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Oral health in residential aged care: Perceptions of nurses and management staff

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Abstract

Aim: This study aimed to explore the perceptions of residential aged care nursing and management staff regarding oral care, to develop strategies to improve the oral health of aged care residents.

Design: A qualitative approach was used.

Methods: Two focus groups were conducted with nursing and management staff at two residential aged care facilities and transcripts were thematically analysed.

Results: All staff had an awareness of the importance of oral health; however, they highlighted the significant challenges in the current system that affect implementation of oral health training and practice guidelines in the residential aged care facility. High staff turnover, time constraints, difficulties in accessing dental services and working together with residents, their families and external staff were barriers to providing oral health care. Staff highlighted the need for formalized clinical guidelines and processes and efficient dental referral pathways to create a more cohesive system of care.

KEYWORDS

aged, aging, gerontologic care, gerontologic nursing, oral health, qualitative studies

1 | INTRODUCTION

Globally, oral health remains a significant issue among the ageing population (Petersen, Kandelman, Arpin, & Ogawa, 2010). Nursing staff receive oral health education and training as they are often the primary oral care providers in residential aged care (Lewis, Edwards, Whiting, & Donnelly, 2017). However, evidence suggests that oral care provision in Australian residential aged care is still insufficient (Webb, Whittle, & Schwarz, 2016). Researchers have proposed that simple interventions involving the provision of financial resources and training are not sufficient to change oral care provision in residential aged care facilities (RACFs). Rather, there is the need to

consider changes in organizational culture, philosophical values and communication patterns in these facilities (Thorne, Kazanjian, & MacEntee, 2001). Regrettably, recent evidence lacks this broad view and tends to target nursing staff, rather than contextualizing the needs of nursing staff with the perspectives of the management staff in residential aged care facilities.

2 | BACKGROUND

The current rate of ageing worldwide has been described as 'unprecedented', with reports that the global ageing population has tripled

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over the past 50 years and is expected to triple again over the next 50 years (United Nations, 2013). With this rate of ageing, the burden of chronic noncommunicable diseases including cardiovascular disease, cancer and musculoskeletal diseases has been increasing (Prince et al., 2015; World Health Organisation, 2011). Often overlooked among these diseases is oral disease, which remains a significant problem worldwide (Petersen et al., 2010). Older individuals, particularly those in residential aged care facilities, experience the poorest oral health in Australia, with 21.8% of people aged over 65 years having untreated dental decay, 53.4% with periodontal disease (gum disease) and 19.1% having complete tooth loss (Chrisopoulos, Harford, & Ellershaw, 2016). International evidence has also highlighted poor oral health among older individuals in RACFs, with studies reporting almost two-thirds to three quarters of residents having dental decay and around a third of residents having signs of periodontal disease (Karki, Monaghan, & Morgan, 2015; Matthews et al., 2012). This high prevalence of poor oral health is concerning due its associated links with coronary heart disease (Bahekar, Singh, Saha, Molnar, & Arora, 2007), cognitive decline (Ide et al., 2016), malnutrition (Walls, Steele, Sheiham, Marcenés, & Moynihan, 2000) diabetes and respiratory conditions such as aspiration pneumonia (Galgut, 2010). Furthermore, oral health plays a significant role in the quality of life, appearance, self-esteem and confidence of older people (Bissett & Preshaw, 2011; Chalmers, 2003; Lewis, Wallace, Deutsch, & King, 2015; Unfer, Braun, de Oliveira Ferreira, Ruat, & Batista, 2012).

Nursing staff have played a key role in ensuring good oral health among older individuals who are unable to care for themselves, including those in RACFs. Being the front-line health professionals, they can assist residents with maintaining oral hygiene and assess their oral health. As such, they are in an ideal position to be advocates for residents' oral health (Wardh, Andersson, & Sorensen, 1997). Although nursing staff acknowledge the importance of promoting oral health for residents, national and international research has highlighted inadequacy in oral health education and training for nurses and nursing aides to enable them to do this (Paley, Slack-Smith, & O'Grady, 2004; Webb, Whittle, & Schwarz, 2013). In response to this, the Australian Government endorsed a national evidence-based oral health model called 'Better Oral Health in Residential Care' (Lewis et al., 2015). The programme promoted a multidisciplinary approach to promoting oral health, with the responsibility shared by doctors, nurses, care workers and dental professionals. Most RACF providers in Australia (89%) participated in the train-the-trainer programme which involved training 4,885 nurses to become trainers and champions of oral health in their workplace. Despite this, recent evidence suggests that oral health care in RACFs still remains inadequate. Less than half (48%) of residents in NSW RACFs had a dental assessment on admission and 74.2% of facilities did not have regular visits by dentists (Webb et al., 2016). Further, there are suggestions that the 'Better Oral Health in Residential Care training' may not be working due to time constraints, staffing issues and workload among nurses in RACF (Hoang, Barnett, Maine, & Crocombe, 2018).

