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**Feasibility of Implementing Oral Health Guidelines in Residential Care Settings: Views of
Nursing Staff and Residential Care Workers**

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Highlights

- Staff in aged care settings lack access to oral care products and equipment.
- Residents with dysphagia or dementia are at risk of not receiving regular oral care.
- Family members asked to provide oral care products may not agree to do this.
- What is recommended for oral care is often not implemented in aged care settings.
- Residential care workers need training and policy support for providing oral care.

Abstract

Purpose: To determine the views of residential care nurses and carers on the feasibility of implementing current evidence-based guidelines for oral care, examining barriers and facilitators to implementation.

Results: This mixed-methods study involved an online survey of 35 nurses and residential care workers, verified and expanded upon by one focus group of six residential aged care workers.

Results reflected that nurses and residential care workers (a) have little or no training in recommended oral care techniques, and (b) lack access to the equipment and professional supports needed to provide adequate oral care. Basic oral care might be performed less than once per day in some settings and patients with problematic behaviours, swallowing difficulties, or sensitivities associated with poor oral health might be less likely to receive oral care. While lack of time was highlighted as a barrier in the survey findings, focus group respondents considered that time should not be a barrier to prioritising oral care practices on a daily basis in residential care settings.

Conclusion: There are several important discrepancies between the recommendations made in evidence-based guidelines for oral care and the implementation of such practices in residential aged care settings. Nursing and residential care staff considered adequate oral care to be feasible if access, funding and training barriers are removed and facilitators enhanced.

Background

Oral Health in Older People in Residential Care

Good oral health and hygiene are essential in maintaining good overall health, and contributing factors in quality of life (Petersen, 2008). Good oral health contributes to clear speech and communication, improved respiratory health, meeting nutritional needs, and overall sense of wellbeing (Health Canada, 2009; South Australia Dental Service & Consortium Members SADSCM, 2009), and requires active involvement of nursing staff in oral care provision to each resident (Salamone et al., 2013). Conversely, poor oral health can impair swallowing, increase the risk of ill health, and reduce quality of life (Kuyama, Sun, & Yamamoto, 2010; Ortega et al., 2014; Pace & McCullough, 2010; Terpenning et al., 2005).

Risk factors for poor oral health. Older people, particularly those with chronic disabling health conditions living in residential care settings, are at risk for poor oral health due to the presence of multiple risk factors (Brady et al., 2011; SADSCM, 2009). They may have a range of co-morbidities associated with disabling health conditions (e.g., stroke, motor neurone disease, Parkinson's, dementia, cerebral palsy), resulting in the dynamic interaction of multiple causal factors for poor oral health (e.g. dysphagia or difficulty swallowing, poor respiratory health, multiple medications, poor dentition). Further, medications taken by residents may decrease saliva flow, causing xerostomia, and increasing risk of tooth decay (SADSCM, 2009). Dentition is also important to consider in relation to maintenance of good oral health. The number of older persons retaining natural teeth for longer has increased, however remaining teeth are often severely broken down, covered by bridges or crowns, or have large fillings, demanding more extensive care than dentures (Roberts-Thomson & Do, 2007; SADSCM, 2009). According to Roberts-Thomson & Do (2007), 6% of Australians aged 75-years or greater with some natural teeth have moderate to severe gum disease.

Consequences of poor oral health. Poor oral health is associated with chronic and systemic infection, cardiovascular disease, cerebrovascular disease, bacteraemia, and aspiration pneumonia

(SADSCM, 2009; Terpenning, 2005). Poor oral health can also negatively impact general health and quality of life, including: reduced respiratory health, lessened ability to eat, poorer nutritional status, pain, weight loss, bleeding gums, tooth decay or loss, halitosis, negative impacts on appearance, decreased self-esteem, reduced social interaction, and discomfort (Brennan et al., 2010; SADSCM, 2009). Inadequate denture cleaning can result in denture plaque, a dense layer of microorganisms on denture surfaces and consequently, denture stomatitis, an oral mucosa lesion characterised by inflammation and reddening (Gendreau & Loewy, 2011) and a potential cause of aspiration pneumonia (de Souza et al., 2009). Poor oral health and oral hygiene practices increase risk for aspiration of infectious or pooled pharyngeal secretions and bacteria (Kuyama et al., 2010) with related serious health consequences.

Being dependent on others for oral care. The high incidence of chronic disabling health conditions in people in residential care setting results in increased risk factors for dysphagia, poor oral health and aspiration pneumonia (Australian Institute of Health and Welfare AIHW, 2012). Functional limitations related to impairments associated with these conditions often result in this population requiring high levels of support from others with feeding and daily oral care (Brady et al., 2011), with up to 70.4% of residents in long-term care have a medium to high level of dependence for activities of daily living (AIHW, 2012). Reliance upon others to maintain a clean mouth and presence of dysphagia impact oral health considerably (Brady et al., 2011). Challa (2006) reported that 29% of American nursing home residents sampled who were dependent on others for activities of daily living had oral health problems, and were 1.5 times more likely to exhibit oral health problems than residents who were independent for oral care. Thus, residents in long-term residential care, especially those with dysphagia who are dependent on others for oral care, are a particularly vulnerable group (Brady et al., 2011).

