

Smiling matters

Oral health care in care homes



Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword

Oral health has a big impact on our quality of life. We express ourselves by talking or smiling. We can take immense enjoyment from what we eat or drink and pride in the state of our teeth and gums.

These things are just as important for people living in care homes, so good oral health care must not stop once a person enters a home. Older people are now more likely to retain their teeth than previous generations, and they need daily care and regular check-ups.

Good oral care helps keep people free from pain – especially important for those who have communication difficulties, who may find it difficult to alert others to where it hurts. For those with chronic conditions, good oral care can help make sure they can take the medicines they need to prolong health.

Good oral health can also reduce the risk of malnutrition, which is thought to affect around 1.3 million older people. And it can reduce the risk of acquiring aspiration pneumonia, particularly in residential settings. These conditions can lead to people becoming frailer and can be fatal.

The NICE guideline NG48, published in July 2016, recognised the importance of good oral care. Their recommendations aim to maintain and improve the oral health, including dental health and daily mouth care, for adults in care homes.

However, our discussions at the Regulation of Dental Services Programme Board and with other stakeholders across adult social care and primary care highlighted that awareness and take-up of the guideline was still low, despite considerable engagement with the sectors, and this was having an impact on people.

We carried out a review to find out how care home and dental providers were implementing the guideline. Our dental inspectors attended 100 routine planned inspections of care homes alongside inspectors from our adult social care team. We spoke with managers and senior members of staff, as well as people who use services and their relatives to find out about their experiences of care.

This is a report of what we found in those homes. Staff awareness of the guideline recommendations was low, and not everyone was supported to keep their teeth or dentures clean. Only around half of the care homes provided specific staff training to support people's daily mouth care.

Although we saw some examples of good, joined-up practice between care homes and dentists, this was uncommon. People using services and their professional and family carers often found it difficult to access routine NHS dental care. They also thought dentists have a limited understanding of people's complex needs and are confused about how to finance dental care.

All too often, treatment would only be sought when people were in pain, but issues with accessing emergency NHS dental care meant care homes would call a GP or NHS 111, or

even take the person to A&E – putting added burden on services that are already under pressure.

While oral health assessments and care were not on the priority list of some care home managers and staff before our review, once flagged they made immediate commitments to improve – sometimes with low cost but effective changes. Stakeholders from the dental sector were positive about making people living in care homes a greater priority when they plan care and treatment for their local populations.

But the change that needs to happen, which is reflected in the NHS Long Term Plan’s commitment to ensure that everyone living in care homes is supported to have good oral health, cannot be properly achieved in a piecemeal way. The recommendations in this report call for action across the health and social care system and ask stakeholders to work together to support care homes and the dental profession to make changes. This collaborative approach to improvement in oral health should be an example of good integrated working.

We want care homes to embrace oral health and ensure that it receives the same priority as physical and mental health. And we want the public to understand the importance of oral care better. This will help friends and families to support people and to know what they can expect from care homes.

Some recommendations can be implemented quickly; others require both planning, training and resources. CQC will play our part by stepping up our focus on oral care in future inspections. By working in partnership, we will help re-define what good oral care looks like for people living in care homes and make a positive impact on their quality of life.

Rosie Benneyworth

Chief Inspector of Primary Medical Services and Integrated Care

Kate Terroni

Chief Inspector of Adult Social Care

Introduction

Why we are looking at this now

People's oral health in the UK has been steadily improving since the NHS began in 1948. In those early years the most common treatments were dental extractions and the provision of dentures. Thankfully, as modern dental techniques were developed many teeth that would previously have been extracted were restored, and those born since the 1940s have been able to retain most of their teeth for life. It is now much less common for people to lose all their teeth, whether through decay or gum disease.¹

Unfortunately, this positive picture has not generally been reflected for people of all ages living in care homes. Despite technological advancements, adults of working age with complex conditions can still struggle to find dental care that meets their needs. And as people become older and some begin to lose their independence it can become harder for them to maintain their oral health. They may also find it harder to access high street dentists and, as some enter care homes, their oral health becomes at risk of deteriorating.²

Poor oral health can adversely affect people's general health – for example, problems with eating and drinking can lead to malnutrition. There is also considerable evidence that links poor oral health with aspiration pneumonia, particularly in residential settings. This is because people can inhale bacteria in dental plaque.³

The dental profession and care home sector have long been aware of this growing issue. In 2016, Healthwatch England produced a report⁴ that highlighted oral health as one of the key themes raised by people across its network. It also featured strongly in Healthwatch's 2017 report, *What's it like to live in a care home?*⁵ Oral health has also been raised at the Regulation of Dental Services Programme Board, which is chaired by CQC.

These were the drivers behind CQC's decision to carry out a review to examine the issue of oral health in care homes. Having engaged with stakeholders, we agreed to find out staff and carers' awareness and implementation of oral care needs, with specific reference to the NICE guideline on oral health for adults in care homes, and understand their ability to access professional dental care when necessary.

The growing importance for oral health in care homes is further demonstrated by its inclusion in Section 1.15 of the NHS Long Term Plan – "We will upgrade NHS support to all care home residents who would benefit by 2023/24... we will ensure that individuals are supported to have good oral health, stay well hydrated and well-nourished and that they are supported by therapists and other professionals in rehabilitating when they have been unwell."⁶

How we carried out our review

We spoke with stakeholders to agree what we thought oral care in care homes currently looked like and to identify any areas that we felt needed to be reviewed as part of this review. We spoke with dental professionals, social care providers, people using the services,

and their families and carers to determine what we would need to focus on and continued this engagement during the development of this report.

We then carried out a specific programme of fieldwork. Our dedicated dental inspectors attended 100 routine planned inspections of care homes that took place between October 2018 and January 2019, alongside inspectors from our adult social care team. This regulatory inspection gave an overall rating of the care home and a judgement of whether it was providing safe, effective, caring, responsive and well-led services. The work completed by the dental inspectors was a fact-finding exercise to help us build a picture of the state of oral health care in care homes.

Our selection of care homes for our review was determined by the adult social care inspection schedule and influenced by dental inspectors' location and availability. However, we achieved a largely representative sample of care homes, covering a range of geographical areas and care home ratings, sizes and service types.

At these inspections, we mostly spoke with managers and senior members of staff about their awareness and implementation of the NICE guideline. We refer to them as 'member of staff' in the quotes throughout this report. We also talked with people who use the service and their relatives. These conversations explored the experiences of people to understand how their oral health was being cared for. We have used their experiences and direct quotes to support our findings throughout this report.

This report also includes experiences of oral health care in care homes that were commissioned through our Experts by Experience programme. Experts by Experience are people who have experience of using (or caring for someone who uses) health or social care services.