A potential reason for this lack of change in practice is the complexity of providing oral health care in RACFs, which involves more than

the provision of on-site dental services, oral health assessments and resources (Thorne et al., 2001). One study highlights that more attention needs to be paid to the organizational culture and values of the RACF and the level of communication in the organization to effect a change in oral healthcare practice (Thorne et al., 2001). Although research has explored the interplay of contextual issues affecting the provision of oral care in RACFs from a nursing and care staff perspective (De Visschere et al., 2015; Forsell et al., 2011; Gibney, Wright, Sharma, & Naganathan, 2015; Paryag, Rafeek, & Lewis, 2016; Villarosa et al., 2018), few studies specifically explore this from the perspective of management staff at the organizational level and contrast this with the perspectives of nursing staff at the front line (Lindqvist, Seleskog, Wårdh, & von Bültzingslöwen, 2013). Exploring both of these perspectives can provide a better understanding of potential barriers and facilitators to the implementation of oral health programmes in RACFs. Furthermore, even less evidence is available in an Australian setting. Only one study has explored the perspectives of RACF nursing and management staff regarding oral care (Paley et al., 2004); however, this was prior to implementation of the 'Better Oral Health in Residential Care' programme in 2015.

Therefore, the overall aim of this project was to evaluate the perceptions of both nursing and management staff in RACFs regarding oral health care. The specific objectives of this study included: explore their current awareness and practices in relation to oral health, identify barriers to managing residents' oral health and discuss potential strategies to improve oral health care in residential aged care facilities. This study stems from a larger study exploring the needs of care staff as well as management and nursing staff to develop strategies to improve the oral health outcomes of people living in RACFs. Getting different perspectives was important because in Australian RACFs, day-to-day oral care is normally provided by care staff (non-registered nurses who have completed vocational training in nursing or aged care) under the direction of nursing staff. The findings investigating the perceptions of care staff in relation to oral health in RACF have been published elsewhere (Villarosa et al., 2018).

3 | METHODS

3.1 | Design

The project used a qualitative design to allow for open-ended discussion and a deeper insight into the perceptions of nursing and management staff in regards to improving the oral health outcomes of residents in the RACF (Creswell, 2009). Focus groups were used to allow the research team to take peripheral roles while discussion took place between participants, permitting for more spontaneous and sincere discussion of the study aims (Nyumba, Wilson, Derrick, & Mukherjee, 2018).

3.2 | Method

Participants were purposively sampled from two community-owned, not-for-profit RACF sites in the Southern Highlands region of NSW, both operated by the same organization. These facilities

provided services for residents with a range of care needs, including independent living units and residential (hostel) care for residents with higher levels of independence, nursing homes for dependent residents, as well as dementia-specific care. As all older Australians can be eligible for subsidies to RACF fees depending on their income, the study sites provided care for residents from diverse socioeconomic backgrounds. All nursing and management staff were invited to participate through flyers that were distributed across both RACFs. Two focus groups were conducted; one focus group for management staff including a Nurse Unit Manager (NUM), Director of Nursing (DON) and the CEO of the RACF group and the other focus group for nursing staff. As nursing and management staff were recruited from more than one site, transferability or potential generalizability of the findings was increased (Cope, 2014; Kuper, Lingard, & Levinson, 2008). The focus groups were scheduled at a time and place convenient to all participants (in-service) and included representation from both facilities. As both RACF sites were operated by the same organization and had similar protocols in place it was deemed that both focus groups would be comparable. Further, both focus groups were conducted separately as we wanted the nursing staff to be comfortable expressing any concerns regarding oral health particularly if it was relevant to management. It would also help in teasing out any differences in opinions between the two groups.

