Engaging dental professionals in residential aged-care facilities: staff perspectives regarding access to oral care

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Abstract. The limited access to oral care for older people living in residential aged care facilities (RACFs) has been noted repeatedly in the literature. The aim of this study was to explore RACF staff perspectives on how to engage dental professionals in the provision of oral care for RACF residents. Semi-structured interviews were conducted with 30 staff from six purposively selected RACFs located in high socioeconomic areas to gain understanding of the multidimensional issues that influenced the engagement of dental professionals from a carer perspective. Analysis revealed that staff perceived tensions regarding affordability, availability, accessibility and flexibility of dental professionals as significant barriers to better oral care for their residents. Participants raised a series of options for how to better engage dental professionals and reduce these barriers. Their ideas included: the engagement of RACF staff in collaborative discussions with representatives of public and private dental services, dental associations, corporate partners and academics; the use of hygienists/oral health therapists to educate and motivate RACF staff; the promotion of oral health information for troubleshooting and advice on how to deal with residents’ dental pain while waiting for support; the encouragement of onsite training for dental professionals; and the importance of gerodontology (geriatric dentistry). Findings highlighted the need to explore alternative approaches to delivering oral care that transcend the model of private clinical practice to focus instead on the needs of RACFs and take into account quality of end-of-life oral care.

Additional keywords: aged care, barriers, geriatric dentistry, oral health care, primary care.

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Introduction

Research indicates that older people living in residential aged care facilities (RACFs) who are dependent on others for oral care have significantly more dental caries and plaque deposits than their community-dwelling counterparts (Chalmers et al. 2009; Hopcraft et al. 2012). Such oral disease may have a considerable impact on quality of life, including eating ability, speech, behaviour, appearance and social interaction (Sheiham 2005; Griffin et al. 2012). It has been suggested that older adults with poor oral health may also be more prone to preventable systemic diseases (Kandelman et al. 2008), including cardiovascular disease and stroke (Mattila et al. 2005).

Studies indicate a lack of appropriate oral health systems for older people in the community (Grytten and Holst 2013). The focus is often on providing dental treatment in response to acute dental distress (Quiñonez et al. 2009). Older people in RACFs have even more limited access to appropriate oral health systems (Hearn and Slack-Smith 2015), preventative dental care and other dental services (Hopcraft et al. 2008). The absence of dental practitioners with skills and training in dealing with older people (MacEntee 2010; Slack-Smith et al. 2015), together with a lack of financial incentives, the need for portable dental equipment and limited provision of continual oral hygiene training for carers, have further hindered the promotion of primary oral care (Weening-Verbree et al. 2013; Bots-VantSpijker et al. 2014). Key barriers to accessing dental services in RACFs have been reported at policy, service and practitioner levels, with specific emphasis on inequalities in access to oral care among low-income adults (Miegel and Wachtel 2009; Tham and Hardy 2013; Hearn and Slack-Smith 2015).

Residential aged care in Australia is government-subsidised and regulated by the Commonwealth Government’s Department of Social Services. RACFs in Australia fall primarily under the non-government sector, usually through religious/charitable and private sector providers/companies. Contributions for a resident’s care are calculated according to an income test. Legislation regulates the upper limit on fees that any approved RACF provider can charge a resident (Department of Social Services 2014). This limits the amount of money available for the RACF to spend on additional activities, including oral care.

In reviewing barriers to oral care, emphasis to date has been placed on economically vulnerable groups (Miegel and Wachtel 2009; Wallace and MacEntee 2012; Tham and Hardy 2013). However, residents with financial and non-financial resources do not necessarily have ready access to oral care or dental services. Acknowledging the importance of single issues like affordability does not adequately address the complexity of accessing care (Watt 2007), nor the diverse barriers that can affect such care in
RACFs; rather, it highlights a gap in this area of research (Hearn and Slack-Smith 2015). The aim of the present study was to explore this gap and investigate the views of staff working in RACFs on how to engage dental professionals in providing better oral care for their residents. The authors chose aged-care facilities in upper socioeconomic suburbs, where residents were more likely to be able to afford dental care and have resources to facilitate access. This enabled an examination of the issues beyond merely the costs of dental services and an exploration of other factors that possibly limit access to oral care.