Providers' response to our work

Throughout our fieldwork and our ongoing external engagement with the sector, providers were positive about this review and were keen to improve where necessary. Some improvements were immediate and included:

- people's oral health being assessed
- toothbrushes, toothpaste and other products purchased for use by people living in care homes
- oral health training being procured
- contact made with local dentists
- new signage in people's rooms to promote good oral hygiene.

The following quotes from inspectors and staff give more detail on specific actions that care homes planned to take. Following this report, we would expect other care homes to review their oral care arrangements and carry out similar improvements where necessary.

“We discussed that the recommended frequency of dental visits for people who use the service is not included on their record/care plans. The manager will adjust the form.” (Inspector)

“The manager will see if the following can be included on the care assessment record: whether people are eligible for free NHS dental care and recommended frequency of dental visits.” (Inspector)

“Following my visit, [the manager] sent me information that more training for staff had been arranged for September 2019.” (Inspector)

“We need more specific training on oral health which we will now arrange.” (Member of staff)

We also gave leaflets to several care home managers about the criteria for free NHS dental care, as well as copies of the NICE guideline.

Summary of the NICE guideline

NICE guidance is a set of evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. The guidelines help health and social care professionals to:

- prevent ill health
- promote and protect good health
- improve the quality of care and services
- adapt and provide health and social care services.

The [NICE guideline NG48](#)⁷ (published July 2016) covers oral health, including dental health and daily mouth care, for adults in care homes. It aims to maintain and improve their oral health and ensure timely access to dental treatment.

1. Are people living in care homes supported in a way that meets the NICE guideline on oral health care?

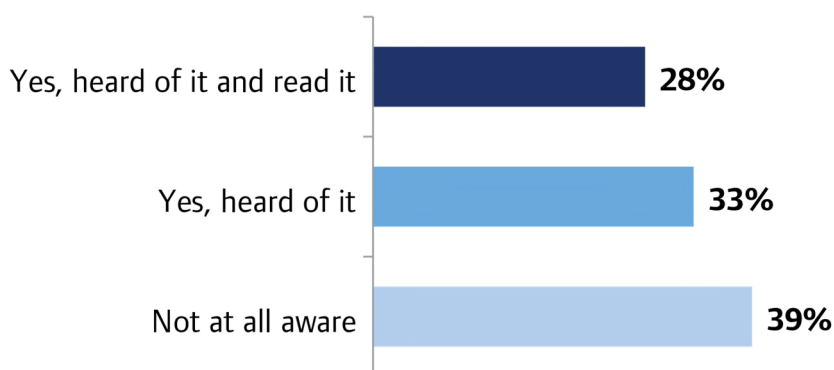
The [NICE guideline \(NG48\)](#) was introduced in July 2016 to maintain and improve the oral health, including dental health and daily mouth care, of adults in care homes. The guideline includes recommendations for care home managers, staff and people who use services and their carers, focusing on:

- care home policies on oral health and providing people with support to access dental services
- oral health assessment and mouth care plans
- daily mouth care
- care staff knowledge and skills.

Awareness and implementation of the NICE guideline

Despite considerable engagement with the social care sector since its launch, awareness of the NICE guideline in care homes we visited was low. Of the care home managers we spoke with 39% were not at all aware of the guideline and only 28% had heard of it and read it (figure 1). Of those who had heard of it and read it, only 39% felt they had fully implemented the recommendations.

Figure 1: To what extent are you aware of the NICE guideline in relation to oral health in care homes?



Source: CQC

Our engagement activities as part of this work told us that one of the reasons awareness and implementation was low was because the guideline does not currently form part of the contractual and regulatory frameworks the care home sector work towards. This meant they were not incorporated in the management systems that care homes had developed. However, it is important to note that Regulation 12 of the Health and Care Act, which is

enforced by CQC, includes the expectation that providers should follow good practice guidance when delivering all aspects of care.

“Lack of awareness is the only current barrier. The home is reliant on its off-the-shelf system to guide it in developing care plans and day-to-day care routines.”
(Inspector)

“[The] challenges [are] not specifically related to the guidance but more to the fact that [the] policies that are followed are company policies.” (Member of staff)

Others told us they lacked the time to effectively implement the guideline due to the high number of people who had very complex needs. Smaller care homes (1-10 beds) or those that cared for people with learning disabilities (which tend to be smaller) were more likely to have heard of, and read, the NICE guideline. The example below about a person with a learning disability shows the impact that a personalised approach to oral health can have on people using services.

Experiences of care – personalised care of someone with complex needs

Joshua is 23. He has a severe learning disability, has communication difficulties, and can display behaviour that can be challenging. He lives in a care home in the community, which is near to his healthcare professionals.

Staff support Joshua to clean his teeth twice a day after breakfast and before bed. They help by cleaning his teeth when he is in the bath or when he is sitting at the table, which he seems to prefer. Staff try to make it fun.

Since Joshua has sensory issues, he would really suffer if he experienced dental pain – especially since he would be unable to show where the pain was. He could also harm himself or others. His quality of life is improved by avoiding intrusive dental work, which would cause him much anxiety and most likely require a general anaesthetic. Since he suffers with epilepsy a general anaesthetic could be dangerous for him.

Joshua’s oral health needs are included in his care plan, which his mother was involved in to help make sure it met his needs. For example, she explained that cleaning his teeth in the bath and singing a song with him would help him feel more at ease.

His mother says, “I am confident that Joshua is treated with dignity and respect. Staff are caring and kind and keep me updated. I feel that Joshua is involved in his teeth cleaning routine – it is not ‘forced’ upon him. I have thanked the staff for the support they give him and I feel that they are pleased that their efforts are acknowledged.”

Note: We have changed people’s names.

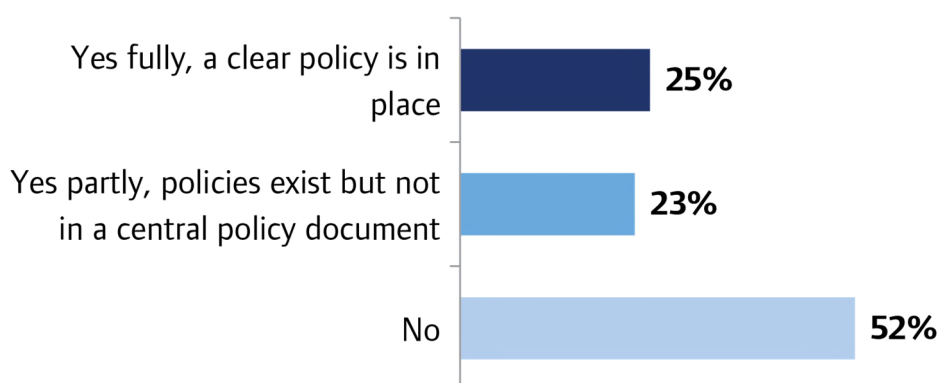
NICE engaged with the sector to support the development and publication of a number of shared learning examples, demonstrating how oral health guideline NG48 could be successfully implemented within care homes.