The focus group sessions, consisting of only investigators and participants, commenced with an overview of the study and its purpose through participant information sheets, describing the aims of the research, requirements of participation and information regarding the study investigators. Written consent was obtained from all participants, following which demographic data were collected, including age, years of experience in residential aged care and highest academic qualification. Due to the diversity in expertise among the investigators, focus groups were facilitated by three investigators (AG, ARV, SC) who each contributed unique skills and insight into oral health care and qualitative research methods. Two of these investigators (AG, ARV) were experienced in interdisciplinary oral health research, from which their professional interest in this study arose and the other investigator (SC) had both a professional and personal interest in the health of aged care residents. Due to the small number of employees at the RACF sites, measures were taken to ensure sufficient interaction and richness of data in the focus groups and included strategies such as prompting, monitoring the group and ensuring all participants had voiced their opinions, repeating questions and clarifying responses with participants. There was only one pre-existing relationship between investigators and participants, being with the DON. Focus groups were approximately one hour in duration. Focus areas used to guide the focus groups can be found in Appendices A and B.

3.3 | Analysis

The focus group audio files were professionally transcribed for analysis. These audio recordings of the focus groups ensured dependability and confirmability of the findings (Cope, 2014). To

preserve their anonymity, participants were assigned pseudonyms with prefixes M_ and N_ for management and nursing staff, respectively. A thematic analysis was undertaken of the de-identified transcribed text, and data were sorted into themes and subthemes using NVivo 11 (QSR International Pty Ltd, 2012) (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013). Transcripts from both focus groups were initially analysed by two investigators separately and findings were discussed with a third investigator until a consensus was reached. This process enhanced the credibility of the findings through independent and peer coding/checking process (Anderson, 2010; Shenton, 2004). The final list of themes and subthemes were determined as listed in Table 1. Triangulating the findings from a separate focus group with the RACF care staff, results of which are presented elsewhere (Villarosa et al., 2018), also provided another perspective on the findings.

3.4 | Ethics

The research protocol and ethics approval to conduct this study were granted by South Western Sydney Local Health District Research Ethics committee (HE16/200).

4 | RESULTS

4.1 | Demographics

As focus groups were conducted in service at the RACF sites, all eligible staff present at either of the two RACF sites on the day of data collection participated in the focus groups, with a total of five management staff and seven nurses participating. Just over three-quarters (80%) of management staff and 71% of nursing staff were female. Among the nursing staff, their age ranged from 20–62 with the number of years of experience ranging from 1–40. The age range among the management staff was generally higher, between 41–64 years and they had between 5–21 years of experience in the aged care sector. The highest qualification achieved ranged from certificate-level to a doctorate degree, with less than 14.3% of nursing staff having educational qualifications higher than bachelor level, in comparison to 40% of management staff. Thematic analysis resulted

TABLE 1 Main themes and subthemes from focus groups

Main themes	Subthemes
The current system: Fragmented oral health care	Conflicting attitudes and varying awareness Unstructured oral care provision Inconsistent training of RACF staff
Barriers to providing oral health care	Staff turnover Access and cost Barriers to implementation
Priorities of nursing and management staff	Strategies to improve delivery and uptake of oral health training A cohesive oral care system

in three main themes namely: The current system: fragmented oral health care, barriers to providing oral health care and priorities of nursing and management staff.

4.2 | The current system: Fragmented oral health care

4.2.1 | Conflicting attitudes and varying awareness

Most management and nursing staff agreed on the importance of oral health care for aged care residents. When asked why oral health care was important for this population, management staff discussed that aged care residents were at increased risk to poor oral health, because: *'their teeth are the oldest'*, *'they probably had the least amount of dental care when they were younger'* and *'they have limited access to dental care'* (M_1). When the nursing staff were posed the same question, one nurse discussed the importance of oral health for the residents' loved ones, recounting their own experiences of poor oral health with their older relatives as being *'horrifying'* and *'something that stays with ... the loved one for the rest of their lives'* (N_1). However, despite acknowledging the importance of oral health, both nursing and management staff highlighted that they did not always prioritize efforts to promote oral care, with one management staff reflecting that in the RACF *'it's an area that is definitely lacking... it's something that we don't promote a lot'* (M_3).

Some management staff also discussed poor attitudes among individuals external to the RACF that were involved in the oral care of residents, such as dental care providers and families. They perceived these individuals had an ageist view that treatment was less worthwhile for older people, with families often reasoning, *'look, they're really old ... what's it going to achieve by having a dentist come and look at them'* (M_2) and claimed that dentists would state, *'they're old, what do you want us to do about that'* (M_3).

Both nursing and management staff discussed the negative impacts of poor oral health among aged care residents, including *'the enjoyment of eating is lessened'* (M_2), *'their nutritional status is challenged'* (M_2), *'pain for some'* (N_2), *'infection markers'* (M_1) and association with *'chronic diseases'* (M_1). In addition, one nurse highlighted that oral health can cause residents to *'end up in hospital'* (N_2). Further, some nurses and management staff highlighted the impact of oral health problems on residents' quality of life and social interactions:

... I wouldn't want my parents in a nursing home with a horrible yucky taste in the mouth and teeth falling out and bad breath. It's a comfort thing as well.