Methods
Following a literature review of oral care in RACFs (Hearn and Slack-Smith 2015), a logic model was developed to explore the views of aged-care staff on the oral health of their residents and how to engage dental professionals with the care team (see Fig. 1). To guide the research questions, analysis and interpretation of results, our model built on the Penchansky et al. model (Penchansky and Thomas 1981). In this case the model defines and reviews access to the provision of oral health services according to overlapping multidimensional issues, including: availability, accessibility, accommodation, affordability and acceptability. Interviews explored the views of RACF staff on current needs for, barriers to and potential enablers of oral care, as well as their preferred means of engaging dental professionals and what roles they perceived dental professionals could play.

Interviews were conducted with 30 staff from six RACFs in the Perth Metropolitan Area, Western Australia, during 2014. Postcode information was used to purposively select RACFs in terms of geographic distribution expressed as the top quintile of ranked Statistical Local Areas (SLAs) in Australia, according to the Index of Relative Socioeconomic Advantage and Disadvantage. This index represents one of the four Socioeconomic Indexes for Areas (SEIFA) measures (Australian Bureau of Statistics 2006). The RACFs were further selected to represent a range of different care types (two high-care, four low- and high-care, including two with palliative care) and different service-provider types (two operated by stand-alone independent providers, two by large private group providers and two by religious charitable providers) (DPS Publishing 2013). All the facilities approached consented to participate in the study. Across the RACFs, interviews were conducted with the six directors of nursing (DONs), 14 clinical nurses (CNs) responsible for the general health of the residents and 10 personal care assistants (PCAs).

The interviews were conducted using open-ended questions, allowing respondents to freely provide their perspectives on how oral health care was provided, the barriers that existed currently, how these could be improved, and what potential roles dental professionals could play (see Box 1). At the end of the interviews, participants were asked for basic demographic information. After permission was gained from the interviewee, all interviews were recorded with a digital recorder and then transcribed verbatim. NVivo10 software (QSR International, Melbourne, Vic., Australia) was used to assist with the analysis. As themes emerged, an iterative coding process was used to clarify and redefine our understanding of each theme (Miles and Huberman 1994; Charmaz 2000) and to build on the logic model (Penchansky and Thomas 1981). Ethics approval for the study was obtained from the Human Research Ethics Committee at the University of Western Australia.

Results

Characteristics of participants
All 30 staff interviewed were female. Participants ranged in age from 26 to 62 years, with a median age of 46 years (two
participants chose not to give their age). Only 12 staff were born in Australia and their median age was 58 years. The remaining 18 staff came from 14 different countries, with a median residency in Australia of five years. All of the six DONs interviewed were Australian. Twenty-three of the 30 staff had a Bachelor of Nursing degree (six DONs, 14 CNs and three PCAs), one had a postgraduate diploma (CN) and one an honours degree (CN). The remaining seven were PCAs who had completed Year 12 (final year of high school) and had Certificate III training (technical college).

Length of employment in the aged-care industry ranged from 6 months to 38 years, with a median length of 11 years. The average length of employment in the aged-care industry for the DONs and CNs was much longer (median = 15 years for DONs and 8 years for CNs) than for the PCAs (median = 3.5 years). The majority of the staff interviewed (67%) had remained in their current RACF for over 80% of their career, with the average length of stay being 6 years. All but one of the PCAs had remained in their current job throughout their career in aged-care in Australia.

Staff perceptions of oral care

Almost all staff felt that oral care was essential, and influenced the overall health and wellbeing of residents. Yet cleaning the teeth of residents – especially those with severe dementia, who can be uncooperative – was described as a serious problem, with older staff emphasising that it was easier in the past, when most residents had dentures: ‘Now, people are having their own teeth and some have plates that can be quite difficult for the staff to get in and out.’ Gingivitis, oral thrush and dry mouths were described as the most common oral health issues. As one CN said: ‘If you lift the stone up, it is a big problem in aged care... I mean, a lot of our antibiotic use and antifungal use is directly related to oral hygiene.’ Nevertheless, most staff agreed that oral health was a low priority, given all their other daily duties: ‘It [oral hygiene] is put on the back shelf.’ Both DONs and CNs highlighted the limitations of oral care in the Commonwealth Aged Care Act 1997, which only requires RACFs to provide oral assessment on arrival, dental check-ups every 12 months and daily oral/dental hygiene. Any further dental treatment required residents to join long waiting lists for public dental care or for their private dental expenses to be covered by the resident or their family.

