Dentistry in care homes research – UK

January 2012
BDA Care homes research

Method

This research is comprised of three strands, a literature review, telephone interviews with a small number of care home managers providing care to older people across the UK, and an online survey of Clinical Directors responsible for providing dental services to care home residents via the Salaried Primary Dental Care Services.

Literature review

Relevant available literature was sought from PubMed, internet searches, and through bibliographical searches of selected articles. The search was limited to papers published in the last 12 years.

Telephone interviews

Qualitative telephone interviews were conducted with 13 care home managers during June and July. The interviews were semi-structured in nature, with a core framework of topics to be covered but allowing for exploration of new issues that arose in each interview.

Qualitative research of this type is designed to provide in-depth and descriptive data. The intention is to highlight some of the problems and examples of best practice rather than provide a statistically significant or representative picture.

In choosing the sample, care was taken to include homes from all spectrums of the following categories:

- Number of residents (small, medium, large)
- Location (geographically spread across the UK and including rural and urban settings)
- Ownership (private, local authority, not for profit)
- Resident needs (specialist categories such as dementia)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>6</td>
</tr>
<tr>
<td>Wales</td>
<td>2</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3</td>
</tr>
<tr>
<td>Scotland</td>
<td>2</td>
</tr>
<tr>
<td>Ownership</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>4</td>
</tr>
<tr>
<td>Local authority</td>
<td>6</td>
</tr>
<tr>
<td>Not for profit</td>
<td>3</td>
</tr>
<tr>
<td>Size</td>
<td></td>
</tr>
<tr>
<td>0-14</td>
<td>4</td>
</tr>
<tr>
<td>15-34</td>
<td>4</td>
</tr>
<tr>
<td>35+</td>
<td>5</td>
</tr>
</tbody>
</table>

Online survey

As part of an annual survey of Clinical Directors of Salaried Primary Dental Care Services, respondents were asked to indicate whether their service provided dentistry to care home residents, and if so, whether they agreed to take part in a further online survey. In total, 39 Clinical Directors agreed and were sent the online survey in mid-July. Twenty-six responses were received, giving an overall response rate of 67 per cent.

Structure of the report

This report begins with an executive summary of the main findings, followed by more detailed descriptions of each component of the research. First, the findings of the literature review are summarised, followed by details of the telephone interviews with care home managers, and finally the results of the online survey of Clinical Directors working in the Salaried Primary Dental Care Services. Appendix 1 gives the results tables from the online survey.

Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>Literature review</td>
<td>5</td>
</tr>
<tr>
<td>Background</td>
<td>6</td>
</tr>
<tr>
<td>Oral health of care home residents</td>
<td>6</td>
</tr>
<tr>
<td>Impacts of poor oral health</td>
<td>8</td>
</tr>
<tr>
<td>Carer knowledge and attitudes</td>
<td>8</td>
</tr>
<tr>
<td>Access to dental treatment</td>
<td>9</td>
</tr>
<tr>
<td>Care home manager interviews</td>
<td>11</td>
</tr>
<tr>
<td>Daily oral hygiene</td>
<td>11</td>
</tr>
<tr>
<td>Check-ups</td>
<td>15</td>
</tr>
<tr>
<td>Salaried Primary Dental Care Services survey</td>
<td>21</td>
</tr>
<tr>
<td>References</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 1 – Online survey results tables</td>
<td>29</td>
</tr>
</tbody>
</table>
Executive summary

• The UK faces a number of challenges from an aging population who have increasingly complex dental needs.

• The literature shows high levels of unmet dental need in care home residents. This was consistent with our interviews with care home managers, many of whom reported that residents will only see a dentist when they are in pain or have a serious problem. Some of the Clinical Directors surveyed also confirmed that the provision of routine dental care for care home residents by their service can become patchy when resources are stretched.

• The literature highlighted a number of examples of care home residents in the UK not receiving assistance with daily oral hygiene tasks. This was not the case in the care homes we interviewed where it was the minority of residents that did not receive any assistance. This may be due to increased focus on oral health in recent years since the publication of this literature.

• Providing instruction for carers about how to provide assistance with daily oral care has been shown to improve the oral health of care home residents in both the short- and longer-term. The training received by carers varied widely across the care homes we spoke to, ranging from nothing at all to comprehensive, externally validated training. Most received at least some instruction from a senior member of staff during the induction process but formal instruction from a dental professional was much less common.

• Overall, most of the care home managers interviewed felt that the daily oral hygiene needs of their residents were being well met. The main reported problems related to resistance from residents, particularly those suffering from dementia. Other residents also refuse to take their dentures out overnight for soaking and in some cases the homes have no choice but to respect the residents’ personal choice in these matters.

• Half of the care homes reported that their residents receive regular check-ups while the remainder only seek dental care for their residents on request or when there is a problem.

• The homes were evenly split between those that use high street dentists and those that use the services of salaried primary care dentists. The care home managers generally felt that there is a lack of information available to them about NHS providers, particularly in relation to who is willing to provide domiciliary care within a care home.

• Homes under the care of salaried primary dental care dentists were more likely to access regular check-ups for their residents and also to receive domiciliary care where appropriate.

• A lack of availability of domiciliary dental services was a major problem for some, with a programme of regularly scheduled domiciliary visits to all residents the most common suggestion for improving the oral health of care home residents.
Oral health of care home residents

While achieving and maintaining good oral health for older people has challenges of its own, doing so for older people within care homes presents an even bigger challenge. The literature is filled with studies showing poor oral health and high unmet treatment needs in care home residents both in the UK and internationally. Residents are more likely than older people living at home to suffer from mobility as well as cognitive impairments which both tend to have negative impacts on oral health. These additional risk factors add to the already elevated dental needs from the normal aging process, and the side-effects from medication.

