Australian and New Zealand
Academy of Special Needs Dentistry

Australian Society of Special Care in Dentistry

Submission to the Royal Commission into Aged Care Quality and Safety

The Australian and New Zealand Academy of Special Needs Dentistry (ANZASND) is the peak national professional body representing the 18 registered specialists in Special Needs Dentistry (SND) and postgraduate students in training across Australia and New Zealand. It is the peak body responsible for advocacy in SND across the country from patient to government bodies. The Australian Society of Special Care in Dentistry (ASSCID) is a broader national professional body representing 65 members consisting of dental practitioners (dental specialists, dentists, dental hygienists, oral health therapists, dental prosthetists) and others (advocates) interested in oral health of people with special needs and Aged Care services. Both ANZASND and ASSCID are affiliate members of the Australian Dental Association (ADA) and advise the ADA in matters related to SND and Aged Care. In 2017, both ANZASND and ASSCID were engaged as Steering Committee members in the development of the first online modules 'Dentist and Dementia', a collaborative project of the ADA and Dementia Australia.

We are jointly providing a submission to the Royal Commission to address matters related to oral health in Aged Care services. We will refer to the Aged Care Quality Standards and Australia's National Oral Health Plans (2004–2013 (NACOH 2004); 2015–24 (COAG 2015), to inform the implementation of expert/evidence-based standards/recommendations that are well overdue.

a. The quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response;

Quality of aged care services provided to Australians	Aged Care Quality Standards have standards for quality of care and quality of life for the provision of aged care services. In a survey by Lewis *et al.* 2018, staff acknowledged that the introduction of new Aged Care Standards would demand more evidence centered in proving the quality of personal care delivery. However, one admitted "… and what does your care plan have in it, and have you met all the hygiene standards and everything else.

	I'm not quite sure about how we're going to prove we meet those standards." Here, we will highlight 'some of the standards' relevant to **quality of oral care** and **oral-health related quality of life** in Aged Care services, with comments on Consumer outcome and/or Organisation statement as relevant. **Standard 1:** consumer dignity and choice **Consumer outcome:** I am treated with dignity and respect, and can maintain my identity. Quality oral care is important not only for eating and chewing, but also to be able to articulate correctly, self-esteem and the ability to socialize. In addition, it is inherent in one's personal identity throughout life, and identification in forensic cases. A healthy mouth and smile is a key to consumer dignity, relationships and quality of life. In contrast, an unhealthy mouth with stale breath, decayed and missing teeth can be a deterrent not only to staff but family and friends. Bad breath can be a reason for exclusion of consumer participation in social activities. Poor swallowing (eg post stroke) can lead to drooling, which may be perceived as socially unacceptable. Ability to exercise 'choice' would be applicable either when the individual has the capacity to make healthy choices or when the person/carer has adequate oral health literacy to make healthy informed oral health choices. **Standard 2:** ongoing assessment and planning with consumers **Organisation statement:** The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer's needs, goals and preferences. Initial and regular on-going and timely dental assessments are necessary to maintain optimum oral health and well-being. Residents should have access to an initial dental assessment with appropriately trained dentists upon entering aged care facilities or where they have chosen to remain in their homes in order to ensure adequate and tailored planning of oral healthcare needs are met. Regular and timely dental reviews are paramount in identifying and addressing dental problems early. This would allow for minimal intervention, thereby reducing the burden to the residents, their family and support staff.

	Standard 3: personal care and clinical care **Consumer outcome:** I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me. **Organisation statement:** The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer's needs, goals and preferences to optimise health and well-being. Personal care should include daily targeted oral care, and clinical care should include regular dental care provided by trained carers as needed. For all residents at Residential Aged Care Facilities (RACFs), oral examinations and treatment should be conducted by a Specialist in SND, or an adequately trained general dentist in Aged Care. **Standard 7: human resources** **Consumer outcome:** I get quality care and services when I need them from people who are knowledgeable, capable and caring. **Organisation statement:** The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services. Residents should receive quality oral care and services when needed from people who are knowledgeable, capable and caring. For this, Aged Care services should recruit and retain skilled and qualified people who can provide safe, appropriate and quality oral care services. This will be possible only when the workforce is adequately trained, including in oral care by practitioners who have advanced skills in managing this cohort of individuals.
Extent to which those services meet the needs of the people accessing them	Staffing levels in many aged care facilities are far from sufficient, resulting in ever increasing workloads that provide no time to take care of clinical care or personal care such as oral hygiene. Several projects that have investigated the role of carers in RACFs in maintaining adequate oral care of residents (Chalmers *et al.* 2009; Fallon *et al.* 2006) have found that with adequate training, participating staff felt better able to provide targeted oral hygiene care even to resistant residents. However, participating staff also noted that lack of time to build relationships of trust with residents and being too busy to follow best practice are major barriers to embedding good oral/dental hygiene and assessment practices into their daily work lives.