(N_7)

Despite this general knowledge, the awareness between these groups regarding poor oral health among the residents they cared for varied. When nurses were asked regarding the prevalence of poor oral health among their residents they concluded *'it would have to be half*

(N_1). On the other hand, management estimated a much lower prevalence of *'I'd say two'* (M_2) out of ten. When asked about the types of oral health problems seen among their residents, nursing staff recounted issues related to *'dentures not properly fitting'* (N_4) and *'poor oral hygiene'* (N_1). Although management echoed concerns regarding *'ill-fitting dentures'* (M_3), the other oral health problems they recounted were different to what nurses recalled, including *'broken teeth'* (M_3) and *'gingivitis'* (M_2).

4.2.2 | Unstructured oral care provision

Regarding the provision of oral care at the RACF sites, management commented that *'there's not a set process'* (M_3). The care provided was *'very individualised, depending on the resident'* (M_3), as for *'residents who can still clean their own teeth, it's left up to them'* (N_2) but for *'residents who can't clean their own teeth, that's up to the carers then to help them clean them, the same with the dentures'* (N_2). Care was also reported to depend on the RACF staff providing it as *'we've modified it to suit ourselves'* (M_3). Most management and nursing staff reported completing a structured oral health assessment for residents on admission to the RACF that was *'something that comes with our programme'* (M_3). This was considered the responsibility of *'a registered nurse'* (N_5) and entailed a visual assessment looking at *'The state of their teeth, fillings'* (N_2) and *'their gums, their tongue'* (N_1). Although some management staff reported the oral health assessment was *'very general'* (M_3), one nurse indicated some difficulty in answering the assessment questions: *'the questions are straightforward, but in my case ... I have basic knowledge ... I don't have that much in the detail of what's going on'* (N_4). Although nursing staff indicated that this assessment *'should be annually'* (N_6), management staff reported *'often that assessment is used simply to assess their mouth on arrival. So how often does it go any further than that, remains as to whether it actually is raised as an issue'* (M_2). Both groups highlighted that certain groups of residents required more frequent oral health monitoring, *'Especially if they're, say early stage dementia, we do need to check... maybe once a week'* (M_4). Both groups agreed that the *'RN's role is really to supervise the work of the care staff'* including oral care and some nurses reported doing this when *'we give tablets, or we talk to a resident'* (N_7). However, other nurses indicated that they did not do this *'unless they complain of pain or you suspect there's a problem'* (N_2). The result of this was that *'it's not always known that they're having problems'* (N_2) and management commented that oral pain may go unreported as residents *'take their dentures out so that the pain goes away'* (M_3) or *'they just accept it [oral pain]'* (M_3).

On identification of dental issues among residents, it was reported that referral to dental services *'happens in various informal ways'* (M_3). For independent or dependent residents with no family, some staff would *'contact one of the local dentists'* (N_1); however, it was reported that *'he doesn't readily come for all of our residents'* (M_2). Management discussed that *'it's a big consideration to send somebody out to dental services'* (M_3). This likely stemmed from a negative experience with the public dental services which

was recalled by both groups, 'our resident went to the Dental Service. He left at 9:00 in the morning and got back past 11:30 at night' (N_6) because 'the non-emergency transport cancelled, he's diabetic, he was there without food, without insulin' (M_3). For dependent residents with family to provide support, there was usually 'discussion with the family about their preferences for treatment' (M_1) because 'that's generally a cost for the family to wear' (M_2). Some sites had access to dental technicians who were willing to treat residents on-site, with one nurse stating 'In our case, at [site name], if it's dentures, we contact [dental technician]' (N_1). Dental emergencies followed a different process with one management staff reporting 'If there's a dental emergency and generally that is pain, so we would call the GP to manage the pain' (M_2). Because of this unstructured oral care system, management reported that there may be confusion among RACF staff regarding what should be done if oral problems are identified, stating, 'they don't know what to do about it, so they'll come to us to ask us, what can we do about this?' (M_2).