Oral Health Recommendations and Practices

There is growing support in the literature for oral hygiene interventions improving oral health in residents with, or at risk of, aspiration pneumonia (Bassim et al., 2008; Pace &

McCullough, 2010; SADSCM, 2009; Van der Maarel-Wierink et al., 2013). Recommended interventions include the following: (a) brushing of teeth and oral cavity with toothbrush (b) brushing dentures (c) soaking or disinfecting dentures (d) antimicrobial cleansing of the oral cavity (e) use of toothpaste, (f) professional oral care, (g) lip and oral cavity moisturising; (h) suction, and (i) flossing or interdental cleaners. However, recommendations vary across studies and clinical guideline documents. For example, denture cleaning is recommended after each meal by Watando et al. (2004), but only once daily by Carman et al. (2011) and Singapore Ministry of Health (2004). In recognition of the importance of oral care, a range of clinical guidelines have been developed for nursing staff to guide their practice across several settings. Current recommendations for oral care (e.g. Carman et al., 2011; Singapore Ministry of Health, 2004; SADSCM, 2009) uniformly emphasise the importance of tooth brushing, toothpaste use, brushing dentures, soaking dentures, antimicrobial cleansing of the oral cavity, and professional oral health care. Table 1 summarises practice guidelines for a standard protective oral hygiene regimen, formulated using an amalgamation of existing guidelines and study conclusions or recommendations. While the guidelines are built upon theoretical foundations and a growing body of evidence, there is little in the literature relating to their feasibility of implementation in residential care settings.

Insert Table 1 about here

Understanding the factors affecting the implementation of oral care from the perspective of nurses and other residential care staff is vital to removing barriers and increasing facilitators to improve oral care for residents in long-term care settings. This information would inform care policies, help guide speech pathologists in their design of recommendations and instructions for residential care staff in dysphagia management, and would be pertinent to the training of care staff in the conduct of oral care. Thus, the aims of the present study were to determine the views and experiences of nurses and care staff in residential care settings in relation to: (a) implementing best practice oral care guidelines with residents of long-term care settings who have chronic disabling

health conditions; and (b) the barriers and facilitators to the implementation of common oral care practices included in clinical guidelines.

Method

This mixed method study comprised an online survey of nurses and nursing assistants and one focus group of six nursing assistant residential care staff in a long-term residential care setting. The study was ethically approved by the Human Research Ethics Committee of the University of Newcastle, Australia.

Design and Delivery of the Online Survey

Current best practice guidelines and recommendations regarding oral care in residential care settings were reviewed to determine the range of evidence-based practices relating to oral care, to inform survey questions. The survey was designed to gather respondents' views on these guidelines/recommendations, the feasibility of their implementation in clinical practice, and barriers and facilitators to oral care in long term residential care settings. A link to the survey was posted from the second author's Twitter handle inviting nurses to participate. The survey consisted of 27 questions in six major sections: 1) demographic information and professional experience in relation to oral care, 2) tooth brushing, 3) denture cleaning, 4) oral care products (e.g. mouthwash, toothpaste, suction, flossing), 5) professional oral care and service support, and 6) oral care policies. The survey utilised a combination of multiple-choice, rating of agreement or frequency on a Likert scale, and open-ended questions, with opportunities to comment on categorical responses. The survey made available to the public online on 12th June 2014, and closed on 30th July 2014. Survey results were analysed descriptively and thematic content analysis of written comments made in response to open-ended questions.

Conduct of the Focus Group

The survey findings informed the focus group questions (Krueger & Casey, 2009) which were: (1) 'Tell us about your current role in relation to 'oral care' in this setting and previous settings you have worked'; (2) 'How often is tooth brushing implemented *ideally* and *actually*?'; (3)

‘What is the usual method for cleaning dentures and how often, *ideally* versus *actually*, for the people you care for? What about denture soaking?’ (4) ‘What are your views on the use of products – mouthwash, high fluoride toothpaste, suction, and flossing, and usual practice here?’ (5) ‘How often do people have access to professionals for oral care, and what are your views on this?’ (6) ‘What are your views on staff training in oral care?’ and (7) ‘Tell me about any policies in oral care at this setting?’ Focus group participants were recruited through the manager of one large aged care residential care facility in Australia. The focus group comprised six care workers, most of whom were enrolled nurses, with recent experience providing oral care to residents. The group was moderated by the first and second authors, and held at the residential care facility. The one-hour focus group was audiotaped and videotaped for later verbatim transcription, de-identification, and verification of speaker turns and analysis by the authors. A two-page summary of the focus group findings was emailed to all participants, to check accuracy and verify that the summary reflected their views. No participants suggested any changes or alterations to the summary.