A study of frail, elderly and infirm residents of nursing homes in Avon found very poor oral health and hygiene levels. On average, residents were found to have two-thirds of each tooth covered in plaque and almost two thirds (63 per cent) had root caries at the time of the examination. In Scotland, one study found that the majority of residents (79 per cent) in three care homes and two long stay hospitals were left to perform their own oral care, with the result that a third received no daily oral care.

The high treatment needs of older care home residents led the authors of an oral health screening questionnaire to conclude that the questionnaire was an unnecessary step. The authors felt that the high needs identified warranted giving all residents full clinical examinations on entry into residential care.

Similarly high levels of unmet need have been found internationally. In a recent study in Austria, 48 per cent of the residents examined were deemed to require surgical treatment. In Northern Italy, 86 per cent of a sample of nursing home residents had poor oral hygiene, while over half (56 per cent) required tooth/root extractions. Many more studies reported consistent findings.

Dementia and related cognitive impairments are thought to affect up to 20 per cent of people aged over 80 and up to 50 per cent of those over 90 years old. Given the direct link between cognitive impairment and the ability to function independently, it follows that the prevalence of dementia is much higher in care home residents than older people living at home. Several studies have shown a negative correlation between the presence of dementia and oral health. One such study in Cheshire found that residents with moderate or severe dementia had worse outcomes with regards to dental plaque and calculus levels, and denture stability than residents with moderate or no dementia.

Associations have also been shown between the level of dependency of the resident, and the presence of dental plaque, with more dependent residents showing higher plaque levels. Interestingly, this study showed no significant difference in denture plaque scores between the dependency groups, and also found that dental plaque scores were higher than denture plaque scores, leading the authors to hypothesise that the nursing staff provide more assistance for denture cleaning, than they do for the remaining teeth of dentate residents.

Impacts of poor oral health

Poor oral health in the elderly has wide ranging health implications, from the more obvious impacts of pain and discomfort in and around the mouth and jaw, to the follow-on effects that difficulties chewing have on nutrition and general health.

Restricted diets caused by chewing difficulties can result in malnourishment and nutritional deficiencies. A recent study in Finland showed that 29 per cent of the residents were malnourished, with a further 60 per cent at risk of malnourishment. Residents with either mixed dentition or full dentures were found to have better nutritional status than those with partial dentition or no dentures. The number of oral health problems such as difficulty chewing or

---

1. Laiing and Buisson, 2010
2. Scotland: 31,000 long-stay residents aged 65+ in care homes (Scottish Government Health Analytical Services Division, 2010)
3. Northern Ireland – 31 March 2008 there were 174 residential homes, providing 3706 places, 90% occupancy = 3335 residents (Department of Health, Social Services and Public Safety, 2008).
5. England, 360,330 in 2010 (Estimate based on figures from Laiing and Buisson and for the devolved nations above)
6. Adult Dental Health Survey, NHS Information Centre, 2009
7. The Gerodontology Association and Blackwell Munksgaard Ltd, 2005
8. Ferro, et al., 2005
10. Wyatt, So, Williams, Mithani, Zad, & Yen, 2006
11. Nicol, Sweeney, McHugh, & Bagg, 2005
13. Adam & Preston, 2006
14. Wyatt, So, Williams, Mithani, Zad, & Yen, 2006
15. Adam & Preston, 2006
17. Walls, Steele, Sheehan, Marcenes, & Moynihan, 2000
18. Soini, et al., 2006
19. Frenkel, Harvey, & Newcombe, 2000
20. Milwaukee Dentistry in care homes research – UK
swallowing, pain in the mouth, or xerostomia was also related to nutritional status with worse nutrition found as the number of problems increased.

Poor oral health can restrict diet through food choices and though food preparation techniques. Foods such as raw carrots, nuts, and certain fruits and vegetables are often eliminated from the diet while preparations such as peeling vegetables and overcooking result in a reduction in dietary fibre, important for cancer prevention, and in antioxidants required for cell regeneration and to combat aging. Further links have been found between these nutritional deficiencies and excess winter deaths in older people, cardiovascular disease, and stroke.\(^7\)

In a survey of care home managers in Wales\(^18\), over a quarter (28 per cent) admitted that the menus in their home assumed that all residents have dentures or trouble chewing. The impact of this is that even residents with functional dentition can be adversely affected by the poor oral health of other residents.

The effects are more widespread than nutrition though, with studies showing higher health-related quality of life scores for 85 year olds with 20 or more teeth than their counterparts with fewer teeth.\(^19\) Significant differences were found in areas such as physical functioning, bodily pain, and vitality. There are also well documented links between the presence of microflora in the mouth caused by poor oral hygiene, and aspirational pneumonia, a leading cause of morbidity in elderly care home residents.\(^20\)

Given the above associations, it is clear that taking steps to improve the oral hygiene of care home residents would facilitate improvements to their general health and wellbeing in addition to improving their oral health.

**Carer knowledge and attitudes**

Improving the oral health of care home residents can be approached from two angles: improving daily oral hygiene practices, and through regular check-ups with dental professionals.

With regards to the first, poor oral hygiene support has been linked with both low management priorities within the homes, and to poor knowledge/training of the care staff responsible for providing oral hygiene assistance.

One Swedish study found that assistant nurses and nursing aides were most likely to regard tooth brushing to be the most undesirable aspect of their job, more so than activities relating to incontinence.\(^21\) The same study found that a third of registered nurses (34 per cent) and slightly more assistant nurses (43 per cent) and nursing aides (40 per cent) agreed that providing oral care is a somewhat repulsive nursing activity.