4.2.3 | Inconsistent training of RACF staff

Both management and nursing staff highlighted the necessity of oral care training in their facility, especially for new staff, as often 'it's their first contact with looking after somebody, cleaning their mouth' (N_1). They agreed that although new care staff 'get on the job training' (M_1) when 'buddied with another care staff on the floor' (N_1), the training they received 'depends who they're buddied with' (N_1). The facility lacked formalized training programmes for staff, with management commenting 'we really don't have a training programme in oral health as such' (M_5); however, they did provide education, stating, 'most of our education is provided by the nurse educators' (M_2). The education provided did use content from the 'Better Oral Health in Residential Care' but 'because of time constraints, we just train a little chunk of it at a time. If different people come to the different chunks, then they miss key aspects of it.' (M_2). Further, there was no way to determine which staff were attending training, as: 'at the moment, our performance appraisal doesn't review the number of training programmes that someone has been to' (M_2). One nurse discussed the recent implementation of small training sessions for nursing staff; however, not all staff were receiving this training: '...we've been running toolbox sessions for the last few weeks. Not everybody's on the same page, but just spreading the word...' (N_1).

4.3 | Barriers to providing oral health care

Both groups discussed at length the challenges that have an impact on the provision of oral care and training at the RACF. The issues highlighted included staff turnover, a lack of access and cost of dental services and several barriers to implementation of oral health care in RACFs.

4.3.1 | Staff turnover

Some management staff highlighted that nursing staff turnover made ensuring consistency of care challenging, both in terms of oral

health and general health, stating: 'there are always new people learning. The older ones have gone off to do something else, so it's a continual teaching as [nurse] would know...you're just constantly teaching people' (N_2) so that it becomes 'a barrier with consistency to most things; it's not just in oral health, but for the whole general care of the residents' (M_3). In addition, staff turnover significantly affected the training provided to RACF staff, preventing information transfer among staff. For example, the nurse educator who attended the 'Better oral health in residential aged care' training no longer worked at the RACF:

... we had a nurse educator here on site who is now no longer with the organisation. So that, again, is another problem, is that people who move from their roles. Because I'm sure that [the educator] would have gone to that training.

(M_2)

4.3.2 | Access and cost

Management staff reported poor access to oral health services and attributed this to the absence of a formal referral process and pathway. Since referral pathways were primarily informal, residents were often not referred to an oral health service:

I think it's something that we don't promote a lot. Probably because we don't know a lot about - you know, you talk about your referral pathways and that happens in various informal ways, but we certainly don't have a formal, okay, now we follow this process.

(M_3)

Transport to dental services was cited as a challenge for less mobile residents. For these residents, staff reported booking patient transport services to take residents to and from dental services, although this was unreliable for residents:

How do we get them there? So if we call the ambulance, they don't deliver to you guys, they'll only take someone to the closest emergency department. If we call a non-emergency transport, then they could pick them up at eight o'clock that night, so that doesn't work either.

(M_2)

... our resident went to the Sydney Dental Hospital. He left at 9:00 in the morning and got back past 11:30 at night. The daughter said never again....

(N_2)

Management further emphasized that cost of obtaining dental treatment was a major barrier to the families of residents:

Mostly the barriers from the family members are costs... If the family are asked to pay for it, oh, do we really need that, does dad really need new teeth, is he - can't you just give him some soft food?

(M_2)

You do get relatives who don't actually comply at all. They'll say they will or they'll just listen, but they never actually get back to you. So it's like they're not really interested...

(N_3)

4.3.3 | Barriers to implementation

Nursing staff also identified several barriers that were preventing implementation of oral health guidelines into practice, such as staff time constraints. One nurse stated: *'one of the biggest barriers is the resident themselves, staff and timing. Staff, carers are often really rushed and there's not a lot of them. So for them it's run, run, run. Teeth take a long time, it's not a good job'* (N_3).

In addition, staff identified issues with residents' compliance with care, including aggression, cognitive decline and personal dignity, as barriers to the implementation of oral health guidelines into practice. Some nurses explained that some residents resisted oral care with aggressive behaviours such as biting, especially cognitively impaired residents with dementia. One nurse described that performing oral hygiene on residents with a cognitive impairment can be as follows: *'Very difficult, almost impossible for some...'* (N_3). Both nursing and management staff identified residents' embarrassment regarding their oral health and maintaining dignity among residents who were becoming less autonomous as major reasons for non-compliance with oral care:

Especially older people, they don't want you looking in their mouth... They're embarrassed about it often too, so they won't really open their mouth very wide.

(N_3)

It's almost harder, because it's that fine line between dignity and them saying, I can brush my teeth.

(M_1)

...that choice to say no, I'm going to brush my own teeth and not have it done properly, as opposed to a staff member doing it for them and taking away that right.