Participants

Survey. In total, 45 nursing or nursing assistant workers with experience providing oral care to long-term care residents commenced the online survey. Ten surveys were excluded as they did not meet the criteria for inclusion ($n = 2$), provided no demographic information ($n = 1$), or only provided demographic information ($n = 7$). Therefore, only 35 surveys were included in the study. Of these, the majority were from respondents within Australia ($n = 30$), with the remainder from the United Kingdom ($n = 3$), Canada ($n = 1$) or the United States of America ($n = 1$). Most respondents identified as being registered nurses ($n = 21$) or undertaking direct support work as carers ($n = 25$), in aged care settings ($n = 24$) supervisors or managers ($n = 3$). Characteristics of survey respondents are included in detail in Tables 2 to 5 outlining years of experience, age, qualifications, and populations cared for in their work.

Insert Tables 2-5 about here

Focus group. Six nursing staff in the same residential care setting, with experience providing oral care to long-term care residents dependent on others for the provision of oral care, took part in the one-hour focus group. Table 6 outlines characteristics of focus group participants.

Insert Table 6 about here

Results

In reporting of survey results, S and the number of the survey will indicate the survey respondent (e.g. S1, S2) and 'P' will be used to represent 'focus group participant' and his or her number (e.g. P1, P2). To reduce repetition across the results, findings are reported first for surveys, then for the focus group including content themes and verification or elaboration upon the survey results.

Views on Frequency of Oral Care Methods, Products, and Professional Support

Tooth brushing. Of 35 survey respondents, 8 considered that residents should ideally have their teeth brushed after each meal, 15 'at least twice daily', 11 'twice daily', and only one 'once daily'. Low frequency of tooth brushing was reflected in the written comments, as S11 wrote: "I have known residents to go weeks without having their oral care attended to" and S8 wrote "every two days". Two respondents (S11, S31) commented that the frequency with which residents could *actually* receive tooth brushing was dependent on the staff delivering oral care, and only one (S25) that the frequency of oral care was dependent upon the individual patient. Written comments reflected respondents' concerns regarding the implementation of oral care, with five noting it to be "generally inadequate". While the focus group agreed that tooth brushing should be completed twice daily, participants also considered that this was not possible routinely. Tooth brushing was most completed less than once daily, as P5 estimated: "Ideally, twice a day. Actually, probably once a week for some of them", and P3 concurred and said: "Yes, most of them..." P2 acknowledged that the frequency varied widely across residents: "Once daily, yes, but I'd imagine there'd be ones that, you know, just, don't get tooth brushing".

Denture cleaning. Overall, survey respondents considered that the best method of denture cleaning was 'brushing of dentures with denture or toothbrush, without toothpaste', followed by

‘brushing dentures with denture or toothbrush and toothpaste’. Furthermore, 18 of 28 respondents (64.3%) indicated that they considered residents should ideally have their dentures cleaned twice per day. Almost one-third of respondents considered that three methods of cleaning dentures could actually be implemented ‘at the most once daily’: brushing dentures with a denture brush or toothbrush (i.e., no toothpaste) ($n = 13$ or 50%), brushing dentures with mild soap and/or water ($n = 10$ or 43.5%), and brushing dentures with toothpaste ($n = 12$ or 52.2%); with the remainder of respondents considering that these methods were possible less than once per day. With regard to the soaking of dentures, respondents supported the use of both soaking in denture cleaning solution and soaking in cold water as denture cleaning methods. The majority of respondents considered the use of denture cleaning solution to be the best method of denture cleaning (77.8%), but some considered cold water to be the best method ($n = 13$ or 54.1%). Focus group participants agreed that dentures should ideally be cleaned once to twice daily; however, in practice, this was usually completed once daily “at bed time” (P2) and be soaked overnight in denture cleaning solution. However, P2 and P3 agreed that dentures were not always removed for cleaning: “...we do have cases where they’re left in” (P2) and “We’ve had lots of cases” (P3). Also, dentures were more typically soaked in water due to several barriers to accessing proper materials and residents or relatives failing to provide the product for soaking. As P3 said: “Nine times out of ten, it’s just in water”. The discussion also reflected the group’s concerns about dentures being ill fitting or becoming loose upon cleaning.

Oral care products. One-third of the 24 survey respondents considered it was possible to use ‘antimicrobial or antiseptic cleansing of the oral cavity (including rinse and/or gel forms)’ twice daily, and almost one-third considered it possible less than once daily. A minority of respondents reported use of these products to be possible: once daily ($n = 5$), three times a day ($n = 2$), and more than three times a day ($n = 2$). Although Chlorhexidine 0.12% solution (or products containing it, such as Peridex or Hibiclens) is the recommended antimicrobial oral cleansing agent (see Table 1) 14 of the 19 responses (73.7%) considered that using Chlorhexidine was not possible even once

daily. Use of high fluoride toothpaste was viewed more favourably by 18 (78.3%) of the 23 respondents. The vast majority of the 23 respondents who answered ($n = 20$) considered lip and oral cavity moistening to be possible at least twice or three times daily. The practice of suctioning was not common, with the majority ($n = 13$) of the 23 survey respondents indicating it could occur less than once daily. Only 6 of the 23 respondents reported that flossing or use of interdental cleaners could occur once per day, and the majority ($n = 11$ or 47.8%) indicated this could be implemented less than once daily. One respondent who had worked as a nurse for 15 years (S13), wrote of flossing: “I haven’t seen it done once”.