	As a result, undiagnosed pain and discomfort due to unmet dental health care needs is often a significant cause of distress, agitation, and/or resistant or disruptive behaviour amongst residents and in particular, those with dementia. Recent Australian research suggests that provision of routine oral and dental health care to residents unable to care for their own oral hygiene is inadequate in many RACFs, particularly for those with dementia or other health conditions who may find it difficult or uncomfortable to co-operate with such care provision.
Extent of substandard care being provided including mistreatment and all forms of abuse, the causes of any systemic failures	Despite standards being in place, dentists (both at specialist and generalist levels) with adequate training in the advanced healthcare needs of this population are rarely employed by RACFs to conduct initial oral health assessments and care planning for new residents. Mouth care, which constitutes part of the activities of daily living is reported to be missed more frequently than other forms of care (Hopcraft *et al.* 2012; Lewis *et al.* 2016). Furthermore, residents are not receiving the help they need (Webb *et al.* 2015). Variability exists in care provided with one survey of nursing home staff reporting tooth brushing frequency as "ideally twice a day, actually, probably once a week for some of them and even "there'd be ones that, you, know, just get tooth brushing" (Hilton *et al.* 2016). Consequently "poor oral hygiene with a high accumulation of plaque and calculus" is a common finding among Australian aged care residents (Hopcraft *et al.* 2012; Hopcraft 2015). Inappropriate dental treatment, emphasis on complex costly treatment rather than quality-of-life care in their final stages of life and unregulated costs of dental care in RACFs have been reported by many care staff (Hearn & Slacksmith 2015). Substandard oral care may not be intentional but can occur because carers are unaware of the importance of daily oral care thereby being unaware of the priority it requires. In addition, they may have constrains in terms of time or adequate training in providing oral care for people with advanced care needs. In particular, there may be issues around providing care in terms of safety when residents are very resistive or aggressive. So when the carer:care recipient ratio is already low, cause of the substandard oral care may be more of a systemic failure.
Actions that should be taken in response	All aged care staff should be made aware of the importance of oral health and systemic implications. All aged care staff involved in direct care of residents should undertake education (theoretical) and practical training that provides them with the specific skills required to provide high-

	quality oral care to residents with complex health issues and special care needs. Utilisation of dental hygienists have been recommended in Aged Care (Chalmers *et al.* 2002). Wallace *et al.* (2016) have reported a successful 'The Senior Smiles model' in New South Wales, utilizing a dental hygienist in preventive oral hygiene care and establishing formal referral pathways. With the introduction of oral health therapists, they could contribute to address the workforce issue in Aged Care, especially in the provision of regular preventive oral care. However, this would need to be under the supervision and support from Specialist in SND, or general dentists with advanced skills in Aged Care. Currently, RACFs make contractual arrangements with private providers and designate a particular dental service for all residents. However, residents/families should have access to the range of choices available, and should have their own choice of dental provider, similar to GPs, as long as they are willing to visit the RACF (ANZASND & ASSCID 2013).

b. how best to deliver aged care services to:
   i. people with disabilities residing in aged care facilities, including younger people; and
   ii. the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services;

i. People with disabilities residing in aged care facilities, including younger people	There are 3626 young people in RACFs (COAG Disability Reform Council Quarterly Report 2018). In the National Disability Insurance Scheme (NDIS), dental practitioners (both specialists in SND and general dental practitioners with skills in managing this cohort) should be recognised as an important service provider and oral health care should be clearly included in the 'Plan of supports' for people with disabilities. This will allow dental practitioners with appropriate skills in managing those with advanced healthcare needs the ability to provide training for carers on daily oral hygiene as an important component of the self-care activity for people with disabilities, at their place of residence.
ii. Increasing number of Australians living with dementia	The ageing Australian population with increasing numbers of people with dementia will continue to need complex oral health care (Hopcraft 2015). However, many dental

