NZDA Position Statement on Oral Health Services for Dependent Older People

Principal resource

The working party has been fortunate in having the paper “Oral health and well-being of older adults in residential aged-care facilities: issues for public health policy” NZDJ 106, 2, 67-73, 2010 by working party member Moira Smith as a primary resource. Her paper has addressed most of the issues put to the working party and has formed a sound basis for the discussion leading to our position statement.

Who are dependent older people?

The proportion of New Zealanders aged 65 years and over is increasing rapidly, with adults aged over 85 years emerging as a substantial population. Most older people live out their lives independently but a proportion of this notionally independent group become less able to access traditional services such as visits to medical and dental practices. Support for these people is generally provided by family, friends and special interest organisations and is an accepted part of society's role. Nevertheless it must be accepted that independently living elderly sometimes require targeted support to maintain good health – including oral health.

Some older people live in residential aged-care facilities, becoming to some extent functionally dependent on others for their personal and health care needs – including day-to-day oral care. Currently, approximately 28,000 people (5% of the 65+ age group) live in residential aged-care facilities in New Zealand. Older adults in residential aged-care facilities are at great risk of developing complex oral health problems. They have a higher prevalence of oral disease than their independent counterparts and treatment needs include periodontal, restorative, surgical and prosthetic therapies. Research shows that older adults often enter facilities with compromised oral health or develop dental treatment needs soon after admission.

So while independently living elders may require support for routine oral health procedures and practice visits the major challenge is the maintenance of the oral health of those in residential care facilities.
New Zealand currently lacks a formal oral health policy for older adults irrespective of dependency level. The NZDA seeks to contribute to the research, planning & evaluation and ultimately the policy making and care delivery necessary to improve health equity for this growing and vulnerable population group.

**Residential aged-care facilities and oral health – the current situation**

Features common to the lives of all older adults together with those unique to age-care residents present potential barriers to the maintenance of a healthy mouth and enable the development of oral disease. These include aspects of health, environment, finance, perception of need, and lack of overall policy.

**Health:** Many health factors common in the dependent elderly impinge on oral health, including medications, visual impairment, musculoskeletal conditions, diabetes and stroke. Dementia and Parkinson’s disease are significant obstacles to self- and supported-oral care procedures.

**Environment:** Support for daily oral health care often fails to meet residents’ needs. This may be due to caregivers’ poor oral health knowledge and training, time restraints, residents’ behavioural problems and inadequate planning. Relatively few facilities in New Zealand have oral health policies or oral health care planning. Cognitive impairment and/or restricted mobility hamper residents accessing dental practices for treatment and the coordination of care often falls to family or support networks.

Domiciliary oral health care is not commonly provided by New Zealand dentists, who are not well prepared academically or technically to provide care outside their practice.

**Finance and perception of need:** Almost all adult oral health care is funded through out-of-pocket private expenditure. This presents a significant barrier to seeking treatment, particularly for those in subsidised care. Dependent elderly often disregard oral health needs for both financial and cultural reasons.

**Public policy to date:** New Zealand has yet to meet the WHO call for the development of comprehensive public policy and oral health targets for older adults. Nevertheless the Ministry of Health “Strategic Vision for Oral Health” (2006) identifies older adults
as a priority group for policy development, focusing on the responsibilities of individuals, the public and private sectors in promoting oral health, and on the implications for funding. The Strategy specifically identifies the needs of dependent older adults.

Guidance for oral health care in NZ residential aged-care facilities comes from three sources.

First is the obligations arising from the National Contract for Age Related Residential Care (MoH, 2007) in which private providers contracted to DHB’s are required to ensure that subsidised patients are adequately cared for by appropriately trained staff. The resource “Healthy Mouth, Healthy Ageing” prepared jointly by the MoH and the NZDA provides a useful framework for carer education in this context. This publication includes a simple format oral assessment / oral care plan which could be the basis of uniform documentation across the rest home sector.