There was consensus in the focus group that oral care for residents is typically limited to tooth brushing and denture cleaning, and that the majority of residents only have a toothbrush and toothpaste supplied by the facility. Unless the resident or a family member provided other products (e.g. Sterident, mouthwash), these were not typically used. Flossing was generally not attempted, and group members did not see this as a feasible practice, with P4 commenting, “Sometimes it’s hard to even get a toothbrush in their mouth, let alone floss”. Suctioning was viewed as being used for respiratory care (e.g. removal of phlegm) rather than oral care, as suction was considered too intrusive. Participants agreed that residents typically have lip balm, but oral cavity moistening was not used consistently. Although the group agreed that lip and oral cavity moistening should be provided more than once daily, this was only possibly done after a meal once per day.

Professional oral health care. Survey respondents ($N = 23$) indicated that consultation for a resident with a dentist occurred either once a year ($n = 10$, or 43.5%); once every 2 years ($n = 3$ or 13%); or ‘never’ occurred ($n = 8$ or 34.8%). One respondent (S28) wrote, “Dentist not keen to come to nursing home”, and another, “County town with limited local service; family members are left mostly to make appointments for dentist” (S31). Similarly, dental hygienists and dental nurses were rarely consulted, as 15 of the 22 (68.2%) respondents reported that they ‘never’ consulted these professionals. However, four respondents (16.7%) reported that they would consult a nursing

specialist about oral care ‘at least daily’. The focus group participants agreed on a need for more regular on-site professional dental care: “That’s what we need here regularly” (P3).

Content Themes in Findings Across Survey and Focus Group Results

Tables 6 provides a summary of the focus group themes, and Tables 7 and 8 outline the focus group themes and provide example quotations from both survey and focus group participants in relation to barriers and facilitators to oral care guideline implementation respectively.

Insert Tables 7, 8, 9 about here.

Access to Oral Care Equipment and Products and Professionals

Findings across both the survey ($n = 16$) and the focus group reflected that staff lacked access to (a) equipment (e.g. toothbrushes, kidney bowls), (b) products (e.g. mouthwash, high fluoride toothpaste, suction, flossing, oral cavity and lip moistening), and (c) oral care professionals (e.g. dentists, dental hygienists). Written comments on the survey reflected that families of residents were asked to fund the provision of non-standard oral products (e.g., gel and rinse forms of antimicrobial or antiseptic mouthwash such as Chlorhexidine solution, lip and oral cavity moistening, and flossing) and funds and consent for visiting dental or oral hygiene services. Respondents viewed lack of access to equipment, products, and professional consultation impeded oral care, and that “more availability of products” (S21), and “good supply of correct equipment available” (S21) would improve matters. The focus group findings reflected this in that residents were typically provided with a toothbrush and toothpaste, and the resident or family were asked to cover the costs of any additional oral care products. Products such as mouthwash and denture cleaning solution were not commonly available, as P5 stated, “some family members refuse to pay for it, so [their dentures] just soak in water”. The discussion reflected that this resulted in many residents missing out on appropriate oral care. As P1 stated: “I think, if the product was supplied, I think you’d try, and the nurses would try... would do the right thing”.

Focus group participants agreed that although a dentist visited their facility once every three months, there was a need for more regular on-site professional dental care, as P3 stated, “Why don’t

we have dental care that comes out once a week?” Furthermore, consultation was impeded if (a) staff did not notice a referral for professional oral care was needed, or (b) family did not give consent for this cost to be incurred to the resident. P5 stated, “They (family) have to approve what we have noticed. And once again, it comes down to family members, and whether or not they want to”. Indeed, the group discussion reflected that owing to costs and the need for agreement from family, residents did not receive adequate professional oral care, and rarely if ever saw a dental hygienist. The focus group agreed that family participation and support is a facilitator to oral care provision and that, therefore, increased support from families is needed, including financial support. P4 commented,

For us to provide better oral care, the families have got to sort of step in... and help us, not be against us all the time. They go, ‘Oh, we can’t afford this, I’m not going to pay’. They always whinge about how much their chemist bill is all the time, and I think well hang on, it’s your mother, you’ve got to give her the best that you can.

Resident factors: Dentition, behaviour, dependence, and dysphagia.

Dentition. Four written comments on the survey reflected that the condition of a resident’s teeth was a barrier to providing effective oral care, including natural teeth being loose or broken, accumulating and trapping bacteria, food and other substances. Focus group participants considered that oral care for those with dentures was easier, in that the dentures could be removed, and that those with dentures typically receive more dental care. P1 described two residents thus: “She’s got nothing at the front and there’s nothing you could do about it. Her teeth are slowly rotting and going on the sides. So what do you do?”, and “There was a lady down there this morning...that her tooth just dropped off ...”.