	practitioners don't feel comfortable or adequately trained in providing dental care people with dementia (Slack-Smith *et al.* 2015). Likewise, people with dementia and their carers have difficulty finding dentists comfortable and appropriately skilled to treat them. A consumer driven and funded initiative *Partnership in Practicing Care* formed a joint project between Dementia Australia and the ADA (2016) to address the current limitations in the dental workforce in providing appropriate and timely dental care for people with dementia and developed online modules 'Dentist and Dementia'. Despite extensive promotion for the evaluation of the online training, participation of dental practitioners was very low. Only 64 dental practitioners completed the pre-training questionnaire, which reduced to 21 for post-training questionnaire. Of the 34 dental practitioners who were interested in a practical training, 11 completed the practical training and face-to-face clinical discussion. However, most participants were dental hygienists and oral health therapists as the practical training was conducted at a RACF in Adelaide, organised by the Dental Hygiene Association of Australia (SA branch). It is apparent that those living with dementia have advanced healthcare needs beyond what is currently taught at academic institutions (Ahmad *et al.* 2017) and as such the focus should be on training and upskilling at ground level. Such practical training for interested dental practitioners and carers at RACF should be encouraged and appropriately funded in this highly competitive era in order to enhance the skill set of the current workforce.

c. the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including:
   i. in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and
   ii. in remote, rural and regional Australia;

i. In the context of changing demographics/preferences: people's desire to remain living at home	Domiciliary care using portable dental equipment will help reorient dental services to the resident, overcoming access to services and transportation issues. These services need to be appropriately funded and maintained in order to ensure ongoing, comprehensive dental care can be provided across the sector with the desire of some individuals to remain living at home.

ii. In remote, rural and regional Australia;	In SA, specialists in SND train dentists with an interest in SND. The dentists have continued support via regular communications (including E-dentistry) and an established SND network. Post graduate specialists in training in SND are rostered to short term country placements. In Victoria, these trainees are also on placements in RACFs via the Domiciliary Service provided through Dental Health Services Victoria. Access to appropriate oral healthcare for those living in remote, rural and regional Australia is problematic with a significantly reduced or in some cases non-existent workforce placing at risk vulnerable individuals. Funding is required to adopt a model similar to that which currently exists in SA. In addition, more funding should also be set aside to improve the potential for domiciliary services to be more targeted to this population.

d. what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe;

Recommendations for Australian Government	1. The Federal Government implement a Dental Benefits Schedule for Aged Care Residents similar to the DVA schedule, with additional item codes based on the complexity of care and time involved. Examples: consent conversations, preparing and attending interprofessional care meetings (dental input when patients receive dietetic/speech pathology input to modify diets), providing written oral health care plans/reports, assessment of possible dental cause in patients with delirium. There is very minimal training in oral health and its links to general health in medical and nursing curricula (Ahmad *et al.* 2017). General practitioners and nurses are at the front line in many instances and may be unprepared to deal with oral health issues. As such they should be upskilled, through training provided by suitably qualified Specialists in SND or general practitioners with training in the field of SND. 2. The Federal Government provides funding support to specialists in SND adequately skilled dental practitioners experienced in Aged Care to help with provision of dental services at RACFs (costs associated with establishment, maintenance and travel (particularly to rural and remote locations).

	3. The Federal/State government fund post graduate training in SND via scholarships and/or paid clinical sessions to produce adequately skilled service providers and build workforce capacity to meet the growing needs in the recognised ageing population with advancing healthcare needs. 4. The Federal/State government support SND specialists across the sector in practice (public and private), academia and research to build research capacity to allow continued development of evidence-based innovative strategies appropriate for people with special needs. 5. Government schemes should not be restricted to private or public only but support a multisectorial approach, necessary to provide optimal service for people with special needs. 6. That oral health assessments are done by a Specialist in SND or an experienced dentist in Aged Care: a) As a specific, mandatory and reportable component of the MBS-funded GP Health Assessment for Aged Care Residents and Australians aged 75 years b) For Aged Care Residents on entry to Level 3 or 4 Home Care packages 7. A Specialist in SND or an experienced dentist in Aged Care is included in the residents' health care planning 8. The National Screening and Assessment Form includes specific questions on oral health problems and last dental visit for timely referrals and appropriate care as needed. 9. Inter-sectorial collaborations are promoted at policy, program and care delivery levels (COAG Health Council 2015), with representation from a Specialist in SND or an experienced dentist in Aged Care.
Recommendations for Aged Care industry	10. The RACF recruit and retain adequately trained staff (carers and dental practitioners) with appropriate remuneration, incentives and supportive working environment with appropriate workloads and skills development opportunities. 11. The RACF allow their staff to access the available learning resources on oral care and participate in practical training on oral care provided by adequately trained dental practitioners. 12. The RACF provide a designated dental treatment area and regular staff to manage the flow of residents to the dental treatment area or resident's room.