Barriers to engaging dental professionals

All staff indicated that there was little or no collaborative engagement with dental professionals and that oral health was not well supported for their residents. As one DON said: ‘I think dentists and hygienists should stop being on the outskirts of aged care.’

Affordability was identified as the major barrier to engaging dental professionals in the oral care of residents, even in these RACFs in areas of high socioeconomic status. ‘These people pay up to the maximum to stay here... so it doesn’t leave them a lot of money, and out of that they still have to clothe themselves and pay for their medications’ (see Box 2). Participants also noted that few residents had private health insurance and even if they did, it rarely covered dental costs. Staff highlighted that as our society is ageing, many of the residents’ children were also on pensions or grappling with their own health issues and costs. Moreover, staff were particularly concerned by the unregulated costs of private dental care and the long waiting lists for free public dental care.

Availability, including both the willingness of dental professionals to meet the demand for oral care and their resourcefulness to supply services to RACFs, was seen as another barrier: ‘There are a couple of mobile dentists, but they don’t come much and their costing is absolutely astronomical – significantly higher than going to a dentist.’ Specifically, the need for flexibility was raised: ‘Better oral health requires more frequent visits... because sometimes the issue is that the resident isn’t in the mood or is unwell and they [the dentist] won’t be able to see the patient.’ Lack of information and resources on which dental professionals were available was also mentioned: ‘We have put out requests and run around and sent letters out and [name] is the only one in this area who responded.’ Half of the DONs responded with some concern regarding the limitations of the lists of available dentists, noting that the lists provided by the dental health service were outdated, with many on the lists now retired, no longer visiting RACFs or having long waiting lists for appointments. Flexibility was also considered to be impeded by
the accepted need for active rather than passive consent for dental treatment, which meant waiting for approval for dental care from the resident’s guardian.

All the RACFs in this study were located in central metropolitan areas where there were numerous dental clinics, but accessibility was mentioned as another major barrier to engaging dental professionals. Many respondents indicated that residents’ physical and mental disabilities can inhibit families from taking them to the dentist and ‘we don’t have the resources to send a carer with them because the carer is required on the floor, so we have to send them with the ambulance service’. Even if the family can organise a wheelchair taxi to take them to the dental services:

...that also requires being transferred from the wheelchair to the dental chair... and that is when the situation becomes a bit more complicated because dentists don’t have the facilities... They don’t have a hoist and they can’t work in the wheelchair so it does create an issue.

Treating residents in their own environment was generally considered less stressful for the resident: ‘When they [dentists] come and do it here, the resident still has their own bed and they can wake up and eat and they are not too frightened.’ Yet staff noted that few dental professionals were able to go to the RACFs. While all RACFs in this study had a room with a dentist/podiatrist chair that was used for regular annual dental check-ups and extractions, staff pointed out that attending to the more disabled residents required the dental staff to ‘actually go around with their trolley to the resident’s room’.

Several staff felt that the dental system, and dental professionals in particular, were not flexible or able to accommodate residents’ requirements. Most staff felt that obtaining government domiciliary dental care required ‘filling in an onerous processing form’, only to be placed on a long waiting list for appointments. ‘We have patients with broken teeth and it horrifies me... a month is a long time to suffer with such toothache.’ They felt that dental professionals needed to be more mindful of and amenable to dealing with residents’ needs. They were concerned that even the private dentists willing to attend would ‘whisk in and whisk out’ without explaining the problem or how to prevent it in future. Overall, staff considered the provision of annual dental check-ups to be a good idea, but the DONs saw them as inefficient, with assessments being carried out under conditions that agitated residents for little outcome.

Dental professionals’ attitudes and inclination to work with residents were also of concern to RACF staff: ‘There are not a lot of dentists who are interested in aged care... It is an area they don’t want to practise in, which is unfortunate, but I think that is the reality.’ Most staff accepted that patients with dementia were fearful of being hurt and their resistive aggressive behaviour hindered oral hygiene, assessment and treatment. They admitted that, at times, it was unproductive and stressful for dental professionals to come to the RACF only for the resident to refuse to open their mouth. However, staff felt that if dental professionals were more available and offered more oral health education, most staff could gain the skills to provide better oral hygiene, reducing the frequency of extreme oral health issues.