Second is the mandatory standards underpinning the Health and Disability Service (Safety) Act 2001 (MoH) which demand safe and reasonable service to consumers, which would presumably include appropriate oral hygiene procedures.

Third is the InterRAI MDS-LC (International Resident Assessment Instrument – Minimum Data Set Long-term Care) assessment tool used within the DHB sector and increasingly in New Zealand rest homes. This has a small capacity for oral health elements but is becoming the common assessment tool in residential aged care facilities. The Ministry of Health has mandated that by June 2014 all aged residential care facilities in New Zealand will be engaged in training on the use of this assessment tool, in preparation for its use becoming mandatory from 1 July 2015.

What do dependent older people need to maintain oral health?

Oral condition prior to entering care: It is axiomatic that a healthy, easily maintained oral condition has the best prospect of retaining health and function in subsequent adverse conditions. Accordingly continuing regular professional evaluation and care through adult life is the best preparation for a later period of dependence associated with age and ill health. This does not mean “all teeth for life”, indeed it may well be appropriate for some or even all teeth to be removed during adult life to ensure the best oral condition during later dependence. When indicated dentures are usually best accepted users in relatively good health.
An oral care plan: Oral examination coupled with a specific oral health care plan should be a required stage in admission to residential care. This would include necessary hygiene procedures and allow for regular review by an appropriate professional.

Appropriate diet: Tooth decay can progress rapidly in the event of unsuitable (high sucrose) diet. Menus and routines should emphasise palatable but “tooth friendly” components.

Support in oral care procedures: This follows the oral care plan and should be individualised to the capability and needs of the resident. All actions should be recorded.

Appropriate and timely professional monitoring and intervention: Day-to-day monitoring of oral health, like all aspects of health, relies much on interaction between carer and resident. Change should be noted and advice should be sought from an oral health professional at the earliest opportunity.

How these requirements are best met?

Continuum of professional care: Ideally a person entering an aged-care facility will have had regular professional oral health care throughout life and will present in good oral health. Increasingly such people will have a useful number of natural teeth and will have benefited from the availability of fluoride both in the water supply and as a component of toothpaste. Desirably that person’s oral health provider would be aware of the change of circumstance and would continue to be involved in treatment planning for routine daily oral health procedures and would provide any necessary operative treatment at the dental surgery. While such care can be undertaken for relatively ambulant people in suitably accessible and equipped dental surgeries, transfer of increasingly dependent elderly patients to a dentist’s surgery can be a fraught activity for all concerned.

For this group professional (domiciliary) dental care is more appropriate. In reality domiciliary care is offered by very few general practitioners. Those who do not offer domiciliary care often quote need for portable equipment, lack of training and experience and disproportionate cost as reasons.
Commonly people entering aged-care facilities have lost touch with their dentist or have sought episodic rather than regular care. In view of the potential risks to oral health inherent in residential care it would be appropriate that new residents have a nominated professional identified in the health care plan to assume responsibility for oral health matters. Regrettably this level of care is not presently the norm.

**Oral care plan:** Increasingly the InterRAI MDS-LC assessment is becoming the accepted tool for rest homes. This is an internationally recognised computer programme providing many benefits to providers and clients. Currently its use for oral health issues is being evaluated at DHB level and it may well be that the simpler and more specific “oral health assessment/oral care plan” offered through the NZDA/MoH booklet healthy Mouth, Healthy Ageing will prove useful, particularly in situations where paper copy remains dominant. It is important that an oral health assessment/treatment plan be simple and easily accessible to all parties.

The key point is that a suitable oral health examination leading to a properly documented and actioned oral care plan is critical to meeting the oral health needs of the dependent elderly.

**Appropriate diet:** Dental caries can progress very quickly in the dentate dependent elderly. This is usually related to a combination of infrequent and inadequate brushing together with a diet high in acidic and sugary food items. It is very important that oral health be considered in providing food and snacks to the dependent elderly.

**Workforce training and qualification:** The workforce involved in providing oral health care for the dependent elderly is potentially both large and diverse – including dental specialists, general dental practitioners, hygienists, technicians and assistants; medical specialists and general medical practitioners; and residential aged-care facility staff including nurses and auxiliary caregivers, volunteers, administrators and managers; and of course, family.