Behaviour and participation in oral care. Residents’ poor behaviour, non-compliance, or lack of participation with oral care was also considered a significant barrier to delivering oral care, particularly in residents with stroke or dementia (e.g., unable to or refusing to open their mouths or become physically aggressive in order to avoid the oral care). The struggle to conduct oral care in

the context of these behaviours was illustrated in one respondent's detailed comment: "Usually, it is a struggle to get them to open their mouth, let alone clean everything adequately. They also bite down on, or try to eat brushes or swabs, refuse point blankly, or swallow toothpaste. Will not let staff remove their dentures." (S8)

Written survey comments also reflected that residents being unable to participate or assist in their own oral care made implementing oral care, particularly tooth brushing, more difficult: "More dependent residents are difficult to provide oral care for" (S14) and, "Dexterity of resident to help with tasks" S31). There was some reluctance to implement oral care in residents with either dementia or dysphagia, particularly in relation to avoiding use of toothpaste or water for rinsing, for fear of residents swallowing and aspirating the water and toothpaste. Respondents' comments reflected that resident cooperation and participation in the process (e.g., holding the toothbrush) facilitated oral care. Some respondents stressed the need for "good behaviour management" (S22) when providing oral care. Findings of the survey were affirmed by focus group, particularly in regards to flossing of teeth, as P4 commented: "Because sometimes it's hard to even get a toothbrush in their mouth, let alone floss", and P6 said: "I don't even know how you'd even be able to floss their teeth really". When encountering resident non-compliance, staff did not persist, as P4 stated: "And the residents as well, if they won't let you get their dentures out, you just, well, "ok"... [acts out backing away]". The focus group agreed that if residents are being noncompliant, staff might cease efforts to complete oral care, without implementing strategies to improve compliance with oral care.

Presence of dysphagia. Dysphagia was also noted as a barrier to oral care particularly in relation to staff concerns over residents inappropriately swallowing oral care products and rinses. P6 stated, "There's people... can't have thin fluids so they can't swallow the water too... so that's a bit hard". Staff were reticent to expose residents with dysphagia to the risk of aspirating water in the process of mouth rinsing, and so avoided oral care altogether.

Staff Behaviours

Survey respondents viewed inadequate staffing and high staff to resident ratios as barriers to the provision of *all* oral care practices. As one wrote: “Staffing restrictions mean that carers have little time for the essentials such as showering, feeding, toileting” (S26). This comment reflected that oral care may not always be seen as an essential aspect of care, and might be a lower priority. Overall, there was insufficient time available to provide each resident with adequate oral care, with one respondent writing: “Time wise it is difficult, as to do this properly you would need extra amount of time and for every resident” (S14). Respondents explained that with the number of tasks that must be completed in each shift, little time remains for intimate personal care. Respondents noted that designating specific staff the role of oral care (a “role specific task” (S41) might facilitate the delivery of adequate oral care, particularly tooth brushing, to all residents, “so it takes the pressure off” (S19). Survey respondents ($n = 11$ or 33.3%) also considered that additional nursing staff would improve standards of personal care, including oral care, for each resident. Survey respondents indicated negative attitude or lack of effort in staff to be a barrier for oral care provision for all specific oral care practices considered, with the exception of suction. Several survey respondents described this as staff being “lazy” or “laziness” (S5, S21, S23, S29, S31), e.g. with the comment “Some staff are lazy and don’t bother with it” (S5). Survey responses also reflected that staff considered oral care was a “low priority” (S9), and “not seen as a necessity” (S39). One respondent commented, “Oral care is down the bottom of tasks to attend” (S26). As a result, it often goes “unnoticed and unprioritised” (S11). Survey respondents suggested that this may relate to gaps in staff knowledge, including failing to see oral care as an “area of importance” (S20). S9 highlighted the ‘unpleasant’ nature of oral care and the ‘impact on resident health’, writing: “I think there is a lot of ‘yuk’ factor with oral care. I think carers do it for dying patients more than as a day to day thing for all”. This result indicates that lack of time might not be the only barrier to residents obtaining oral care, but that the task might require additional effort, particularly if difficult or unpleasant.

In contrast to survey results outlining lack of time as a barrier to oral care, there was strong consensus in the focus group that lack of time is not a *valid* barrier to the provision of oral care. Indeed, lack of time was considered to be an “excuse” (P2) and the result of poor attitude and “staff laziness” (P3). This supported the notion put forward in the survey that some staff might not want to put in the effort required to conduct adequate oral care regularly. Participants also agreed that lack of time might rather reflect negative attitudes towards conducting oral care or else it not being a priority. P3 stated:

I really don't understand the time barrier cleaning their teeth, because how hard is it when they get up in the morning, you know, while we're making their bed, the capable ones, they clean their teeth, or even if they are bed-bathing, someone's washing them and the other one's cleaning their teeth. I don't understand the time barrier. To me there is no time barrier (P3).

It was suggested that although staff needed to make time and prioritise oral care, more staff being on duty could ease time pressures for all aspects of oral care. Participants were also judgemental in regards to the level of oral care that some residents received, as staff provide more extensive oral care than others. As P5 stated, “And it does depend on the nurses as well... You get some shocking nurses that only do a half-arsed job”.