Perspectives on how to engage dental professionals

Despite these barriers, all staff wanted greater interaction with dental professionals. Specifically, participants talked about the

<table>
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<tr>
<th>Box 2. Summary of perceived barriers to engaging dental professionals in aged-care facilities</th>
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<tr>
<td><strong>Barriers related to affordability</strong></td>
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<tr>
<td>• High cost of residential aged-care facilities and medication leaves few funds for oral health care</td>
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<tr>
<td>• Lack of private health insurance</td>
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<td>• Financial expense of accessing private mobile dentists</td>
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<td>• Unregulated costs of dental care</td>
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<td>• Emphasis on complex costly treatment rather than quality-of-life care in their final stages of life</td>
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<td>• Family unable or unwilling to support dental care</td>
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<tr>
<td><strong>Barriers related to availability</strong></td>
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<tr>
<td>• Annual check-ups fail to meet the behavioural needs of those with dementia</td>
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<tr>
<td>• Lack of willingness of dental professionals to go to residential aged-care facilities</td>
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<td>• Lack of resourcefulness to see the growing market for oral health care for residents</td>
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<td>• Long waiting lists for public dental services and long ‘red tape’ process to organise domiciliary care</td>
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<td>• Dearth of ambulant transport for frail, bed-ridden residents to attend dental care centres</td>
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<td>• Lack of current information on where to find dental professionals willing to go on-site</td>
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<tr>
<td><strong>Barriers related to accessibility</strong></td>
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<td>• Mobility issues, lack of appropriate transport and difficulties transferring residents in and out of vehicles</td>
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<td>• Lack of staff support and education in dealing with oral care as a result of lack of oral health promotion, training and information resources and lack of leadership and motivation</td>
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<td>• Age/frailness of family members limits their capacity to support and transport residents</td>
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<tr>
<td><strong>Barriers related to accommodation</strong></td>
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<td>• Lack of flexibility of dental professionals to meet residents’ changing needs</td>
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<td>• Lack of willingness to attend and treat residents in RACFs</td>
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<td>• Lack of involvement and communication with staff at residential aged-care facilities</td>
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<td>• Lack of 24-h call-up service</td>
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<td><strong>Barriers related to acceptability</strong></td>
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<td>• Fear and lack of training/experience in handling patients with dementia</td>
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benefit of having a team of dentists, dental hygienists and oral health therapists to assess, clean and treat residents’ oral health, and to provide education and ongoing support ‘so that staff feel empowered, because it is a hard job that the carers do and they need motivation’.

Most staff doubted the probability of any government changes being introduced in the short term. Instead, they felt that dental associations, pharmacies, the dental industry and even local dental clinics could play a greater role in promoting information and educational resources on oral health care for older people, and suggested that these groups should have more frequent meetings with DONs: ‘We need more communication together to make it happen ... so it benefits the residents.’

Nearly all the respondents identified oral hygiene rather than dental treatment as the principal need and suggested that dental hygienists and oral health therapists could play a central role in educating and motivating the staff, and keeping them up-to-date with the latest oral health products, treatments and equipment. ‘Now, we have more people who have their own teeth than ever before and that is a new issue because not only do they have gingivitis ... we don’t know they have got it’. In particular, the respondents wanted in-house education ‘to keep that motivation going with the staff’.

The importance of educating dental professionals was also mentioned: ‘Dentists need to learn to communicate and deal with people with dementia.’ Specifically, staff emphasised the need for dentists to focus less on advanced treatment and more on quality care in the provision of better oral care for RACF residents. Tensions regarding affordability, availability, accessibility and flexibility of dental professionals to meet the needs of older people, especially those with dementia, were perceived by staff as significant barriers to better oral care for the residents. Despite these barriers, participants raised several achievable ways that dental professionals could support efforts to improve the oral health of residents. Interviewees felt that by working more closely with dental professionals, they could improve the oral health of their residents.

