioner/public dental clinic is highly recommended.	**Moderate**
Patient has dental restorations (fillings, implants, crowns, bridges) that are defective. Routine referral to a dental practitioner/public dental clinic is required.	**Moderate**
Toothache, recent trauma (not yet seen by a dental practitioner), facial swelling from infection, or visible abscess (see Appendix 2). Immediate referral to the nearest dental practitioner or a medical practitioner/ emergency department is required.	**High**
Protective factors that reduce risk of poor oral health and caries	
• Patient drinks fluoridated water (tap water in communities with fluoridated water supply). • Patient has seen a dental practitioner for a check-up (not just emergency care) in the past 12 months. • Fluoride varnish has been applied in previous 6 to 12 months. • Patient brushes teeth twice daily with an appropriate fluoride toothpaste.	

Appendix 4 – Duraphat® application

Equipment

- Hand sanitiser or hand washing station
- Duraphat® varnish (single dose (0.4 ml) pack or multi dose tube)
- Duraphat® dosage pad
- Cotton gauze
- Disposable microbrush/applicator
- Appropriate personal protective equipment (PPE):
  - gloves
  - protective eyewear
  - single use surgical mask
  - apron (optional).
- Single use, self-adhesive bib to protect patient clothing
- Clean dry soft-bristle toothbrush (optional).

Dose

As per the manufacturer's instructions for use, the dose of Duraphat® varies based on age (and subsequently, dentition type)[5,21]:

- young children with primary teeth only: up to 0.25 mL Duraphat ® (5.6 mg fluoride)
- older children with mixed dentition: up to 0.4 mL Duraphat® (9.04 mg fluoride)
- adolescents and adults with permanent dentition: up to 0.75 mL Duraphat® (16.95 mg fluoride).

A single use Duraphat® Dosage Pad that indicates the amount of fluoride to be applied or Duraphat® Varnish Single Dose (0.4 mL) must be used to ensure the correct amount of varnish is dispensed and applied.

Application procedure

The following application procedure is based on the Queensland Health Fluoride Varnish Guideline (QH-GDL-410:2013) and the Remote Primary Health Care Manual – Clinical Procedures Manual and has been contextualised for the community pharmacy setting[5,11]:

1. Explain the procedure to the patient and what they can expect e.g. teeth will feel sticky, keep mouth open, and tongue away from teeth during application.
2. Don appropriate PPE, perform appropriate hand hygiene. As per WA Department of Health - Donning and doffing in healthcare settings.
3. Position the patient; young children may be positioned as per the 'lift the lip' technique, otherwise the patient should sit facing the pharmacist with their head tilted slightly back.
4. Dispense the correct amount of fluoride for the age of the patient using a single use dosage pad or a Duraphat® Varnish Single Dose pack.
5. Remove any visible plaque from teeth using cotton gauze, or by brushing with a wet toothbrush (without toothpaste).
6. Dry the teeth using a clean piece of cotton gauze:
   a. one quadrant (quarter of the mouth) should be dried and isolated at a time for application; although thorough drying is not necessary as the varnish sets on contact with saliva
   b. isolate the teeth by putting a finger and thumb on each side of the tooth for application. Older children and adults may tolerate rolled up gauze tucked into the space between the gum and cheek. Change the gauze periodically as it becomes wet.

7. Apply a thin layer of the varnish to 2 to 3 teeth (as required) in one quadrant at a time using a disposable microbrush/applicator, starting with the upper front teeth, moving to the back, then lower teeth. Do not overload the applicator and periodically check the tongue and cheeks for varnish and wipe away as required:
    a. the varnish can be applied to the chewing surfaces of the back teeth and around the gumline on the outside of front teeth if there are white spots indicating early tooth decay
    b. for restless young children who may struggle to sit still, prioritise the upper front teeth (apply to outside, inside, and biting surfaces).
8. Finish the procedure by checking the tongue and soft tissues for varnish residue and wipe away.

Note: Duraphat® is indicated as a spot application fluoride treatment for at-risk tooth surfaces. It should not be applied to the whole dentition in one session (systemic treatment)[6].

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