(M_4)

Finally, nursing and management staff highlighted that the family members of residents were key in the implementation of oral health guidelines to practice, as they were often required to consent and arrange for dental care for the residents. Both groups agreed that families having a limited awareness and understanding of the importance of oral health were a significant challenge to obtaining dental treatment, as it significantly affected their willingness to organize and pay for dental treatment:

... if the family can't take them ... they'll say can you get someone to go with them. But then some of them aren't happy with the cost of the actual escort.

(N_3)

This lack of family engagement resulted in nursing staff having to organize and coordinate dental treatment options, with their only option often being to consult a GP:

They'll [the resident's relatives] ... never actually get back to you... and it's like well what do we do now? We can't get anything done for this person unless we just take control and just do our own thing here. Usually that runs through the GP then...

(N_3)

4.4 | Priorities of nursing and management staff

Both nursing and management staff discussed their priorities to improve the current system of care to better address residents' oral health needs. They highlighted the need to improve the delivery and uptake of oral health training among nursing and care staff and for a cohesive oral care system to be implemented in the facility.

4.4.1 | Improving delivery and uptake of oral health training

Management and nursing staff discussed their desire to improve the delivery of oral health care training in the RACF setting. Although the training that was delivered to staff was part of the Better Oral Health in Residential Care package, most staff members agreed that there was a need to make the training mandatory and formally monitor training attendance to increase uptake. Nursing staff suggested the inclusion of CPD points as an incentive for RNs to attend training; however, management staff also identified the need for additional incentives for care staff to attend training such as including: *'in-service education as part of someone's performance appraisal - [since] a lot of people, they want the promotions, they want to go up to the next grade'* (M_2). Another suggestion included the use of oral health champions where *'...we could develop ... oral health champions who could then go around and train the trainer...'* (M_2); however, they also recognized that this model had limitations in the existing RACF framework: *'when they go and they do the training, they get the knowledge themselves...they go back to do their job and then they realise, someone is buzzing, someone is on the toilet, someone needs help, someone else needs - I don't have time to do this'* (M_2).

Management staff expressed preference for nurses to receive face-to-face, practical training in the onsite dental therapy room. In contrast, nurses discussed the importance of having a combination of training methods to ensure it is accessible to all nursing staff:

I'm a great believer in face-to-face training.... Online training is great while you're reading it, while you're looking at it. But ... right there on the spot training really has the greater impact.

(M_2)

'Yes, a combination would probably be ideal. Everybody has different learning styles. A face-to-face issue—section would be good, but then not everybody can attend that. So later down the track it fades, but at least then if it is online you can go and refresh' (N_2).

4.4.2 | A cohesive oral care system

Both nursing and management staff highlighted the need for a set process informed by formal oral healthcare policies and practice guidelines in RACFs to better enforce staff roles and dental outreach. This would help create a more cohesive system of care by ensuring consistency of care in the facility and seamlessly linking their care with external dental services. One management staff stated: *'we could really benefit from [formal guidelines], because we don't have that at all for our residents'* (M_3). This included more structured, routine assessments and pathways, including *'having a clear pathway to say, what are the indicators? At what point – so if we had, is there pain?...Is there swelling?...Then if we had contact with the local community dental health providers as an emergency option'* (M_2). Nursing staff specifically emphasized the need for practice guidelines to be interdisciplinary and extend across all levels of RACF staff, from the organizational level through to the front line, with one nurse explaining:

...if there was a way of going through the steps, each of us at our different levels. As [Leah] said, the RNs supervising the care staff, the care staff being accountable, it goes down the chain, that the resident gets all the care and specifically oral care...

(N_3)

They discussed the importance of enforcing staff roles by first monitoring and supervising oral care at the management level, which would have a 'trickle down' effect to other levels of staff, with one nurse stating, *'Probably if it starts at the top it usually works better down the line'* (N_4) and another echoing, *'...if we had an awareness, if we're starting in this program and we are all aware - again it does filter from the top and come through...'* (N_3).

All management staff also discussed the potential for outreach services at the RACF involving an onsite dental chair for onsite dental hygiene services, stating that *'but whilst we'd like to have it as a full-blown dental practice, it's really probably dental hygiene that we're*

talking about' (M_5). They suggested that this model would be *'user pays'* (M_5) through the resident or their family. However, this would improve residents' access to dental services by eliminating the need for transport offsite:

...if there was a dental practitioner, a service that was able to come to the facility, ...we could run a clinic on a regular basis, [and] facilitate better oral health for the residents.