One study\(^22\) covering 22 care homes in England found that while three-quarters of the dentate residents had difficulty or were unable to clean their natural teeth, none received daily assistance and just 2.5 per cent received occasional support. Residents with dentures were more likely to receive daily support in oral health care but the study found that 18 per cent of the residents needed support but did not receive any.

Interventions aiming to improve the oral health of care home residents have shown varying degrees of success in both short- and longer-term outcomes. The most common intervention involves education programmes for carers.

In Bristol\(^23\), oral health care education resulted in improved outcomes on measures of denture plaque, and denture-induced stomatitis after one and six month intervals. This study estimated the costs of rolling out the training to the Health Authority with 100 homes to be around £6,700. The carers also demonstrated improved knowledge and attitudes towards oral health at one and six month intervals after receiving the training.\(^24\)

A similar intervention in Scotland\(^25\) also found improvements to the number of residents receiving daily oral hygiene assistance, and in levels of mucosal disease and denture hygiene following training provision. Another study in Norway\(^26\) found that improvements were still observable six years after a programme including training, procedure cards and cleaning appliances, and the appointing of an oral care contact person was put in place.

A survey by the National Care Forum in 2008\(^27\) found that over 40 per cent of care home staff leave their job within a year and 60 per cent leave within two years. Such a high turnover of staff has an impact on the knowledge that can be retained in the sector and the continuity of care that can be provided by staff to patients in residential settings. High turnover will also affect the level of training that staff have access to, which will have a further impact on residents’ oral health.

**Access to dental treatment**

There is not a lot of information available about the uptake of professional dental care by care home residents in the UK, but the little information that is available does suggest that there are high levels of unmet need. The earlier mentioned study of care homes in the Avon area\(^28\) found that 71 per cent of the residents had not seen a dentist in the last five years.

Less than half (48 per cent) of the care homes in a Welsh survey\(^29\) reported that they have mechanisms in place to ensure that residents attend regular dental check-ups.

Other statistics also point to under-use of services by this group. With the proportion of older people increasing dramatically, it could be expected that the number of people requiring domiciliary care would have increased. It is somewhat surprising to see that the rate of domiciliary care provided in Primary Care Dentistry reduced by 44% in the five years to 2005.\(^30\)

Research has also shown that care home residents may be unlikely to complain unless their symptoms are particularly severe.\(^31\) This finding reinforces the need for regular oral health assessments and check-ups with a dental professional.

\(^{17}\) See Walls, Steele, Sheeham, Marcones, & Moynihan, 2000 for a review
\(^{18}\) Welsh Oral Health Information Unit, 2008
\(^{19}\) Alkulfas, et al., 2005
\(^{20}\) Sarin, Balasubramaniam, Corcoran, Laudenbach, & Stoopler, 2008
\(^{21}\) Wardh, Anderson, & Sorensen, 1997
\(^{22}\) Frenkel, Harvey, & Newcombe, 2000
\(^{23}\) Frenkel, Harvey, & Newcombe, 2001
\(^{24}\) Frenkel, Harvey, & Needs, 2002
\(^{25}\) Nicol, Sweeney, McHugh, & Bagg, 2005
\(^{26}\) Samson, Berven, & Strand, 2009
\(^{27}\) National Care Forums 2008
\(^{28}\) Welsh Oral Health Information Unit, 2008
\(^{29}\) The Gerodontology Association and Blackwell Munksgaard Ltd, 2005
\(^{30}\) Nicol, Sweeney, McHugh, & Bagg, 2005
Care home manager interviews

Daily oral hygiene

The information collected about the oral health of newly admitted residents varied hugely from home to home. In some homes this was barely touched on, but in most it was very least covered whether residents have dentures or their own teeth and whether they have any current problems with their oral health. The assessments were generally undertaken by the Care Home Manager, the admitting nurse, or a senior member of the care team. None of the care homes routinely arranged physical examinations as part of the admissions procedure; the information was gathered through interviews with the resident themselves, their families, or the Care Manager.

“Nothing specific, just the Care Plan which shows what kind of assistance they need.”

“We find out when they were last seen by a dentist, whether they have dentures or their own teeth and what their own ability is with regards to maintaining their own oral hygiene and what it is that we will have to provide for them to achieve that.”

“We check that amongst all of the other health checks. We check whether they have got all of their own teeth, whether they have got dentures, who their dentist is, when they have last been seen. Do they want to be seen?”

The one consistent action taken by all homes was to document in the resident’s Care Plan what assistance they require with regards to daily oral hygiene.

“Each resident, as part of their Care Plan has an oral health assessment. In it they get a score from one to three and there are about six different questions, are they able to look after their teeth themselves, are they able to brush their teeth, do they have dentures and things like that.”

“There is a six week assessment before they decide they are definitely going to stay – just to make sure we can meet their needs and everything. At that time we find out the things they can manage and what they can’t manage and that’s all put into their Care Plan.”

One of the managers described how they actively encourage residents to take back responsibility for daily oral hygiene where they are physically able.

“If they clean their own teeth at home then that is what we would want them to do when they come in with us, to continue their independence. If they are not able to clean them at home and they have carers that come in and do that, then we would duplicate what is happening, or if we feel it’s possible, try to encourage them to take back some of that responsibility themselves.”

In contrast to some of the literature, it was a very small minority of residents in each of the care homes that did not receive some form of support with daily oral hygiene. The assistance required varied from resident to resident as documented in their Care Plan, which is regularly updated during reviews. Some residents required a simple reminder to brush their teeth or soak and clean their dentures; others required minor assistance with putting toothpaste on the brush or turning the taps on, while many needed care staff to undertake the whole range of appropriate procedures.