Although this study was conducted with RACF staff working in high socioeconomic areas, there was a strong belief that the exceptionally high costs of private dentistry impinged on families’ abilities to support residents’ dental needs. Moreover, in line with recent research, staff felt that this was exacerbated by government fiscal restraints that limited the provision of public dental services (Grytten and Holst 2013). While costs were considered a key barrier, staff emphasised numerous other policy, service and practitioner level barriers that hindered both quality and maintenance of good oral care in their RACFs and the engagement of dental professionals. Specifically, the DONs considered that this was partly a result of the limitations of the Government Aged Care Quality Agency (2014), which provided little support for oral care.

As shown in previous studies, it was suggested that not all PCAs had the skills or knowledge to provide oral hygiene, and this – together with time restraints and lack of ongoing training and support – limited their capacity (Chalmers and Pearson 2005; Reed et al. 2006). Nevertheless, the DONs felt that most of their staff would be keen to learn how to address the oral care of their residents. They believed that the lack of support from dental health services, dental professionals, dental associations, pharmaceutical agencies and dental technician industries hampered the promotion of better oral health in their RACFs.

While all those interviewed were keen to see greater engagement of dental professionals in RACFs, the majority of DONs and CNs felt that to achieve any realistic change in the long term would require an overhaul of the current policy and protocol. In particular, they were concerned that all too often policy decisions were made without their involvement, even though DONs and their PCAs were responsible for providing oral care for their residents on a daily basis, making them aware of the barriers and how these could be overcome. DONs felt that RACF staff should be invited to play an active role alongside the dental health service on panels or committees to review the current resource allocation and assess the structural logistics regarding delivery of better oral health policy and practice for residents (See Box 3).

The inclusion of RACF staff in collaborative discussions with representatives of public and private dental services, dental associations, gerontologists, Primary Health Networks, corporate partners and academics could be an effective strategy to identify and elucidate a range of prerequisites for change, including suitable timelines for implementation, clarity of roles and responsibilities, and adequate training and support for staff to adapt to change.

Although most participants felt that the current annual dental check-ups were beneficial, in practice they found the provision of more regular oral cleaning procedures for residents, and education for staff by dental hygienists/oral health therapists, a better use of government financial support. As indicated in recent research, they felt that regular visits by dental hygienists and/or oral health therapists was a more efficient means of educating their PCAs to promote better oral health and to encourage early intervention/treatment of gingivitis and oral health issues (Hopcraft et al. 2011). Furthermore, many suggested that more frequent, shorter visits by dental hygienists/oral health therapists in the morning, when residents are less tired and resistive, would enable them to attend to all residents over the course of a year, while at the same time providing staff with training, keeping them motivated and maintaining oral care on their agenda.

For more immediate achievable improvements, staff proposed an updated list of dental professionals by regional area, outlining
Additional course options for RACF staff include workshops, webinars, and mentorship programs. These resources can help RACF staff develop the necessary skills to provide better oral care to residents. However, there is a need for a more collaborative model of oral care for RACFs facilitated through increased coordination at service and administration levels, greater use of hygienists/oral health therapists and a greater involvement by dental/oral health students, with emphasis on the type of oral care most needed, in what form and by which dental professionals.

Conclusion

The concerns raised and insights identified through this study emphasise the interest of RACF staff in the development of a more collaborative model of oral care for RACFs. The findings of this study confirmed the complex barriers that currently limit the ability of RACF staff to help residents access oral care (Hearn and Slack-Smith 2015). It also provided useful insights into how to promote greater involvement of dental professionals in RACFs, with the goal of improving the oral care of residents. While the qualitative nature of this study and the small number of centres involved means that the findings may not be generalised, the credibility and validity of the themes were substantiated through the interpretive rigour employed for data collection (Tong et al. 2007). Further, the process of reflecting back on the main themes and issues raised according to each topic in the logic model helped verify whether the content of the transcripts yielded repeated information according to the participants’ job position and demographic data. The dynamic nature of this process further clarified the views of RACF staff and provided a greater in-depth understanding of the primary issues they perceived could offer practical, achievable ways of engaging dental professionals, with emphasis on the type of oral care most needed, in what form and by which dental professionals.
investigations are under way to understand the various perspectives, and to review geriatric dentistry education in dental schools (Slack-Smith et al. 2015), there remains a need to explore alternative approaches to delivering oral care in RACFs and to respond to residents’ needs, taking into account their diverse socioeconomic, cultural and geographic contexts.

Competing interests
None declared.

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