The NICE field team has also continued to promote NG48, its oral health quality standard⁸ and quick guide⁹ during conversations with regional and local networks in 2018/19. For example, they linked up with providers through Skills for Care registered managers networks and care associations. These groups have been positive about the availability of the guideline and quality standard and, in particular, the quick guide as a way of improving quality.

Policy

The guideline recommends that managers ensure their home's policies set out plans and actions to promote and protect people's oral health. The majority (52%) of care homes we visited did not have such a policy (figure 2).

Figure 2: Do you have a policy that sets out plans and actions to promote and protect people's oral health?



Source: CQC

NICE recommends that care home policies set out plans and actions to promote and protect people's oral health that include information about:

- local general dental services and emergency or out-of-hours dental treatment
- community dental services, including special care dentistry teams
- oral health promotion or similar services, depending on local arrangements
- assessment of people's oral health and referral to dental practitioners
- plans for caring for people's oral health
- daily mouth care and use of mouth and denture care products

- what happens if someone refuses oral health care (in line with the Mental Capacity Act and local policies about refusal of care)
- supply of oral hygiene equipment (for example, basic toothbrush or toothpaste).

Our inspectors reviewed available policies to check to what extent they promoted day-to-day oral health, and access to routine and emergency care. Where policies existed, we noted that care staff were not always aware of them, they were not always followed in practice, or they had not been embedded as part of the daily care routines of the care staff.

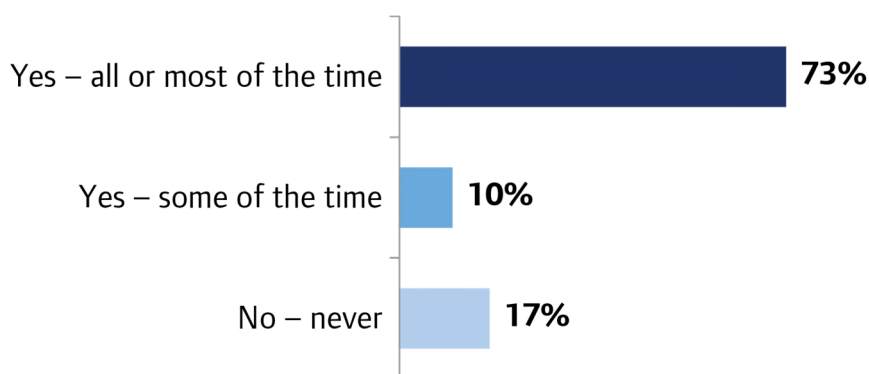
Some care homes that did not have a specific policy had information available elsewhere in their documents, such as the ‘residents’ handbook’ or within the care plan.

Again, during our engagement work we were told that, since the need for a specific oral health policy did not form part of regulatory and contractual assessment frameworks, it was given low priority.

Oral health assessment

The guideline recommends that “care staff carrying out admissions or assessments assess the mouth care needs of all residents as soon as they start living in a care home, regardless of the length or purpose of their stay.” Seventy-three per cent of care homes said people did have some form of oral health assessment when they were admitted to a care home, but with varying degrees of detail, and less than half of all care homes (44%) used a recognised assessment tool. Seventeen per cent said they never assessed people’s oral health on admission (figure 3).

Figure 3: Do people have their oral health assessed on admission?



Source: CQC

A frequent reason given for why oral health is not assessed for every person was that it did not feature as part of the admission assessment process. Comments did not suggest care homes would be opposed to including oral health in their assessments, just that this had not yet been specifically considered.

“Not all people have had a specialised assessment of their mouth care needs yet on admission. Mouth care needs were being picked up as part of the generalised care assessment, although information on that in the assessment was brief.” (Member of staff)

In some instances, it was felt that people’s lack of ability to give informed consent to treatment was a challenge to assessing and providing oral health care.

“Challenges in carrying out assessment as people with advanced dementia won’t understand the reasons behind oral health care.” (Member of staff).

The guideline suggests using the Australian Institute of Health and Welfare Oral Health Assessment Tool, which gives a score to each area of the mouth and prompts care plans and dentist appointments.

Although figure 3 suggests that most people’s oral health needs are assessed on entry to the care home, we found a significant variation in the level or detail. Some simply asked whether the person was able to brush their own teeth or had dentures.

During our engagement work, some providers showed us how they had developed their own assessment tools which linked electronically through to care planning records. We also saw excellent examples of person-centred care planning, which was driven by a thorough assessment of needs and preferences, in line with other parts of a person’s care provision.

This approach to holistic care and support planning is shown in this example, which highlights how important it is to someone’s general wellbeing.

Experiences of care – oral care as part of a person’s overall care support and planning

Ann had different experiences of oral care at the three care homes she lived in.

She was admitted for emergency respite care to the first home. She had four lower teeth of her own plus upper and lower dentures. Ann’s daughter noticed that both her toothbrush and denture brush were dry and that her toothpaste had not been opened, so she helped her clean her teeth and dentures.

Ann moved into long-term residential care, where she had a good supply of dental products which staff bought using money from her petty cash account. Care staff encouraged and supported her to clean her teeth and dentures and complimented her for her “sparkly teeth and lovely smile”. Ann beamed with pride when this was said and it was reassuring for her daughter to see her looking so cheerful.

When Ann’s Alzheimer’s became advanced, she moved to a specialist dementia care home. She enjoyed having her hair brushed and her teeth gently cleaned by cheerful and patient care staff. Her daughter could see from her mum’s smile and the twinkle in her eyes that she was happy. The home posted on their Facebook page (with permission)

photos of Ann at events like the Halloween Disco. It was very reassuring for her extended family to see her enjoying herself and smiling.

Note: We have changed people's names.

In care homes where staff told us they did not feel competent to complete an admission assessment, most managers also told us the staff did not receive training in oral health care. Others felt able to complete simpler forms of assessment in terms of daily mouth care needs, such as whether people wore dentures or not.

“There is no specific prompt for it on the admission assessment, although all other aspects of people's health and wellbeing were covered well in the assessment tool. There is a small prompt that asks, ‘Does the resident have their own teeth?’ on the pre-admission assessment, but that's all.” (Inspector)

“We use our own template but we do not really know what to look for.” (Member of staff)

Care planning

The NICE guideline stresses the importance of reviewing and updating people's oral care needs in their personal care plans to meet their changing needs. Of those care homes we visited, 70% said they included an oral health section in all, or mostly all, of their care plans, and 10% said that some people had an oral health section within their care plan. In the remaining 20% there was no indication at all how oral care should be delivered.