Organisational Issues

Staff training. Of 25 survey respondents, only 12 (or almost 50%) indicated that they had received any training in oral care, either through training in the workplace ($n = 4$ or 16%) or during their initial nursing training ($n = 3$ or 12%). One nurse noted that: “upon starting my job we got a booklet about oral hygiene” (S29). The participants in the focus group described having basic skills training in oral care at the very beginning of their nursing careers, but none had received recent oral care training. As reflected in the survey, only one focus group participant (P2) reported having had onsite education or training in oral care. S31 was moved to write at some length on the topic:

The amount of poorly trained staff put on the floor to deal with a large amount of residents makes it impossible to spend too much time off the floor in individual bathrooms to deal with constant oral care. Staff are left to their own devices most of the time, and do not complete these essential and simple things to provide comfort for the resident. (S31)

Survey respondents emphasised the need for mandatory education for all staff, encompassing: the importance of oral care, instructions for proper oral care, and demonstrations of oral care techniques as facilitators to effective oral care. One respondent suggested that “easy read leaflets; videos to demonstrate techniques; gold standard training... delivered by dental hygienist” (S45) would also improve the provision of oral care. Another (S21) suggested that education should also encompass strategies for managing and overcoming resident noncompliance with oral care. P3 suggested, to agreement from the group, that compulsory periodic oral care training and audits, where competency would expire and must be renewed every three years, similar to a first aid certificate. Focus group participants agreed that education would raise awareness and increase the ability of staff to identify and manage oral health issues, as many oral health problems go unnoticed. Participants suggested that the onsite speech pathologist, registered nurses, or higher level nursing staff would be good candidates for providing education to staff and indeed residents, as P2 stated, “I think the actual residents themselves, could do with some, not an education, but a ‘it’s your right to have them brushed’ – don’t let the nurse leave”.

Organisational Systems and Policies

Policies supporting regular oral care. In total, seven (31.8%) respondents said that their workplace did not have an oral care policy, and four (18.2%) indicated that they did not know of any policy. Specifically, respondents considered that their workplace required: ‘Cleaning of teeth with toothbrush twice daily’ (n = 12 or 54.5%), ‘each time teeth are brushed, also clean other areas of oral cavity with toothbrush, including for patients with dentures’ (n = 12 or 54.5%), ‘brush dentures with denture or toothbrush at least once daily’ (n = 15 or 68.2%), ‘remove dentures at night and soak overnight’ (n = 13 or 59.1%), and ‘moisturising of lips and oral cavity after oral

care' (n = 12 or 54.5%). However, participants considered that their workplace did not specifically require: 'clean teeth using high fluoride toothpaste' (n = 14 or 63.6%), 'use antimicrobial or antiseptic oral cleansing rinse or gel twice daily' (n = 15 or 68.2%), 'weekly professional oral health or dental care' (n = 16 or 72.7%), 'suction given with oral care' (n = 16 or 72.7%), and 'daily flossing' (n = 17 or 77.3%). Written comments did not explain whether a policy was not needed because these practices were routine (e.g., using high fluoride toothpaste) or exceptional (e.g., suctioning). However, the survey findings reflected a policy gap in relation to oral care routines. One respondent wrote: "No policy for procedures for oral care accessible for care staff; oral care audits are supposed to be conducted three-monthly by Registered Nurse but aren't" (S31). Respondents highlighted the need for written documentation or orders for oral care for each resident, to facilitate the provision of oral care in long-term residential care settings.

Focus group participants also were not aware of any specific policies relating to oral care at their work setting. They agreed that toothbrushes and toothpaste were to be replaced every month; however, there was no system in place for staff to adequately monitor whose oral care equipment had been replaced and when it was replaced. Current lack of organisational systems with regard to the labelling of toothbrushes and dentures was also a problem in relation to infection control. Nursing staff reported that if toothbrushes are not properly labelled, staff may avoid oral care for fear of using the wrong toothbrush and any cross-contamination that might result. Participants suggested that a checklist in relation to the provision and replacement of oral care equipment, along with a daily oral care plan with residents being supported to participate in their own oral care, might aid in removing these systemic barriers to oral care. The focus group emphasized the importance of having a set daily oral care plan in facilitating the provision of oral care but seemed disappointed that this might be necessary: "We shouldn't need to do a checklist though, you should just know that that's your job" (P5). However, implementing an oral care plan would be beneficial, but not sufficient, to instigate substantial change and there might be staff-related barriers to implementing this: "...if you want to add it to the routine, you get a lot of headaches there... with the staff" (P2).

Discussion

Implementation of Recommended Oral Care: Problems in Translation to Practice

The results of this research indicate that nurses' and residential care workers' understanding of best oral care practices was similar to that outlined in the literature and in current oral care clinical guidelines (Bassim et al., 2008; Pace & McCullough, 2010; SADSCM, 2009; Van der Maarel-Wierink et al., 2013). However, the results highlight substantial 'knowledge to practice' gaps in what nursing staff consider *should* be enacted in routine care and what was *actually* implemented in everyday care. This 'knowledge translation' gap in all aspects of oral care investigated in this study is concerning for all involved in providing care in long-term care settings, given (a) the harmful adverse events associated with poor oral care (Brennan et al., 2010; SADSCM, 2009; Terpenning, 2005); and (b) the growing evidence indicating they could be prevented by a range of simple interventions (Pace & McCullough, 2010; SADSCM, 2009; Van der Maarel-Wierink et al., 2013).