“Only two residents don’t need any assistance, everyone else either needs full assistance or prompting and some assistance. Full assistance as in somebody going in and either brushing and cleaning the dentures and putting them back in and sweeping the mouth. Most need total assistance, the remainder get support to varying degrees, either prompting the person to brush their dentures themselves or to brush their teeth, or they are assisted in some way even if it is just helping to hold it under the tap.”

“Those with dentures it might just mean them being given the facility to clean themselves or maybe the carers have to help them get the teeth out and actually clean them and soak them. Those who have teeth, all the ones that have their own teeth do need the care staff to brush them for them.”

The care staff had responsibility for providing this assistance, and most managers felt that care staff accepted this as part of their role and did not generally have a problem providing the assistance required. Consistent with the literature, some managers did note that it is one of the less desirable aspects of the job for some of the carers.

“I suppose it’s 50:50. Some of them probably don’t like doing it, they probably don’t like touching somebody else’s dentures but it’s part of the job.”

“You do occasionally get a carer who doesn’t see it as being important but we can address that through supervision and they up their game.”

“When I started in care it’s not something I relished doing but once you have done it a few times it’s just like some of the other tasks that aren’t so great. You just stop thinking about it, or at least I did. You just accept that it’s one of the jobs.”

There were no reported problems with the provision of tooth and denture pastes and other cleaning supplies although one of the homes did say they found it easier to supply all the materials themselves than requiring the residents to do so. For the most part though, either the resident or their family would provide the necessary products. In cases where this was not done, a key worker assigned to the resident would take responsibility for purchasing these on behalf of the resident. Most care homes stocked all of the necessary supplies to sell to residents.

“Each resident has a key worker, one of their main tasks would be to make sure there are adequate toiletries and that the resident purchases them. Some need more prompting than others. The care staff are pretty good at making sure the residents have those basic things. It’s not always easy to persuade them but we do our best!”

“We have a little trolley shop that comes around once a week and they sell toothbrushes and toothpaste and various things. They can buy that themselves.
If the resident is not able to purchase it themselves then the Key Worker or a family member are able to do that.”

Training for care staff about how to provide daily oral hygiene support was fairly patchy. Some carers receive in-depth training by dental professionals and achieve formal qualifications, while others receive little or no specific training. For the most part, staff received at least some training or underwent a supervision period by a senior member of staff during the induction procedure. Staff with NVQ qualifications also cover oral hygiene as part of the personal care topic. Some homes reported that most or all of the staff held at least NVQ Level 2 qualifications.

“They don’t really get training. They would learn on the job, it is talked about in the induction but that is all really. We do have a lot of formal training but not on oral hygiene.”

“They have quite an in-depth induction and go on lots of mandatory training that they need to. Part of that is assistance with oral hygiene needs and part is the oral hygiene so they feel quite comfortable in assisting them, if they have any problems they just seek support off other members of staff to get what they need to get it done.”

“Staff have induction and shadow sessions with other staff. We get them to work with another competent key member of staff. And then they have regular supervisions and issues or concerns from both parties can be raised.”

“The Dental Service come out. They came out one day last week and did two training courses for the staff at about an hour at a time. So they usually provide them but we also have our own in house training pack that is externally verified. People have to go through the dental hygiene course and they complete a knowledge paper and that is sent off to the assessors.”

“We don’t get approached by dentists offering services and we don’t get any training about oral hygiene. It would be good if local dentists offered that so that the staff do understand the importance about oral hygiene and correct oral hygiene, it’s easy to brush someone’s teeth for them but are we doing it right? I think a lot of us don’t, even those who are able to clean their own teeth don’t clean them as thoroughly as we should do.”

One manager noted that while general training from dental professionals is very valuable, the biggest challenge for the care staff is dealing with resistance from the residents. This is where in-house training and guidance on which techniques work best for specific residents to obtain their cooperation.

“If you are new to care work you learn mostly from working with the supervisors and they pick it up from them. It isn’t just about oral hygiene, it’s about how you persuade this lady or gentleman to let you do it. It is really good that the Dental Service come out and train the staff and teach about mouth cancer and the rest of it but they also need people who are experienced to say this is how you apply that to this lady in this situation.”

Resistance from residents was the most commonly cited problem with regards to daily oral hygiene and was often the only problem that managers reported.

“They might start off co-operating then suddenly slap you! Or the other way around they say no, no, no then you say 'but you’ve got such a lovely smile when you’ve got these in’ and then suddenly they want them in. It varies.”

“Sometimes they don’t want to part with the dentures or they will shut their mouth tight. We have one who doesn’t want anyone near their mouth so we have to use quite a lot of gentle persuasion sometimes.”

“Resistance from residents is the main problem. It’s difficult because they may be used to brushing their own teeth or seeing to their own dental needs and suddenly they have developed dementia and they maybe don’t understand what you want. It can be quite difficult sometimes but we just include the family and usually after a while you gain that trust and they get to know you and it does become easier.”

“It very much depends on the mood of the individual and their comprehension, their understanding of what is going on.”

Some of the care managers also commented on the fine line between fulfilling their care obligations and respecting the right of the resident to maintain their own personal standards of care.

“A lot of these people have looked after their own teeth for many many years and if they just put the toothbrush in each side once and they have always done that we are not going to be able to convince them that they should clean them more thoroughly. It’s their own personal routine and their own standard of hygiene that they have achieved during their lifetime and it’s specific to them.”

“There are quite a few people who would be lucky if they do clean their teeth every day. I have some people from time to time who will completely refuse to see the dentist. We would note that in the Care Plan that we advise them to see a dentist and that they have refused. If they are Compos Mentis then that’s their right, they can refuse. It does happen.”

A common problem in this regard was residents not wanting to take out dentures overnight.