We also reviewed 291 care plans across the 100 care homes that we visited, which showed that:

- 27% of care plans fully covered oral health
- 63% of care plans partly covered oral health
- 10% of care plans did not cover oral health at all.

Care homes that cared for people with dementia were less likely to have an oral health section within care plans, with 19% of staff saying they did not cover oral health at all. This compares with only 5% for care homes that cared for people with learning disabilities.

The amount of detail included within care plans varied greatly between care homes, and sometimes varied between different people within the same care home. Some care plans were very basic and the only oral health information captured was whether someone had their own teeth or dentures.

“In this home, we found one or two of the care plans had an assessment but it was only partially complete. However, none of the other people had an assessment.” (Inspector)

Care plans often lacked details about a person's oral health preferences. Other care plans included a great amount of detail about:

- whether the person required support with their daily oral care and what this involved
- their dental check-ups and any changes to their daily oral care as a result
- their preferred time to receive oral care and which products they like to use.

We noted that detailed oral health plans could result from the care home using an electronic care management system, which populates personalised care plans from assessment records. In one care home, we found that each time a person's teeth or dentures were cleaned, the care staff recorded this electronically on a hand-held device which subsequently populated the person's daily care record.

The example below shows how homes with good planning and recording can respond to people's changing needs.

Experiences of care – good oral care adapts to a person's needs

Nancy is 81 and lives with dementia. She lives in a nursing home where she is fully supported with her personal needs.

When she started living at the home, she had all her own teeth, which were in good condition. She had always taken considerable care of her oral health and was very proud to have reached her age without the need for dentures.

This was recorded in her care plan, and care staff were directed to ensure her teeth were cleaned twice a day. Initially, staff were asked to remind Nancy to clean her own teeth, and to ensure she managed this for herself.

As her capacity and ability to take care of her own oral health has declined, staff have increased their role in keeping her teeth clean.

Nancy's son said, "It has been very difficult for our family to witness dementia take our mother's independence, memory and dignity. Positively, however, it has not taken her teeth, and given how important we know this is to her, we thank the staff at her nursing home for their help in securing this outcome."

Note: We have changed people's names.

Daily mouth care

The NICE guideline recommends that care homes ask people living in services how they usually manage their daily mouth care (for example, toothbrushing and type of toothbrush, removing and caring for dentures including partial dentures), and provide any support needed.

Teeth cleaning

People were supported to choose how they looked after their own oral health in some care homes and this promoted their independence. Most care homes encouraged twice-daily brushing and would share any associated health risks or even have notes on display to remind people to brush.

“I don’t need any help, but the staff ask me if I am alright and have my toothbrush.”
(Person living in a home)

We were also told about instances where people refused to have their teeth cleaned or to clean them themselves. Staff used strategies to encourage brushing, such as going back later, keeping a record of whether this was successful or not and referring the person to a dentist or GP if it continually happened. People we spoke to as part of our ongoing engagement activities told us other personal care was prioritised over teeth cleaning due to time pressures and the continued distress of the person. This was particularly the case in homes that cared for a high number of people with dementia.

“[We] don’t prioritise mouth care when all other personal care is difficult, and if [the person using the service] is non-compliant [the care staff] would prioritise other personal care.” (Member of staff)

A small number of care home staff told our inspectors that people were supported to clean their teeth daily, but when the inspector went into the person’s room the dental products showed no signs they had been used on the day of the visit. Some people living in a home told inspectors they had to remind staff to clean their teeth:

“[It has been] three days since [my teeth were] last cleaned.” (Person living in a home)

“My mum’s breath used to smell and it was because no-one helped her to clean her teeth. Since coming to a new home, I have noticed the change not only in her breath but in her whole self-esteem.” (Relative of a person living in a home)

Dentures

Care home managers told us that people with dentures usually had these cleaned once or twice a day – either in water or a denture cleaning product. A small number of care homes supported people to clean them as they prefer, or specified that dentures should be cleaned after meals. While most homes used a denture soaking pot kept in the person’s room, we found dentures stored in mugs, cups, drinking glasses and bowls.

“Normally [dentures are] soaked each night, but this can be based on individual preference, such as after meals.” (Member of staff)

A small number of staff said that they did not know how often dentures were cleaned because it was the responsibility of people living in the home themselves. However, the lack

of a documented oral health routine in some homes meant that staff sometimes did not check this was taking place.

“Staff told us that people with dentures had these removed and cleaned each day. However, we could not verify this as there were no records. One person who wore dentures told us that they were not cleaned daily as sometimes ‘staff forget or are too busy’.” (Inspector)

“Some staff take my dentures and put them in a pot. However, they will keep just running them under the tap. I have said they are too big for me now but I can’t do anything about it.” (Person living in a home)

Over half of the staff interviewed told us that people who wore dentures were helped to remove them at night time. Some people chose not to remove their dentures at night, or refused to allow staff to help them.

For people whose behaviour challenges the service, there is a danger that dentures may remain dirty for some considerable period. Although our fieldwork did not check the capacity of people to make decisions about their oral health care, through our ongoing engagement activities it became clear the lack of training on how mouth care can be delivered to people with cognitive impairment means that care staff are unsure how to deal with this situation.

This lack of awareness across care staff can affect people’s dignity and feeling of self-esteem, as illustrated in the example below.

Experiences of care – when oral care is not a priority, it can have a very negative effect on people’s dignity

Lucy had Alzheimer’s and died aged 89 having spent 18 months in a care home.

Throughout this period, staff needed to help Lucy take care of her teeth and dentures by encouraging her to brush her teeth regularly and by cleaning her dentures for her daily.

However, over time her family had to repeatedly encourage the staff to help her to maintain good oral health and to look after her dentures, which were lost on two occasions.

Generally, Lucy would not be wearing her dentures when a family member visited her. They would still be in her bedroom because the night staff who helped dress Lucy in the mornings would forget to ask her to wear them.

As Lucy’s dementia progressed, she began to not recognise her own reflection if she didn’t ‘have her teeth in’. The physical effect of so many missing teeth was to make her look much older and frailer, her cheeks sucked in and her lower jaw receding. She would look unhappy and never smile without her dentures in place.

In the last few months of Lucy's life, her family found it increasingly difficult to engage staff about oral health on her behalf.

Her son reflects, "It seemed to us that oral hygiene was completely neglected and just not a priority. It is hard to say exactly how this impacted upon Mum's emotional state as she found it difficult to communicate by this stage, but it made the family feel very sad to see her looking so unhappy, unhealthy and uncomfortable. We felt she was no longer being treated with dignity, kindness and respect."