Dentists, hygienists, therapists and technicians are registered by the Dental Council of New Zealand and it is a requirement that they have passed the qualifying examinations of their primary teaching institution. Anecdotally it appears that many undergraduates have little or no contact with the realities of providing care for the dependent elderly. This contributes to the later reluctance to become involved in domiciliary care.
Presently there are no dental practitioners offering specific domiciliary care.

Within the public sector the DHB’s generally place a low priority on domiciliary care (regardless of need). An exception is the Canterbury District Health Board who have for many years accepted limited referrals for domiciliary evaluation and treatment. The DHB’s dentist liaises with all parties and provides professional support for carers at the patient’s home or residential facility.

Training programmes for rest home carers usually have a small oral health component. This is generally not regarded a high priority and the (voluntary) programme for rest home carers initiated by the MoH and NZDA goes some way to improving carers’ knowledge and subsequent actions. We need a uniform training scheme and qualification for all rest home carers. Only after proper training can carers be expected to meet the challenges of supporting the oral health care of the dependent elderly.

Concurrent with these greater expectations and requirements should be sufficient funding to facilitate learning and staff retention in an area which currently suffers from variable knowledge and behaviours and high staff turnover.

**Funding:** DHB funding (for workforce, equipment and ancillary costs) should be increased and supplied through a specific funding stream for oral health care to subsidised residential aged-care facility residents – the bulk of the dependent elderly. “Routine” care, including examinations, relief of pain, prescribed therapeutic agents – such as fluoride containing agents and gels for dry mouth – and treatment by referred specialists should be entirely publicly funded. Such a care arrangement might be provided by salaried hospital based dental personnel or by general dental practitioners on a combined capitation/fee-for-service system like the current Adolescent Oral Health Agreement.

**Implications of Policy Proposals**

The suggested policy embraces a “collaborative” approach to the maintenance of oral health in the dependent elderly. It would require the involvement of all stakeholders (DHB’s, oral health professionals, tertiary institutions, NZ Dental Council, NZDA, primary care providers, PHO’s, HealthCare providers NZ, residents, families, residential aged care facility staff and administrators etc) in comparison to the isolated dental practice.
Improving access through coordinated, community-based services and increasing the capability of clinical providers at the primary healthcare level would benefit the dependent elderly (and their families) as well as reducing pressure on secondary services.

Implicit in the provision of appropriate oral healthcare is the place of dental hygienists, who would have a key role both in oral hygiene provision and support for carers in their oral health-related duties.

Implementation of the proposed developments in management and service will be demanding on aged-care facilities - in time, workforce & experience, contract compliance and provision of facilities. Improvement has a cost which must be appropriate and realistic.

Treatment needs of the dependent elderly have yet to be quantified and it will be necessary to develop the overall proposals carefully, maintaining a balance between available staff/facilities, funding and meeting needs. Accordingly it would be prudent to initiate a pilot project in one DHB region with appropriate evaluation and development prior to national adoption.
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Goal

- To establish a coordinated approach to the improvement and maintenance of the oral health and well being of Dependent Older People

The New Zealand Dental Association proposes the following policy objectives:

- To support the education, training and interaction of all involved health professionals so that they can work in a collaborative manner

- To endorse the benefits of community water fluoridation together with use of fluoride supplements to enhance oral health throughout life

- To encourage appropriate oral health behaviours throughout life – reducing the risk of adverse events during dependency

- To ensure that all dependent elderly have equitable, timely, affordable and accessible oral health services

- To institute national standardised protocols for oral hygiene care and oral health monitoring in residential aged-care facilities

- To ensure that all older adults entering residential aged-care facilities are assessed for oral health needs and have oral care plans developed

- To support the public funding of dental care for the dependent elderly provided by either or both DHB’s or contacting general practitioners

- To promote and raise awareness of older adults’ oral health and well being

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