“The relatives of one gentleman here asked that we don’t take the dentures out at night, the dentures are actually well fitted at the moment but we have told them that that is not advisable and certainly if there were any problems, if they weren’t fitting properly then they would be taken out. But then again you can’t just reach into someone’s mouth and take the dentures out. It’s mostly patients with dementia, that’s where the problem is.”

“I would say maybe 25-30% of them would refuse to take their dentures out in the evening so then we can’t even get them cleaned. They just won’t take
them out. Others are happy to take them out and then the staff can clean them then put them back in and that’s OK, but certainly there would be quite a few that would be extremely resistant to taking them out or cleaning them or doing anything with them at all. Sometimes they would go for days with dentures in day and night and not wanting to take them out and not letting the staff help.”

The only other problem regarding daily oral hygiene was a lack of staff availability reported by one of the managers. This lack of staffing means that they are forced to prioritise their care to those that need it most, possibly to the detriment of the more able residents.

“I have 27 residents and two staff, at times the residents are fairly high dependent, it would be great if we had more staff to do it! We do have to concentrate on the people that need the higher level of care.”

Aside from the lack of staffing reported by this manager, and the other request for additional oral hygiene training mentioned earlier, the managers generally felt that the arrangements for daily oral hygiene were working well for both the staff and the residents.

Check-ups

Half of the care homes reported that their residents receive regular check-ups while the remainder only seek dental care for their residents on request or when there is a problem.

The care homes were evenly divided between those that used high street dentists, and those that used salaried primary dental care dentists. Residents of homes that used the services of salaried primary dental care dentists were much more likely to receive regularly scheduled check-ups than those in homes that use high street dentists. Even when annual health checks are undertaken by the home, it was generally only followed up if a problem was identified.

 “[The salaried primary dental care dentists] usually contact us for routine care and check-ups. They contact us and tell us this is the date that we will be coming and these are the people we want to see. And that is also the time for us to check and make sure that if we forwarded the name of a new resident that they are on that list… They come out quite regularly, they were out this morning and they see maybe ten people. Because we are such a large home and because we have a lot of people moving in and people leaving or passing away so they come several times during the year.”

“If they are registered with their own dentist they would get letters saying they are due a six monthly check-up and that’s on-going. When they come in without a dentist, usually it’s just as and when they require something.”

“To be honest it was only really if they had a problem and they would mention it to us.”

“Obviously we do oral health care every day so we are aware of the teeth and the dentures so if we feel there is something like the dentures aren’t fitting properly or if they are causing ulcers or if they are rubbing then we will pencil that in straight away.”

“We tend to do general health checks once a year or so, just to check on them and make sure that everything is fitting right.”

“Most of our people are residential so we would know if something is wrong with their dentures, they would ask to see a dentist... The family member or a staff member will bring them to their own dentist if they wished.”

“There are people who maybe haven’t seen a dentist for years and if we have any concerns we would, with the family, contact a dentist.”

“We would do a Care Plan and we would also do a review when someone has been in here 6 weeks and one at 3 months then annually after that and one of the things you would look at is have you had your eyes tested, have you seen a dentist, have you seen a chiropodist. At that point you would be prompted to ask, if they haven’t seen a dentist, if they have any problems and if they have dentures.”

Many of the residents, and indeed some of the managers, believe that once a person has dentures they no longer need regular dental check-ups. In some cases, this low demand for routine dental care was put down to a generational issue, as regular check-ups have not historically been part of the healthcare regime for this cohort of residents.

“Only if they have got a problem with their teeth or their mouth do they go to the dentist. I myself go every nine months now for a check-up. I don’t know that dentists even call people for a check-up once they get to a certain age. I don’t know.”

“They are elderly and haven’t been in the habit of having regular check-ups as you or I would. I think it’s a generation thing, it’s probably why so many of them have dentures. They don’t seem to be bothered about it. If I’m honest if we offered them six monthly or annual check-ups I don’t think they would want them. I think they only want to see a dentist when they have got a problem.”

“Most of them have dentures and a lot of them think that they no longer need a dentist.”

On the whole though, the managers seemed to have a good understanding of oral health, the importance of regular dental care, and the knock on effects that poor oral health can have on other aspects of residents’ health and wellbeing.

“We are aware that oral hygiene is very important, the state of their mouth can indicate a lot of other health problems or concerns that we may have for them so we realise it’s an important part of the role here.”

“Some residents with severe dementia will always be a challenge but you have got to try because the mouth area is so important, especially when it comes to
Dentistry in care homes research – UK

Inability to access domiciliary visits for residents was one of the most commonly reported problems. Almost all of the homes that do not currently receive domiciliary visits would like to have this facility available to them. Many would like dentistry to be provided in the same way as chiropody and audiology, with at least annual visits to the home where all residents are checked with their teeth if they have still got their own teeth. So when you are working with dementia that can be a problem - them letting us know that they have pain. You have to look out for facial expressions if they have got anything sore.”

Care homes served by salaried primary dental care dentists were also more likely to receive domiciliary visits than those services by General Dental Practices. About half of the homes had a medical/treatment room or salon that was used for treatments and the remainder used the resident’s bedrooms or flats. This seemed to work fairly well for both the residents and the homes although it was acknowledged that only basic treatment and check-ups could be provided onsite. For the most part this was sufficient, particularly given the high proportion of residents who have partial or full dentures.

“We have a hairdressing room that has also got a meeting room attached to it. So the dentist will use that room or he will go into their bedroom. That works well.”

Inability to access domiciliary visits for residents was one of the most commonly reported problems. Almost all of the homes that do not currently receive domiciliary visits would like to have this facility available to them. Many would like dentistry to be provided in the same way as chiropody and audiology, with at least annual visits to the home where all residents are checked and treated arranged if necessary.