Note: We have changed people's names.

Mouth care products

Care home managers told us that people living in the care homes we visited had access to a standard toothbrush, although in a small number of our visits our inspectors could not always see one in people's bathrooms. Availability of other products, such as denture cleaning tablets and adhesive, varied greatly. Some care homes explained that it was the responsibility of the person living in the home or their family to supply them since they were regarded as a toiletry item.

We found most dental products to be in good (66%) or fair (29%) condition, with the remaining 5% in poor condition. Toothbrushes were most often replaced when care home staff and carers decided they needed to be replaced, or when people or their families decided, if they were responsible. A few care homes had set criteria on replacing toothbrushes:

"[The] policy states after three months or when toothbrush bristles look splayed."
(Inspector)

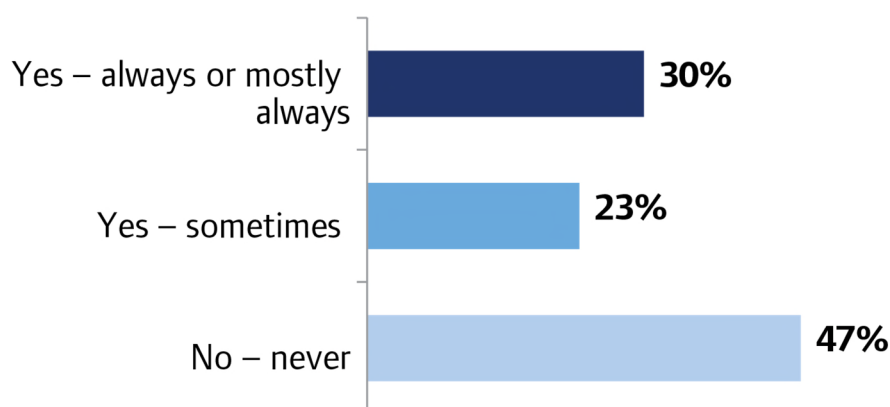
There were also some good examples of care homes that gave out a welcome pack or carried spare stock in case replacements did not arrive in time from families.

Supporting staff knowledge and skills

While the NICE guideline does not state oral health training is a requirement, it does recommend that care home managers ensure care staff who provide daily personal care know how and when to deliver daily mouth care, report any oral health concerns, and respond to a person's changing needs and circumstances.

One finding from our ongoing engagement activities was that oral care training was not seen as a priority. This was reflected in our visits, with nearly half (47%) of the care homes saying that staff do not receiving any specific training in oral health care (figure 4).

Figure 4: Do staff receive specific training in oral health care?



Source: CQC

Where training took place, it mostly covered how to care for teeth and dentures. Some included caring for other areas of the mouth, such as the lips, tongue and gums, as well as understanding the importance of good oral health and what problems can be caused by poor oral health.

There was a range of training methods and sources used, including from:

- the provider itself (such as sessions run by senior staff, online learning modules and shadowing more experienced staff)
- dentists and the community dental service
- the NHS (including local hospitals or NHS England)
- the clinical commissioning group, local authority or Public Health England
- external training companies.

Our inspectors saw the lack of detailed training as a barrier to implementing the NICE guideline.

“My findings showed that training was around consent rather than oral health care itself. When asked, staff did not seem competent and confident in offering support and encouragement with oral health care.” (Inspector)

“There is no ongoing training provided for oral care as it is not considered mandatory. [The care home] are looking at assessing competency as part of ongoing skills of staff. If issues are identified then more training would be provided.” (Inspector)

During our ongoing engagement activities, we were told that, where training was not provided, this was due to a lack of time, financial resource, or perceived priority. Also, current regulatory and contractual assessment frameworks do not necessarily promote such training to the sector as ‘mandatory’.

We were told that the lack of any learning requirement in the Care Certificate meant that other areas of care staff training were prioritised. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme.

2. How well are people who live in care homes supported to access oral healthcare services?

As well as aiming to maintain and improve the oral health of people in care homes, the NICE guideline also aims to ensure that they receive timely access to dental treatment.

The guideline makes recommendations for health and wellbeing boards to ensure local oral health services address the identified needs of people in care homes, including their need for treatment. They also recommend that dental practitioners provide people in care homes with routine or specialist preventive care and treatment as necessary, in line with local arrangements.

The work of health and wellbeing boards is out of scope of our review, but we were able to investigate how the needs of people were being met in care homes, and whether they reported receiving treatment from dentists.

Where people's needs were being met, care homes gave examples of dentists providing routine check-ups, ongoing treatment, and emergency care – both in and outside the care home. When this was discussed as part of our wider engagement, we were provided with examples of where dental practices had developed good relationships with care home staff through ongoing discussions about people's general state of health.

“All the people either go to [dentist A] or [dentist B] and they have a good relationship with the staff there. They are lucky to have this as it's a one stop for specialised mental health, dental, speech and language therapy and podiatry all in one clinic.” (Member of staff)

“They all go to the same dentist just along the road. They are all able to go to the dentist at the surgery which means they have kept their NHS places. They have check-ups every six months. I don't know what would happen if they could not get there due to mobility. But we would talk with the social worker or mental health nurse or consultant if we experienced any problems.” (Member of staff)

Good relationships between care home and dental care staff can have a positive impact on people's wellbeing.

“The staff let me know when I am going, and we talk a lot about what they will want me to do; look in my mouth, at my teeth, ask me if I have tooth ache, shine a light in my mouth (which is funny), play 'find the tooth' game.” (Person using the service)

However, this positive picture of dental provision was uncommon in the care homes we visited due to three main issues:

- People's dental care was not always reflected in their care plans and records.

- People found it difficult to access dental provision.
- People experienced barriers to receiving care, including accessibility and financial issues.

Issues with care plans and records

Care plans

We found that some care homes routinely asked for the details of a person’s dental practice for inclusion in their care plan, in the same way they would for a GP or chiropodist for example. Other care homes did not. It is standard for all care homes to ensure a person is registered with a GP when they are admitted – whether an existing or new one. Potentially, this is not the case for dental care. When homes fail to collect information about people’s registered dentists, this may not to be followed up until their oral health deteriorates to an extent that emergency treatment is needed.

“People are not routinely registered with a dentist, so the dental practice is contacted only when a someone has a problem or is in pain. None of the people living in the home routinely have check-ups. Two people told me they used to see the dentist every six months before being admitted to the home, but now don’t see a dentist at all.” (Inspector)

In one care home, staff told us that people would be registered with a dentist if they did not already have their own. But three people living there told us they had not been registered for routine care and had no dentist. We fed this back to the lead nurse.