That the recommended twice-daily tooth brushing and daily brushing of dentures (e.g., Carman et al., 2011; Pace & McCullough, 2010) and soaking of dentures overnight in denture cleaning solution (e.g., Sarin et al., 2008) was not routine practice poses a risk to residents' oral health. Making the responsibility of funding for oral care products that of distant family members risks lack of support for basic care, particularly if family members are also not aware of the dangers of poor oral health to their family members in long term residential care settings.

The results of this study suggest that residents might have better access to lip balm than oral cavity moistening in long term residential care settings, and very little exposure to flossing (Carman et al., 2011; Pace & McCullough, 2010; Sarin et al., 2008) or suctioning (Bassim et al., 2008; Sarin et al., 2008) with oral care. Given the concerns outlined by participants in this study regarding dysphagia and potential aspiration of oral care products, the use of suctioning is important in preventing the negative health outcomes associated with aspiration. Indeed, the results of this study suggest that rather than use suctioning to reduce the risk of swallowing mouth rinsing materials or

oral care products, nurses might simply avoid providing oral care. The barriers to oral care raised in this study are important in designing interventions to prevent the harmful outcomes of poor oral care, such as aspiration pneumonia. It is vital to remove existing barriers and embrace facilitators to oral care, in order to improve oral care for those in long term residential care settings, and hence, reduce the negative impacts of poor oral health.

Consulting oral care professionals. Findings regarding access to professional oral or dental care reflected a substantial gap in relation to the implementation of recommended practices. Given the high level of vulnerability of the residential care population, professional oral care is recommended weekly (Van der Maarel-Wierink et al., 2013). However, nurses in this study reported that professional dental care providers (including dentists, dental hygienists and dental nurses) were rarely, if ever, consulted. In considering the difficulties experienced by nursing staff in providing oral care to residents with their own dentition or poorly fitted dentures, professional oral care may be particularly useful in helping staff overcome barriers to tooth brushing and denture cleaning. Reliance upon family members to approve funding for oral care professionals might mean that residents and family members who withhold approval for funding are contributing to the increased risk of poor health arising from poor oral care.

Implications for Service Providers: Better Access to Equipment and Oral Care Products

Participants in this study reported lacking access to needed equipment and products for the provision of adequate oral care. The vast majority of oral care guidelines and recommendations require other oral care products or equipment in addition to toothbrush and toothpaste (e.g. Bassim et al., 2008; Carman et al., 2011; Pace & McCullough, 2010; Sarin et al., 2008; Singapore Ministry of Health, 2004; Sørensen et al., 2013; SADSCM, 2009). Therefore, funding and resources should be re-examined in order to allow facilities improved access to the equipment necessary to adequately provide oral care. The finding that dysphagia is considered a barrier to oral care, along with suctioning rarely being used, is an area of particular concern, given the presence of dysphagia is common in long term residential care populations and is a risk factor for poor oral health and

development of aspiration pneumonia (Ortega et al., 2014). The finding that dysphagia is considered a barrier to oral care, along with suctioning rarely being used, is an area of particular concern, given the presence of dysphagia as a risk factor for poor oral health and development of aspiration pneumonia (Ortega et al., 2014). In effect, it may be that those residents most vulnerable to poor health arising from high risk are the least likely to receive appropriate oral care practices.

Implications for Staff, Resident and Family Education and Training in Oral Care

The results of this study indicate that lack of staff education and training, along with resident noncompliance with oral care, were viewed as barriers to routine oral care practices and education and resident compliance viewed as facilitators. Participants were enthusiastic about improving staff education concerning oral care, and proposed regular compulsory oral care training. There is support in the literature for staff education for oral care as an intervention to improve oral health (Brady et al., 2011; Sørensen et al., 2013). It is possible that the compulsory periodic oral care training suggested by nurses in this study, would provide an opportunity for staff to increase confidence and competence in implementing oral care in difficult resident populations such as dysphagia or dementia. Results reflecting the view of some staff being 'lazy' in relation to conducting oral care, show that negative attitudes and a strong rationale for the increased effort in oral care may need to be addressed in training. The finding that residents themselves might benefit from education on their right to good oral care is an important finding, as resident or patient education was recommended by Singapore Ministry of Health (2004). Given that families are asked to fund oral care products and consultation with adequately trained oral care professionals, educating families on the importance of oral care and consequences of poor oral health may also help them in making informed decisions in relation to the decision to provide funding or consent for interventions.

Implications for Policy in Long Term Residential Care Facilities

The results of this study suggest that long term residential care facilities lack policies on oral care that sufficiently guide education of staff or quality management of oral care practices. Oral

care policies must acknowledge and best address the apparent barriers and facilitators to the implementation of oral care in clinical practice in order to effect change in current oral care practices. Although time was highlighted in the survey as one of the most common barriers to the provision of oral care, focus group participants did not view lack of time as a valid reason for not providing routine oral care. The development of a systematic auditing tool in relation to the provision of oral care may facilitate and support oral care policy enforcement and monitoring.