“We didn’t arrange regular check-ups because it’s difficult. A lot of them are not mobile, it’s difficult to get them to a clinic and it’s difficult to get a visit here. We did get visits here but not easily.”

“[We would like to] have a dentist that would come in and see our clients as a when needed or perhaps have a dental clinic twice a year where they came in. We have a chiropodist that comes in every six weeks to do the clients feet, it would be helpful if we had a dental surgery like that.”

“It would be brilliant if they did come to us annually and if they did have any concerns about somebody then that could be flagged up and they could get somebody seen.”

“Regular home visits once every six months or once a year even would make a huge difference. That’s what happens with chiropody and we have an optician that would come in and they keep it on record and they just come in and see the people they need to see when they need to be seen.”

“I think if we had regular visits from the dentists to the home, like we do for vision and audiology and these kinds of things. Somebody who was assigned to come for a day and check everybody.”

Domiciliary visits were seen as particularly important for residents with dementia or other cognitive impairment in order to reduce the disruption to their lives.

“It would be much easier if the dentists came to us, especially for the clients with dementia because you are not taking them out of a safe environment that is comfortable and they are familiar with. It would be easier for them, unless of course they need in-depth treatment in which case that would have to be looked at on an individual basis but for clients with dementia someone coming in to see them is definitely easier and less traumatic than them being taken out to an appointment.”

“Sometimes it’s just too traumatic for them to just pick up sticks and go to a dental surgery.”

“The patients with dementia have house calls, it’s unsettling for them, they like to stay in the home with familiar surroundings. If they needed the equipment we would need to take them down to the surgery, we have had to do that before when they have needed the tooth to be extracted.”

Some of the homes were lucky enough to be located close to a dental clinic, in which case they were able to either wheel the resident in a wheelchair, or walk them to their appointments. This arrangement seemed to work well for the care homes.

“We are actually very close to the RNI which isn’t far from us and if it’s a nice day we can wheel them along in the wheelchair which makes it easier.”

“It’s been going a long time but the access centre has moved and from what I understand the old location was a little bit difficult to access for wheelchairs etc. but it’s been here for 12-18 months. It’s all very easy now to access. Logistically in the environment this one is much easier to access, lots of parking, it’s superb. It’s all very flat. It’s worked out all round very well.”

Most of the homes expect family members to accompany residents to offsite appointments where possible, but most were able to send a carer with the resident if this was not possible. In one home, where there are not enough carers to accompany residents to appointments, the manager reported some problems with family members who do not feel they should have to do this.

“Generally we would expect family to do that but some people don’t have family close enough so then we would but we don’t generally provide staff for that sort of thing, that’s usually family, only in a real emergency would we do it. We would catch a taxi.”
“It tends to be on request, there are residents who have more capability or capacity than others they will have their regular check-ups and their family or loved ones will pop them up to the local dentist practice.”

“We have not got staff that we can release to take people to appointments so family members have got to come in and do it and some of them have been quite begrudging at having to come and take Mum to an appointment because that’s what they think we are here for. We support them on a day to day basis but this is over and above day to day living. But it can be very difficult on occasion.”

Waiting times for routine appointments were two to three weeks on average but most homes could get an emergency appointment the next day or within a few days.

“I have rung in the morning and the dentist has come out on the evening after his normal surgery. He is very good. It’s usually the next day or the day after, it depend on the severity.”

“They are fairly flexible with us and they will come out as soon as they can really. If we phone them early enough in the morning they would usually come out in the afternoon and if not we might be able to take them down to be fitted in if they are in a lot of pain.”

“The Dental Access Centre] is brilliant because if there is anyone who wakes up in pain then we call them and they can usually make an appointment within a few days or the same day, and we can go up to them – it’s literally just a half mile up the road so it’s not a problem. Or they come down to us. Usually we would go up to them, that’s the usual. It depends on the resident.”

“Everybody seems really happy with the care they receive. We had a lady admitted 8/9 weeks ago and she hadn’t seen a dentist in 2 years and I rang the dentist up and explained the situation and he came out and saw her within 2 days.”

Some of the homes found that appointments for home visits were prohibitively long. Reducing the wait for these would be of great assistance to the home.

“Where able, we take them to the clinic because that’s the quickest way because home visits have long, very long, waiting lists. We have been waiting several weeks for one at present. It’s not always easy to take them.”

While it was the minority of homes where waiting times are a problem, where there were problems, they were a significant cause of concern.

“[Emergency dentistry is] not so good, and that’s not a criticism of the dental service itself I think it’s because they just have too many people to see, it’s not exactly brilliantly funded so they are stretched…if somebody has got a toothache it isn’t always possible for someone to come out the same day so we also contact the doctors to try and manage the pain while they are waiting for the dentist to try and sort out what the problem is. Even though I think they are under a huge amount of pressure they pull out all the stops, they do everything they can to get here as quickly as possible.”

“Some of the residents are registered with their own dentist when they come in they continue that if possible. We have others who attend the RNI where they have the NHS dentists and that is difficult to access sometimes, we can have quite a long waiting list for that. Especially for home visits, we have one lady who is very elderly and frail and who had her own teeth and we have got lots of concerns and I’m constantly requesting [appointments], and I’ve been waiting for a number of weeks for someone to come and see this lady…she is on a waiting list but home visits take a long time.”

One problem reported by a couple of the homes was the length of time take to replace lost or broken dentures. The delay in some cases leads to permanent damage to the gums and results in the resident no longer being able to wear dentures at all.

“There is a big delay in the dentist being able to come out and take the moulds and send off for the new dentures by which time there could easily be damage to the gums and in one or two cases it’s been that it is no longer appropriate for the person to have a denture so everything else has had to change in terms of their diet simply because [of the lost dentures].”