Some care home managers told us they believed the responsibility for ensuring access to routine dental care rested with the person themselves or their family, and the home would not get involved.

“Mum’s regular dentist (before she moved in here) was upstairs and she couldn’t manage the stairs. [A dentist] did visit the home, but I believe he retired, and they haven’t been able to find another dentist to visit. I am trying to find Mum a new NHS dentist but it’s not easy.” (Relative of a person living in a home)

Access to dental care would improve if care homes actively involved people’s support network, such as families and friends, in planning dentist provision and routine check-ups.

The experience of Sam shows how important it is to listen to people’s families and others who know them. It also highlights the importance of having a consistent dentist who is known and trusted.

Experiences of care – oral care as part of a person’s overall care support and planning

Sam is 22 and has autism, learning disabilities and obsessive-compulsive disorder. He has behaviours that challenge and does not use verbal communication. He has lived in two care homes.

Sam's sister saw that his toothpaste was not being used and could see a build-up of plaque on his teeth. Staff didn't listen to her or seem to consider oral hygiene a priority.

Sam's dentist, who he had seen since age three, highlighted his "high levels of plaque... was starting to attack and weaken the tooth enamel" and that there was "no doubt that he will develop rampant decay and gum disease". Staff started to prompt him. His sister reflected that staff "seemed to listen to professionals more than family and people who know him best".

Sam moved to another residential home. Staff arranged and encouraged him to visit a new local dentist, but Sam refused three times. His sister repeatedly told staff that he wanted to go back to his original dentist as it was familiar. Finally, staff listened and arranged for him to continue to attend his original dentist, which he accepted. Sam's last visit to the dentist showed surprising improvement in his oral health. His sister believes if staff had listened sooner, issues with his oral health could have been prevented.

Note: We have changed people's names.

Care records

People's dental care and treatment was not well recorded. We would expect all dental care to be recorded in a person's care record, usually within its 'professional visits' section. There were some care homes where a member of staff told us they recorded such visits, but we could not find any evidence of this taking place.

A small number of care homes did not record visits at all. Others noted very little detail – for example a brief reference to say that someone had been taken to see a dentist but nothing about what happened or if there were any follow-up actions. Some entries were included in the same section of the care plan as podiatry, massage therapy, or hairdressing. Inconsistent recording meant that staff were unable to tell the inspector when someone last saw a dentist or whether any ongoing treatment was needed.

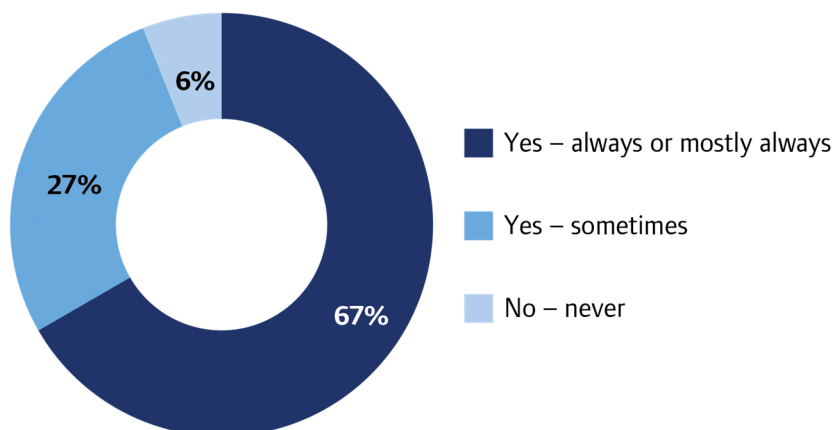
Where this lack of recording applied to when a person last had their dentures fitted, any change in their mouth shape could result in pain when they ate. People with significant cognitive impairment may be unable to express this, leading to weight loss. One care home told us of an example when they had clearly tracked weight loss to problems with teeth and dentures.

Issues with recording dental check-ups or treatment can mean that care home staff are unable to understand the oral health needs, treatment, and outcomes for people. This means that oral health care is not always given the same level of scrutiny as other aspects of personal care within the care home. This should be a fundamental part of person-centred care planning. It prevents a comprehensive picture of a person's health to be developed to help all professionals involved in their care. For example, a lack of information about someone's poor oral health may prevent staff from monitoring their eating and drinking, which could lead to tissue viability issues, such as pressure ulcers, resulting from malnutrition.

Issues with dental care provision

Two-thirds (67%) of the care homes that we visited said that the people who used their services could always, or mostly always, access NHS dental care. Of the remaining care homes, 27% said that the people who used their services could access NHS dental care sometimes and 6% said never.

Figure 5: Can people access NHS dental care routinely



Source: CQC

Domiciliary dental services

During our engagement for this review, people told us that one of the main challenges to people in a care home being able to access NHS dental care was a lack of dentists who were able or willing to visit care homes (to provide a domiciliary service). This means that people were not able to access routine NHS dental care.

“There are no dentists who provide domiciliary visits to people who cannot get out. Staff feel like this is a serious problem as many of the people living in the care home could do with this service.” (Member of staff)

The view from the external advisory group that supported this review, which included representatives from the dental and care home sectors, gave several reasons why dentists may be unwilling to visit care homes. One is a concern around infection control and lack of necessary equipment; another is the lack of financial re-imburement to dental practices following the changes to the General Dental Services contract in 2006.

While recognising that dental surgeries are the most suitable place to provide care, and particularly treatment, members of the advisory group thought that domiciliary care should be commissioned and targeted at a particular group of people who are physically unable to visit a dental surgery or who would be find it too distressing.

Domiciliary dental care is an important part of the care for this group of people. However, we were unable to determine whether the requests from care homes for this type of provision were always based on what was best for the person using the service, or just for convenience.

Availability of NHS dental provision

Other challenges that people living in care homes faced included local dentists not accepting new NHS patients and long waiting times to get an appointment with an NHS dentist or to get dentures fitted. We were told of waits of up to three months for a response to get a dental appointment.

Other people reported even longer waits for more complex dental treatment.

“One person waited a very prolonged amount of time to complete treatment (four extractions of lower molars). The dentist had prescribed a number of courses of antibiotics over the course of the 18 months it took to finally have the teeth extracted. The person was originally referred to community dental services, who were unable to help under sedation, and this was then referred to hospital for general anaesthetic.” (Inspector)

Using data from NHS England, we carried out analysis to see whether issues around availability of NHS dental provision could be explained because there were not enough practices close to the 100 care homes we visited. However, generally, there were a high number of surgeries near to the homes – each care home within our sample had an average (median) of 22 dental practices situated within a three-mile radius.