Recommendations for Australian families and the wider community	13. The consumers provide constructive feedback on the quality of oral care received at RACF and dental surgeries for continued improved of services and outcomes. Clients and their families reported that they did not recall having discussions about oral healthcare with staff nor were they informed that they could access priority dental treatment if they were eligible for public dental care (Lewis *et al.* 2018).

e. how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters;

To ensure that aged care services are person-centred	Develop individual oral care plans at the time of entering RACFs which can be regularly reviewed by trained Specialists in SND or experienced dentists in Aged Care. Provide an individually-appropriate level of assistance with oral hygiene for individuals that can be maintained by carers at RACFs.
To allow people to exercise greater choice, control and independence in relation to their care	Ensure that staff and residents at RACFs and those who chose to remain living at home are informed regarding choice of suitably qualified Specialist in SND or dentist experienced in Aged Care through schemes such as the NDIS.
To improve engagement with families and carers on care-related matters	Improve personal communication with families and carers on care-related matters or via phone, newsletters, or emails.

f. how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure;

How best to deliver aged care services in a sustainable way: Examples of good practice	Follow-up successful projects like the *Better Oral Health in Residential Aged Care Program* suggests that the processes introduced to boost staff capability, care planning, care provision and access to dental treatment are not continued, once funding for project staff who facilitated implementation of the project and who had championed a focus on oral health care expired (Lewis *et al.* 2016). To ensure sustainability, workplace culture needs to change to allow best oral care practice: • Ongoing training should be provided to new staff • Attention should be given to recruitment and retention of adequately trained staff

	• Oral health needs to be given a higher priority, with better integration into general health care A study by Yoneyama *et al.* (2002) conducted with 417 nursing home residents in 11 nursing homes in Japan, showed that a collaborative management through daily brushing by nurses and weekly professional care by a dental professional significantly reduced the risk of pneumonia among elderly nursing home residents. A more recent Cochrane review (Liu *et al.* 2018) showed that "professional oral care" (oral care with instruction or assistance from dental professionals including brushing, regular dental visits, possible use of oral disinfectants/mouth rinses) may reduce pneumonia-associated death by 60% in comparison to "usual care" (brushing teeth or dentures at varying intervals without help, or with the help of carers with no professional oral-health knowledge). Additional actions include: – Utilisation of both private dentists through their clinics, and public dentists through public sector clinics; – Utilisation of dental hygienists and therapists working in structured professional relationships with participating dentists, within their scope of practice; – Utilisation of participating Specialists in SND and dentists (with adequate skills in Aged Care) willing to provide dental services in hospitals, or on-site at suitably equipped RACFs; – Private dentists participating in the scheme to have the same options to either charge their customary fees, or to bulk-bill, as per the principal that operates for GP services under Medicare; – Co-payments should be covered by private health insurance rebates where patients have applicable private health cover; – Access to all services for residents based upon the current edition of the ADA Schedule, with additional item codes for alternative strategies, anxiolysis, and under general anaesthetic for Specialists in SND and dentists experienced in Aged Care.
Innovative models of care, increased use of technology	Some dental consultations and advice can be provided remotely (E-dentistry), if it involves opinions in treatment planning. However, direct care will be needed if behaviour management is needed in addition to the technical skills. Oral health services in Australia primarily operate on a fixed-chair model, where patients travel to a dental clinic to receive dental care. This model lacks the capacity and flexibility to address the needs of people who have difficulty accessing dental

	clinics due to physical (frailty, bed-bound) and sometimes even behavioural barriers (severe intellectual disability or psychiatric condition). This is also evident in later stages of dementia for example. As such, access, maintenance and increased utilization of portable dental units should be fully supported. Two recent NSW examples of innovative, dental team-based approaches to provision of better oral and dental care for aged care recipients that have received support from the ADA, individual ADA members and the ADHF are Concord Repatriation General Hospital's Reach-OHT program (Wright *et al.* 2017), and the Senior Smiles program (Wallace *et al.* 2016). These programs help to ensure that aged care individuals have access to professional assessment, diagnostic and treatment services, as well as regular preventive care from professionally trained oral health practitioners who also function as champions for oral health, through on-site provision of oral health care education to aged care residents and their families, and aged care staff. Innovative partnership models between the public, non-government and private sectors and regional and remote communities would create opportunities for broader service distribution by sharing resources, training, education and research integration, clinical governance, workforce support and mentoring across sectors and regions (Dyson *et al.* 2014).
Investment in the aged care workforce	There are currently only 18 practising registered specialists in SND (Dental Board 2018), with still fewer dentists providing care for people with physical and intellectual disabilities and the frail elderly. General dentists report inadequate training (Slack-Smith *et al.* 2015) and many are not comfortable or even interested in providing dental care for people with special needs, with some stating "nothing" would encourage them to provide domiciliary care (Sweeney *et al.* 2007). Lack of dentists with adequate skills in SND was the most frequently reported problem by parents/carers (Pradhan *et al.* 2009). For dental practitioners, inadequate reimbursement was cited as a major barrier to the provision of dental care. More than half of Canadian, New Zealand, American and Australian respondents cited insufficient financial reimbursement as a barrier to care provision (MacEntee *et al.* 1992; Hopcraft *et al*. 2008; Antoun *et al*. 2008; Nunez *et al.* 2011). So there is a growing concern in regards to the relationship between the limited workforce and unmet oral health needs. In order to build the current workforce, equitable funding would need to be dedicated to support full time Academic clinicians in