(M_2)

Participants also suggested the involvement of an alternative dental workforce to service the onsite facility including a *'dental hygienist... probably a couple of days a week, to come and see our residents'* (M_5). They also proposed involving *'dental students coming here and doing oral assessments and doing - even if they're dental hygienists in training, whatever it is, that would be a great advantage'* (M_2). However, management staff agreed that having dental students would require supervision, which meant that supervisors would also need to be provided.

5 | DISCUSSION

This study aimed to explore the perceptions of nursing and management staff in RACFs regarding oral health care and was part of a larger study that also investigated the perceptions of care staff. There is limited evidence both in Australia and internationally in this particular area of aged care. As such, this study, along with our previous findings (Villarosa et al., 2018), has the potential to address this gap by providing a unique, rich insight into key contemporary challenges to the provision of oral health care to aged care residents and identify potential strategies to overcome these challenges, from all levels of the RACF workforce.

In the current study, all nursing and management staff were aware of the importance of oral health and understood the relationship between oral health and general health. Yet despite the awareness of its importance, staff agreed that oral health was not always given priority in the care of their residents and this incongruity is a trend seen internationally (Lindqvist et al., 2013; Miegel & Wachtel, 2009; Paley et al., 2004). A potential contributor to this disconnect is that management staff estimated a lower prevalence of oral health problems than the nursing staff, indicating that those who should be promoting oral health care may be underestimating the oral care needs of residents. Other studies in Australia have also found inaccuracies in managers' reports of the oral health status of their residents (Webb et al., 2016). This emphasize the need to ensure management staff are kept aware of the oral health status of residents in the RACFs.

Management staff identified that ageist attitudes, particularly among dentists and families, affected the dental care of residents. Studies in Canada corroborate this, identifying that few dental practitioners had ever treated residents in long-term care and this was attributed to perceptions that providing treatment to elderly

people was financially and professionally unrewarding, interfered with their practice and limited options for treatment (Chowdhry, Aleksejuniene, Wyatt, & Bryant, 2011; MacEntee, Weiss, Waxler-Morrison, & Morrison, 1992). These attitudes are slightly more complex among families, with studies highlighting that feelings of entitlement or power can contribute to abusive behaviour towards older individuals, such as withholding financial support to access health services (Saveman, Hallberg, & Norberg, 1996; Setterlund, Tilse, Wilson, McCawley, & Rosenman, 2007). In light of this, importance should be placed on oral health promotion and awareness raising among those who are external to RACFs, such as dentists and family members and not just the staff and residents in the facilities.

It was evident that oral care provision in the RACF was relatively unstructured, with a paucity of oral care standards and processes. This resulted in the modification of oral health care practices, inconsistent monitoring of oral health problems across the facility and confusion around dental referral pathways. This is reinforced by a study from the United States which reported low adherence to oral health standards in RACFs (Coleman & Watson, 2006) and Australian studies which have identified a lack of oral health monitoring in residential aged care facilities and up to a third of residents with untreated dental decay (Hoang et al., 2018; Webb et al., 2016). These issues echo the global need for formal policies and practice guidelines that has been emphasized in previous studies, which have highlighted a lack of explicit oral care plans internationally and varied care provision in Australia (Lindqvist et al., 2013; Paley et al., 2004; Petersen & Yamamoto, 2005; Slack-Smith, Durey, & Scrine, 2016). Participants discussed that formal interdisciplinary clinical practice guidelines could address the barriers to implementation of oral health care in practice such as time constraints, difficulties working together with residents to comply to treatment, which have been identified internationally (Gibney et al., 2015; Paley et al., 2004; Paryag et al., 2016; Webb et al., 2013). Although there is a lack of interdisciplinary oral health guidelines in Australia, interdisciplinary oral health guidelines for oral health during pregnancy and early childhood have been developed in the United States and these could be adopted for use in aged care (California Dental Association Foundation, 2010).

Other barriers to the provision of oral health care in RACFs seen in previous studies worldwide were emphasized in this study, including staff turnover, barriers to implementation in practice and access and cost of dental services (Australian Institute of Health and Welfare & The University of Adelaide, 1999; University of Adelaide, 1999; Gibney et al., 2015; Hoang et al., 2018; Macentee, Thorne, & Kazanjian, 1999; Paley et al., 2004; Paryag et al., 2016; Webb et al., 2013). To overcome the challenges that high staff turnover presented to the provision of oral care and training, participants in the current study suggested the provision of mandatory training or incentives for training such as professional development points and recognition in performance appraisals. This need has been echoed by another Australian study, which highlighted a lack of attendance to non-compulsory training programmes held in RACFs (Wallace, Taylor, Wallace, & Cockrell, 2010). Management staff at RACF's can play a key role in facilitating change and addressing these training issues at an organizational level.