Emergency and out-of-hours NHS treatment

Ten per cent of the homes we visited told us they had no way of accessing emergency treatment for people living there. Another 14% reported they could ‘sometimes’ access emergency care. A worse picture emerged when we asked about the availability of dentists out of hours – 34% of homes told us they had no or only partial access to out-of-hours care.

Several care home staff indicated they would not know how to access emergency treatment, while others suggested that, since families are responsible for organising dental visits, they would have to arrange access to emergency NHS dental care themselves. This would likely result in people suffering with pain for several days until treatment was arranged.

Some care home managers told us they would call a GP or NHS 111, or even take the person requiring emergency care to A&E because it was the only option.

“No dentist would come to the home. During the site visit one person broke a tooth. The home tried to contact over 10 dental services – in the end the person was taken to A&E on the GP’s advice.” (Inspector)

A recent article, using British Journal of General Practice data, highlighted that almost 400,000 people consult a GP because of dental problems each year, because people struggle to get fast access to dentistry.¹⁰ In the article, Dr Steve Mowle, Honorary Treasurer of the Royal College of General Practitioners, said it was “essential” for people to understand where to turn to with dental problems in order to “ensure scant NHS resources are used most effectively.” While the article does not detail the exact number of

appointments used by people living in the care environment, it points to a systematic failure within the system.

The issues around a lack of NHS resourcing and funding, as well as cost efficiency of NHS dentists treating people living in care homes, was also raised by our advisory group. We used NHS England data to see how the availability of resources might affect the people living in the 100 care homes we inspected. Our analysis indicated that there may be excess capacity in the dental system that could be targeted towards vulnerable patient groups, including those living in care homes.

Other barriers to people receiving oral care

Accessibility and transport

Some people were not able to visit a dental practice due to the physical practicalities of transport, the accessibility of the dental surgery premises, or getting onto the dentist's chair. These issues could be increased if people had cognitive difficulties.

“Access to NHS care is difficult to organise due to dentists refusing to come in to the home and the subsequent problems of transporting a person with significant cognitive impairment to a dental surgery and the distress this would cause.”
(Member of staff)

“There were no routine dental visits taking place at all. The challenge around this was completely based on access. The home had contacted several local dentists in the past and had been unable to secure any routine visits. Some appointments were offered at the dental surgeries but the fact the people had significant levels of dementia meant this was impractical.” (Inspector)

Care home managers said that there was also a real financial issue in providing transport for people to visit the dentist, as usually two members staff would have to accompany them. We were told that care homes simply could not afford to take two members of the care team away from the care environment as well as pay for transport.

Complex needs

Care homes told us that treating people living with complex conditions can be perceived as too difficult for some dentists and that they might lack an understanding of people's needs.

“There is a limited understanding by the dental practice of people's needs and how quickly things can change, such as appointments being missed because the person has changed their mind – we cannot force them to go! Unfortunately, the dental practice will threaten to strike people off due to this, and it can be frustrating when it can't be helped.” (Member of staff)

This lack of understanding of how to provide dental care to people who are living with dementia or who have a learning disability or autism, for example, also applied to private dental care.

“Staff told me no one at the care home was signed up for private dental care and doubted any private dentist would be able to cope with them given the complexity of their needs.” (Inspector)

Participants in our engagement activities told us that dentists’ lack of awareness of people’s complex needs was also because their regular appointments stopped on entering a care home. Some felt an ongoing dialogue over the best way to provide either routine check-ups or treatment would help the care home and the dental surgery to meet people’s needs. This would also include discussions around consent and best interests in line with the Mental Capacity Act, though this was not specifically examined by our inspectors.

It should be acknowledged that enabling independence and choice of dental care also enables people to refuse care, if they do not see it as a priority.

“Some people just refuse outright to go to the dentist. One person I spoke with told me she had seen a dentist all her life and simply couldn’t be bothered now as she only had a few teeth left.” (Inspector)

Financial barriers

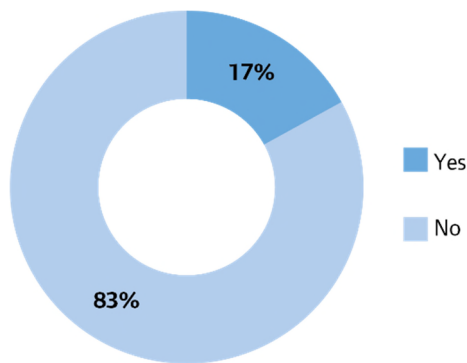
Another barrier to receiving NHS dental care was a worry among people and their families about the costs.

We were told during engagement activities that many people and their families had believed NHS dental care was free for all people living in care homes. Once some people found out a cost was involved they stopped routine check-ups or even treatment. This could partly be explained through the lack of staff awareness, with only 64% of care home managers saying that senior staff were aware if people in the care home were eligible for free NHS dental care. Awareness was higher in care homes that care for people with learning disabilities (89%). However, there were some instances across all care homes where staff had told the inspector they understood the eligibility criteria, but their knowledge was incorrect.

Reasons why senior staff were not aware of eligibility included financial information being kept separate for personal reasons, and difficulties in confirming eligibility or organising finances and paperwork with the person’s funding authority.

Poor awareness about eligibility was exacerbated by problems in recording. Only 17% of care homes we visited said that they included information about a person’s eligibility for free NHS dental care in their care record (figure 6).

Figure 6: Is information about eligibility for free NHS dental care included in people's care records?



Source: CQC

Very few people accessed private dental care. Generally, people could choose their dental service and most chose the NHS dental service.

The main issue that prevented access to private dental care was affordability, since people's perception was they could not afford to pay a premium for private dental care, especially when they can receive NHS dental care at a reduced cost or for free.

"Two people said that they were previously registered as private patients, but cancelled before moving into the home as they could no longer afford it. Both wanted to see an NHS dentist, however did not know how to find one, had not registered, and did not mention this to staff. Neither of these people had seen a dentist since being in this home (one for over one year and the other for over four years)." (Inspector)

Conclusions and recommendations for action

Our findings show that too many people living in care homes are not being supported to maintain and improve their oral health. Three years on from the publication of the NICE guideline, oral health in care homes is still not a priority. Positive change across England can only happen by different parts of the health and care system coming together to improve oral health care to enhance the quality of life of people in care homes. The areas most in need of improvement are:

1. People who use services, their families and carers need to be made more aware of the importance of oral care.
2. Care home services need to make awareness and implementation of NICE guideline NG48 a priority.
3. Care home staff need better training in oral care.
4. The dental profession needs improved guidance on how to treat people in care homes.
5. Dental provision and commissioning needs to improve to meet the needs of people in care homes.
6. NICE guideline NG48 needs to be used more in regulatory and commissioning assessments.