Most of the care home managers did not feel there is adequate information about the availability of NHS dentists in their area. With the exception of two homes that receive great support and advice from salaried primary dental care dentistry services, the managers felt that this could be improved and would welcome more information about who is available to provide NHS dentistry, and specifically, who is willing to provide domiciliary visits to the home.

“If there are mobile dentists that are able to come in and do a visit I don’t know…I’m not really clear what OAPs get dental wise – if anything.”

“[resources], but given how they are working and the number of them and the
number of patients they have to see across the entire county I think they are extremely good”

“I think everybody is very pleased with what they have and certainly we can call this access centre up and they have been very good that we can book residents in pretty swish without any problems and they can be seen pretty quickly which is obviously very important. We are very happy with the service they are providing for us.”

“We’ve had no problems whatsoever, we’ve always had a good working relationship with him...there have been no problems; it’s always been a really good arrangement.”

“It’s very good, we have a good relationship with the dentist, he is always very professional when he comes. He is very good with the residents, considering that a lot of them do have quite advanced dementia, he can relate to the residents and understands that it is difficult some times.”

“They are getting a good standard of care from here, we do our best.”

“I only ever had positive feedback from the service that the residents have had.”

Of the managers who rated the care as poor, in one instance they felt that the demand was being met but the demand was low. In the other two cases, the main problems were in accessing domiciliary dentistry. Fortunately in both case the homes had recently been approached by salaried primary dental care dental services that were going to provide regular domiciliary visits.

Salaried primary dental care services survey

The majority of the Salaried Primary Dental Care services that responded to the survey provide domiciliary visits, providing an average of 66 hours per month (ranging from three to 240 hours). Just two of the services that responded provide mobile clinics, one providing five hours per month and the other 75. While many services do not measure or know the number of hours of care they provide at their clinics, those that do provide an average of 33 hours per month.

It was a minority of services that provide a full range of treatment at domiciliary visits. The services provided by the remainder varied widely, with most services providing examinations, and dentures/prosthetic work. Around half also provide simple fillings, dressings and simple extractions but most were limited by the lack of portable equipment, and in particular by lack of portable x-ray facilities.

“Limited to minimally invasive treatments due to lack of x-ray facilities and limitations of emergency backup. So we would do all denture work, exams, emergency visits, writing prescriptions, temporary dressings and simple permanent restorations, hand scaling.”

In the majority of cases, the care home would take responsibility for scheduling appointments with the service (64 per cent), in the others, the service would either contact the home to let them know that a resident is due for a check-up or make regularly scheduled visits to the home(s). Some homes reported that they do a mixture of the above. Within the Sheffield ROCS scheme and in other areas, care homes receive regular visits from GDPs, with the SPDCS receiving referrals where necessary. A number of the services reported problems keeping up or offering routine examinations due to staffing and funding pressures.

“Check-up dates can slip when the service is under pressure.”

“Patients who attend the clinic rather than receive domiciliary care will be on a regular recall programme. We do not have a system in place to offer routine checks on domiciliary patients due to pressure of numbers on the domiciliary service.”

“Although at present we do not have capacity to offer routine examinations.”

Problems were also reported with the system for booking appointments in one service. The process there is so long-winded that it can take months before the appointment is actually booked.

“We have to adhere to the process whereby the home/patient requests a visit. This request is screened by an independent dentist and if approved, passed back to us to proceed with the PR forms and other paperwork before an appointment is offered. This may take up to a month. The appointment may not be for another 6 weeks depending on the current workload.”

The majority of these services provide emergency (or urgent) dental care for care home residents. Most (92 per cent) provide this facility at either the clinic or the care home as necessary. Emergency appointments at the clinic were usually available within three days (92 per cent). Over a quarter provide these on the same day (28 per cent), and a third the next day (36 per cent).

As reported in the interviews with care home managers, domiciliary emergency appointments did have longer average waiting times, with a quarter reporting waits of six days or more (26 per cent). This was not the case in all services though; thirteen per cent did report next day domiciliary appointments and 35 per cent within 1-3 days.

“They have to really try hard to get an emergency visit in the home; most would be directed to attend a clinic.”

“Not always possible to provide same day domiciliary care.”

“We still have to adhere to the [long-winded referrals procedure]. This means that there are delays for emergency treatment.”

Contracting arrangements varied but PDS, and PDS+ agreements were the most common. In many cases, the services for care homes were provided under broader domiciliary and/or special care dentistry contracts. A number of the services had no contracted requirements and provided the services under informal arrangements.

“Not contracted, or formal SLA. Health Board wide protocols and policies only, no formal commissioning.”
“No formal contract exists.”

“Sessional fees for domiciliary. Normal PDS/CDS for clinic appointments.”

“This would be covered as part of the domiciliary and special care elements of our PDS contract and SLA remit.”

“We have a PDS contract for CDS which includes a domiciliary component. The contract is not broken down into specific aspects of care.”

Patient contacts were the most commonly reported performance monitoring used, closely followed by UDAs. Four of the services were monitored on waiting times and referral to treatment time targets, and two were monitored on Case Mix data. Four of the services reported that they have not had their performance monitored at all in recent times.

Care Home residents pay NHS charges where appropriate in most services (92 per cent). This was a source of frustration for some services because of difficulties finding out which patients are exempt and in collecting payments from those who are not.

“Often difficult to ascertain whether or not exempt - no-one willing to pay and thus client can’t be seen as patient charge will be deducted from our budget.”

“Often difficult to establish exemption and collect payments.”

“Time consuming and difficult to collect.”

“Many carers do not know if patients are exempt from charges and many assume that because residents are pensioners, they are automatically exempt. The above two concerns make the administration for care and nursing home residents time consuming and expensive. Once residents find out that they are required to pay, many change their minds and even if there is a treatment need, they will decline treatment. Often citing reasons such as “I won’t be here much longer, no point in spending a lot of money on my teeth”.