	Special needs Dentistry at our Academic institutions across the country. In addition, funding needs to be provided to support specialists in training at these institutions together with enhancing current teaching models to support general dentists and oral health therapists with an interest in providing such care. Academics in SND should also be supported in their role in undergraduate and graduate dental curriculum to increase exposure of dental students to Aged Care services. Unless such exposre takes place it would be impossible to see how an interest in working in the Aged Care Sector can be fostered, the result of which would be poor workforce outcomes.
Capital infrastructure	Funding should be dedicated to develop dedicated oral healthcare spaces in RACFs together with provision of mobile dental units that can be used for individuals unable to access dental clinics.

g. any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.

Additional matters for consideration are:

i. increasing incidence of chronic and complex conditions;
ii. medication management;
iii. mental health;
iv. nutrition;
v. positive behaviour supports to reduce or eliminate the use of restrictive practices;
vi. end of life care;

i. Increasing incidence of chronic and complex conditions	Frail and vulnerable older adults are at increased risk of oral disease and often present with extensive oral health needs, complicated by medical, functional, behavioral and situational factors. While the dental needs of frail older people are not always technically complex, it is the associated multiple comorbidities, including behavioural, and polypharmacy issues that increase the complexity of treatment planning and management. The proportion of aged care consumers with dementia and/or physical/cognitive impairment is also increasing. These individuals develop reduced capacity for oral self-care and difficulty seeking and accessing dental treatment. Moreover, they may also have difficulties communicating that an oral health problem is causing them pain/discomfort. Swallowing problems combined with poor oral/denture hygiene can lead to choking and aspiration pneumonia,

	and associated costs of preventable hospitalizations and even premature deaths.
ii. Medication management	Residents have multiple comorbidities with polypharmacy regimes and may be unable to co-operate during treatment. They are subject to the problems associated with polypharmacy such as dry mouth which not only increases caries risk, but causes general oral discomfort, burning sensations, bad breath, intolerance to spicy foods, poor retention of removable dentures, altered taste, difficulty in chewing, swallowing, and speaking (van der Putten *et al.* 2014)
iii. Mental health	Poor oral health can cause pain, infection and tooth loss, which can affect speech, appearance and self esteem. This can lead individuals to avoid smiling, talking, and socialising and hence results in depression and mental health issues affecting emotional and physical wellbeing. This can also have a significant impact on the quality of life (Slade *et al.* 1994).
iv. Nutrition	Tooth loss and poor oral status have also been associated with malnourishment in older adults. Tooth loss results in a reduced ability to chew, affecting a person's intake of certain food types, such as fruits and vegetables rich in vitamins and dietary fibre (Walls *et al.* 2000). A recent study found that residents with decayed or broken natural teeth had more trouble eating firm foods compared to residents with the same number of healthy teeth and were hence more likely to be malnourished (Hugo *et al.* 2015). Malnutrition resulting from poor food intake has in turn been associated with a decline in ability to perform activities of daily living (Furuta *et al.* 2013) and an increased risk of falls in elderly patients (Neyens *et al.* 2013).
v. Positive behaviour supports to reduce or eliminate the use of restrictive practices	Positive behaviour supports should be encouraged to reduce or eliminate the use of restrictive practices, when appropriate or possible.
vi. end of life care	Often, carers hesitate or simply do not provide oral care for people nearing the end of life, due to difficulties in patient compliance, staff time constraints in prioritizing care, underfunding, or a lack of perceived need. However, Soileau & Elster (2018) provide physiological and psychosocial reasons for properly and regularly implemented oral care for people nearing the end of life and why dental practitioners have an ethical responsibility to address the current void in hospital-

	based oral care. Therefore, dental practitioners should initiate, develop, promote, and implement appropriate standard of oral care and keep one comfortable and maintain identity and dignity near the end of one's life.

Thank you for the opportunity to participate in this inquiry. We hope that the Royal Commission will consider the range of evidence-based recommendations presented in this submission for access to appropriate and timely dental care at RACFs to improve the oral health and quality of life for older Australians.

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