Finally, there was a consensus among participants, as well as care staff in the previous study that difficulties in accessing both public and private dental care posed a major barrier in ensuring good oral health for their residents. Concerns raised by nursing and management staff centred around a lack of cohesion between the RACF services and dental care due to referral and transport difficulties, which are concerns also highlighted in previous studies (Australian Institute of Health and Welfare & The University of Adelaide, 1999; University of Adelaide, 1999; Lindqvist et al., 2013; Paley et al., 2004; Webb et al., 2013). To overcome this barrier, nursing and management staff placed high priority on the implementation of a formal referral pathway, via which individuals eligible for free dental care in public dental services (Centre for Oral Health Strategy, 2018) could have priority access to dental care, as waiting periods exist for this pathway. They had specific interest in promoting dental outreach to their facilities and were willing to provide on-site facilities to enable this. Other researchers in Australia and Canada have already explored and successfully implemented approaches for dental outreach, such as the use of dental hygienists, dental students on clinical practicums and the training of care staff by dental hygienists as 'oral care specialists' (Macentee et al., 1999; Wallace, Blinkhorn, & Blinkhorn, 2014; Wallace, Mohammadi, Wallace, & Taylor, 2016). Evaluation of the model of care developed by Wallace et al. (Senior Smiles program) which placed dental hygienists in RACFs to provide oral health assessments, develop oral healthcare plans, deliver oral health education and establish referral pathways, showed a significant improvement in oral hygiene indices for residents (Wallace et al., 2016). As this study highlighted, there is the need for trained dental practitioners to deliver dental care on-site, as suggested by Wallace et al. (2016). However, one drawback of the Wallace et al. (2016) model is that it does not address the need for formal oral health training among nursing and care staff to assess and refer patients, which is facilitated in the Better Oral Health in Residential Care model. One alternative could be to integrate both models in the RACF setting. However, this study also suggests that policies around formal oral health training for all staff will need to be enforced in a system of care that prioritizes monitoring the oral health of residents.

Despite the significant findings of this study, there are some limitations to be considered. Since the study was limited to the perceptions of staff, other studies with residents and their families are needed to further understand some of the underlying barriers to implementation. The purposive sampling technique used in recruitment for this study may result in volunteer bias, as voluntary participants were more likely to have an interest in the oral health of their residents and be more aware of oral health. Further, the transferability of this study is limited due to the fact that this study was only conducted with one RACF organization located in the South Western Sydney area and with a small sample of participants. As such, the particular demographics of the residents and aged care workers in this area may have produced different results to those that may be seen in other areas. To address this, further research should be conducted in multiple RACF settings to reach data saturation and confirm the findings of this study.

6 | CONCLUSION

This study has highlighted that although staff were aware of existing training resources and acknowledged evidence-based training programmes (Better Oral Health in Residential Care) (Lewis et al., 2015), evidence from this was not being translated into practice due to a fragmented oral care system in their RACF. Along with our previous findings (Villarosa et al., 2018), this study suggests a consensus among RACF staff that there is a need for awareness raising, mandatory training, interdisciplinary practice guidelines and clear referral pathways to ensure adequate oral health care in RACFs. Future research should explore integrating these strategies into existing programmes in Australia (like the 'Better Oral Health in Residential Care' and 'Senior Smiles') and assess their effectiveness in improving the needs of residents and staff at RACF's.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

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APPENDIX A

Management staff focus areas

- The importance of maintaining oral health for residents of RACFs;
- Current practice of management staff regarding oral health care provision;
- The perceived role of RACFs nurses and carer staff in maintaining the oral health of residents;
- Current training;
- Management staff recommendations on overcoming difficulties and barriers of delivering oral health care for the elderly;
- Specific further education and training skills required for RACF staff to provide oral health care and promotion;
- Suggestions to assist in improving the oral health of residents.

APPENDIX B**Nursing Staff focus Areas**

- The importance of maintaining oral health for residents of RACFs;
- Current practice of nursing staff regarding oral healthcare provision;
- The perceived role of RACFs nurses and carer staff in maintaining the oral health of residents;
- Current training;
 - Perception of RACF nursing staff regarding the 'Better Oral Health in Residential care' train-the-trainer programme;
 - Suggestions for further training including content, duration and medium of training preferred by nursing staff;
- Nursing staff recommendations on overcoming difficulties and barriers of delivering oral health care for the elderly;
- Specific further education and training skills required for RACF staff to provide oral health care and promotion;
- Suggestions to assist in improving the oral health of residents.