“Dental charges are also a problem, it takes large amounts of time both at the care homes and in clinic to ascertain if the patient is exempt or not and if not who has access to their money to pay the charges.”

The Clinical Directors did not have particularly positive views of how well the oral health needs of care home residents in their area are being met. Not a single respondent felt the needs were being met very well. A third (35 per cent) felt they were fairly well met, but the majority thought they were either very poorly (19 per cent), or fairly poorly met (35 per cent).

Figure 1 How well do you think the oral health needs of care home residents in your area are being met at present?

Problems were reported with demand for services outstripping the funding allocated, and, in one area, vacancy controls meant that there were insufficient staff to provide the service and spend the allocated budget.

“Within our limited resources [50% of national average per 10K population, and only 33% of London average] we spread our budget (i.e. staff time) according to need. We basically provide three days per week of domiciliary salaried primary dental care dentistry, -- one day per week per 115K local population.”

“The level of DVs the commissioners want is far more than the service can provide with resources available.”

“There is a GDP who also has a small contract for domiciliary visits. In one of our areas however this has been withdrawn with no consultation leaving us with a greater workload.”

“Demand exceeds capacity and have to balance amount of time dentists spend in and out or clinic.”

“The number of domiciliary visits we are contracted for is small and at present we do not proactively seek to provide dental services to care homes. At present it is a more reactive than proactive approach. We are currently undertaking the BASCD survey in care homes and hope that this data will support our view that this is a big area of unmet need within the salaried primary dental care. We have also been contacted on occasions by the commissioners to provide domiciliary care if it is not available locally in general practice.”

“We have a vacancy freeze at the moment which results in our budget being underspent because of the reduction in staff numbers.”
When asked what changes they would like to see to the way dental services for care home residents are contracted or provided, the Clinical Directors wanted to see formal contracting arrangements to ensure sufficient provision of services.

“Specific contractual arrangements would be helpful in identifying our responsibilities but this would require needs assessments and some planning which does not happen in this area.”

“Contracted care for individual nursing homes to provide emergency and routine care, annual check-ups and OHP services.”

“Would be good to have contract which specified that care home residents are offered to have routine examinations and care.”

“Would like to see screening and treatment (domiciliary and clinic) specifically commissioned, also dental health education for staff commissioned.”

“Dental commissioning needs to be considerably more robust. Alternatives to the PDS+ contract should be developed by the Department of Health as a matter of urgency, to protect services for vulnerable patients, including those in care homes.”

“Probably better commissioned with a defined and explicit set of resources (i.e. dentists and dental nurses, etc.) and how many sessions per week or month will be provided rather than an ad hoc add-on to the contract.”

“We would like to see commissioners engage in developing the services for care home residents. PDS+ is an entirely unsuitable contract for this service. The service we provide has been developed with minimal input or interest from commissioners.”

“More commissioning of services specifically aimed at domiciliary care for care home residents. Those able to travel are in a more fortunate position although access to dental care from experienced/ specifically trained dentists in care of the elderly is often not available.”

Many felt that services are not well coordinated across their authority, and that formalised arrangements for salaried primary dental care services to provide a defined level of care for all care home residents would improve services.

“CDS provision is not comprehensive throughout the PCT and so care homes may receive varying levels of service.”

“Co-ordinated programme to provide consistent care.”

“Extension of the ROCs arrangement to involve 100% of care homes for the elderly in the city- current coverage is about 70%.”

Of course, any additional responsibilities defined in such contracts would need to be sufficiently funded in order to improve services.

“More dedicated time and funding is required to adequately tackle a large, hidden problem.”

“Increased funding for all aspects of treating care home residents. PCT needs to enlarge the numbers of dentists involved especially now that CQC is causing homes to try to get domiciliary visits for all residents.”

“We really only see the tip of the iceberg, as we respond to symptomatic patients. In order to provide a full preventive service, there would need to be far more investment in services.”

“Once the level of need has been established this would give us a good case for seeking additional ring-fenced funding for this growing group of patients. A proactive approach could then be established with the possibility of an ‘Elderly’ specialist post being developed.”

While many felt improvements could be gained through better domiciliary care, improvements to transport arrangements were also suggested, in order to make the most of facilities available at the dental clinics.

“Transport arrangements to allow residents to be brought into clinic.”

“I also believe that the best standard of treatment can be provided at clinics, so investment in transport mechanisms to support care homes would be useful.”

At least one of the Clinical Directors did not agree that domiciliary visits should be provided to care home residents as a matter of course.

“Care home managers continually complain about a lack of dentists willing to visit their residents. However, many of these residents can travel and do go out regularly. There seems to be a culture of asking for domiciliary care from all health care professionals for all care home residents.”

Education and training of care home staff were also seen as vital to improving the oral health of residents. Recent improvements were reported in Scotland as a result of Health improvement programmes.

“The care homes need to provide hands on oral hygiene measures if the oral health of residents is to improve overall.”

“Health Improvement programmes by Public Health have included training for care home staff in oral assessments for new residents, training in basic oral hygiene by staff and reinforcement of responsibilities care homes have to their residents, including that of transporting them to a dental clinic for care if required.”

“We also are commissioned to provide a comprehensive oral health training/education to all staff working in care homes in our area - this has been very well received.”
References


Laing and Buisson. (2010). *Care of elderly people UK market survey 2010-2011.*


National Care Forum. (2008). *NCF Annual Survey of Staffing*


Welsh Oral Health Information Unit. (2008). *Nursing and residential care home oral health policy and access to dental care survey.* Cardiff University School of Dentistry.