1. Awareness of oral care by the public, people who use services, and their families and carers

Our work indicates that once people enter a care home, it is common for them to stop receiving routine check-ups and paying attention to their overall oral health.

We recognise that people's support networks, such as friends and relatives, can play an important part in ensuring their day-to-day care and routine needs can be met. For many recent topics, national awareness raising initiatives have brought about large-scale change and public awareness. A notable example is that of STOMP (Stopping over medication of people with a learning disability, autism or both) – a multi-agency initiative launched in 2016 that has successfully changed people's thinking.

We recommend that a multi-agency group, including care providers, is convened to significantly raise awareness among people living in care homes and their families and carers of the importance of day-to-day dental hygiene and routine check-ups. This should focus on preventing a deterioration in oral health by encouraging people to look after their own teeth and to challenge care providers to support them with this as part of their care package.

2. Awareness and implementation of NICE guideline ‘Oral health for adults in care homes’ (NG48)

We recommend that care home providers should:

- Make the NICE guideline (NG48) the primary standard for planning, documenting and delivering oral care.
- Re-frame day-to-day oral hygiene to be of equal priority to other personal care tasks. Care home staff will need to be supported effectively through adequate training and time to achieve this.
- Assess people’s oral health and their ongoing day-to-day oral hygiene needs when they enter the home. We recommend that the person’s support network, including family and carers, is included as part of this planning if the person receiving care wants them to be.
- Make sure oral hygiene is a fundamental part of person-centred planning and that each person living in the care home has a comprehensive oral health care plan. This plan should be informed by the person’s initial assessment and reviewed every six to 12 months in line with other sections of the care plan. The care plan should clearly identify the person’s dentist or practice and should list a schedule of routine check-ups, clearly recording the outcome from each.
- Make sure that each care plan shows whether people are exempt from NHS dental charges. Where they are not, we would expect the care home to have discussed and documented within the care plan people’s ability to afford routine check-ups and treatment. This would allow the care home and the person’s family or carer to understand and plan for any associated dental costs.
- Routinely check the state of people’s oral health when they experience weight loss that cannot be explained through ill-health or other ongoing conditions. This should be carried out by a suitably qualified dental professional and should include an assessment of the fit of dentures.
- Establish an ‘oral health champion’ within their portfolio of staff roles and responsibilities. The champion would work to promote the implementation of the NICE guideline, act as a conduit between the home and dental professionals, and ensure people have the right products in the right condition to assist with day-to-day care. A key element of this role would be to work with people and their families and carers to ensure all aspects of care is planned in line with their preferences and, in cases where people lack capacity, to make their own decisions, in their best interests.

3. Training for care home staff

CQC and social care commissioners (both clinical commissioning groups and local authorities), through their contract monitoring and quality frameworks, do not routinely check whether care home staff have received specific training in oral care and dental hygiene. This means that care homes rarely prioritise it as ‘mandatory’.

We recommend that local social care commissioners introduce the need for oral health training as part of their assessment frameworks.

As a fundamental we recommend that all care home staff are routinely trained in the basics of daily mouth care. We were told that the omission of oral health within the Care Certificate was also a major factor in the low prioritisation of oral health training.

We recommend that Skills for Care, Health Education England, and Skills for Health introduce a mandatory oral health component in the next iteration of the Care Certificate qualification, to include the impact of poor oral health on general health and associated diseases.

4. Guidance for the dental profession

We recommend that all dental providers make sure they are clear about their NHS and private charges and make every effort to assist care homes in making applications for exemption from charges. This could be linked to a national awareness raising campaign.

We recommend that Health Education England updates and re-issues guidance for the training of dental professionals on how to provide care within care homes, particularly in relation to:

- People with complex conditions and cognitive impairment, including issues of consent, and those who may have had a previous negative experience of dentistry.
- The frequency of routine examinations for those living in care homes.
- The most appropriate setting and appropriate dental care professional to deliver routine and urgent treatment, based on people's individual needs.

5. Dental provision and commissioning

We recommend that NHS England and local commissioners:

- Work with the care home sector to avoid lengthy waiting times for appointments and treatment and provide emergency appointment times.
- Work with GP practices and other primary care contractors, such as community pharmacists, to establish local arrangements to signpost people to dental provision.
- Provide adequate capacity to provide routine and emergency treatment to people in care homes. This should be linked to a clear measurable outcome around avoidance of GP appointments and A&E attendances resulting from dental crises.

We recommend that NHS England works with other bodies, such as Public Health England and Healthwatch to develop accessible information for the public and care home staff to signpost them to what NHS services are available to them for routine and urgent dental care in the local area. This guidance should also be explicit about the associated charging and exemption structures.

We recommend that NHS England reviews how the domiciliary dental care pathway is provided to vulnerable groups, particularly for those living in care homes. While it is generally understood that better care and treatment can be provided in a clinical setting, there is a need for dental care in people's own homes, including when that is a care home.

For example, people may have access issues that stop them visiting a dental surgery, or they may find it too stressful if they are living with advanced dementia. Domiciliary dental care, therefore, should be targeted to those who would benefit the most, rather than being a universal provision for all.

We recommend that NHS England considers a more local and responsive approach to dental commissioning, given the inclusion of oral health in care homes within the NHS Long Term Plan:

“We will upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH [enhanced health in care homes] model rolled out across the whole country over the coming decade as staffing and funding grows. This will ensure stronger links between primary care networks and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support. As part of this, we will ensure that individuals are supported to have good oral health, stay well hydrated and well-nourished and that they are supported by therapists and other professionals in rehabilitating when they have been unwell.”

(NHS Long Term Plan 2019, Section 1.15)

We recommend that commissioners should recognise the opportunities for a more diversified workforce – for example, make available hygienists, therapists and dental nurses to provide services for people living in care homes.

We recommend that NHS England explores how the developing primary care networks and local dental networks can work with NHS dental services to develop services that meet the needs of vulnerable groups and address health inequalities for those living in care homes.

This would require a multi-disciplinary approach including GPs, dentists, dental hygienists, community nursing and peripatetic visiting, as part of an overall package of support to people.

6. Assessment of NICE guideline NG48

Currently most social care commissioners do not assess awareness of and implementation of NICE guideline NG48. Consequently, there is no routine check if there are specific oral health assessment and care plans in place for people living in care homes.

We recommend that local social care contractual monitoring and quality frameworks include awareness and implementation of NG48 as part of their assessment of the overall quality of care.

We recommend that CQC, as the regulator, reviews and clarifies how oral health care should be part of the monitoring and inspection of care homes.

We recommend that the Regulation of Dental Services Programme Board, chaired by CQC, continues to work collaboratively towards a shared view of quality in relation to the awareness of the NICE guideline, oral health training, and commissioning of services.

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