Limitations and Directions for Future Research

This small study involved an online convenience sample of only 35 respondents, most of whom were Australian, and 6 nurses in one focus group. The small sample size for the survey limited statistical analysis to descriptive statistics. While the focus group was not designed to represent the survey respondents' profile, only one member of the focus group was a registered nurse. With the exception of findings regarding 'time' being seen as a barrier to oral care, focus group results aligned well with the survey results, increasing confidence in the findings. However, further insights might have been gained had more focus groups been conducted including staff from other sites and nurses with higher levels of qualification. As such, the findings might not reflect the views of all nurses or direct support workers providing care and support to older people in long term residential care settings and the results should be interpreted with caution. Further research is needed to determine whether good oral care might save time in care or be more efficiently delivered if some of the other barriers (e.g., access to dental professionals, access to products and equipment) are removed. An *observational* study of current oral health practices in long term residential care settings would serve to verify and expand upon the results of this research, and may uncover further barriers to and facilitators for better oral care. It would also be important to examine the extent of the problem regarding oral care by investigating other long-term care facilities and other settings (e.g. rehabilitation settings, acute care). The survey and focus group results could inform revisions to the survey instrument for use in large groups and over periods of time, to track changes in practices as interventions to improve care are instigated. Furthermore, an important direction for

future research would be to examine the impact of increasing facilitators and removing barriers to oral care on residents and nursing staff.

Conclusion

This study provides rich detail on specific aspects of oral care that nurses and residential carers implement in long term residential care settings, and apparent inadequacy of current oral care practices in relation to recommended practices in clinical guidelines. The results support the notion that nursing and residential care staff have a reasonable understanding of recommended practices, however this knowledge is not being translated into routine practice owing to many systemic barriers to equipment and lack of policy support. A number of barriers to implementing oral care best practice routine oral care were identified. The alignment of the online survey and focus group results suggests that problems implementing oral care, particularly in patients with dysphagia, behavioural difficulties associated with dementia, poor dentition or loose dentures, or poor oral health conditions might be a common problem that needs to be urgently addressed. Interventions to help move the current evidence-based recommendations for oral care into clinical practice are needed. Findings of this study have implications for future oral care policy development, and training of nursing and residential care staff caring for older people with chronic disabling health conditions.

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Table 1

Evidence-based and Best Practice Guidelines for Standard Protective Oral Hygiene Practices

Area	Recommendation	Source or Clinical Guidelines
Tooth brushing	Soft toothbrush	Pear et al., 2010; Sarin et al., 2008; Singapore Ministry of Health, 2004; SADCM, 2009.
	Electric toothbrush	Pace & McCullough, 2010; Sarin et al., 2008.
	Unspecified / other toothbrush	Bassim et al., 2008; Carman et al., 2011; Sørensen et al., 2013; Van der Maarel-Wierink et al., 2013; Watando et al., 2004;
	Including other areas of oral cavity (gums, tongue, etc.) - including edentulous patients	Bassim et al., 2008; Carman et al., 2011.; Pace & McCullough, 2010; Pear et al., 2010; Sarin et al., 2008; SADCM, 2009; Watando et al., 2004;
	Twice daily	Carman et al., 2011; Pace & McCullough, 2010; Sarin et al., 2008; SADCM, 2009.
	At least twice daily	Pear et al., 2010; Singapore Ministry of Health, 2004
	After each meal	Van der Maarel-Wierink et al., 2013; Watando et al., 2004
Denture Cleaning	Brush dentures (denture/tooth brush)	Carman et al., 2011; Pace & McCullough, 2010; Sarin et al., 2008; Singapore Ministry of Health, 2004; SADCM, 2009; Watando et al., 2004
	Mild soap and/or water with brushing	Sarin et al., 2008; Singapore Ministry of Health, 2004; SADCM, 2009.
	Toothpaste	Carman, Davies, Dziubek, Sim, Tensen, & Wilson, 2011; Singapore, Ministry of Health, 2004.
	After each meal	Watando et al., 2004.
	Twice daily	SADCM, 2009.
	Once daily	Carman et al., 2011; Singapore Ministry of Health, 2004; Van der Maarel-Wierink et al., 2013.
	Soak in cold water overnight	Singapore Ministry of Health, 2004; SADCM, 2009.
	Soak in denture cleaning solution overnight	Sarin et al., 2008; Singapore Ministry of Health, 2004.
	Disinfect weekly	SADCM, 2009; Watando et al., 2004.
	Unspecified cleaning methods	Bassim et al., 2008; De Souza et al., 2009.
Antibacterial/ antimicrobial/ antiseptic cleansing	Daily	SADCM, 2009.
	Twice daily / every 12 hours	Singapore Ministry of Health, 2004; Sørensen et al., 2013.
	After meals	Carman et al., 2011
	Chlorhexidine (0.12%) rinse or gel	Pace & McCullough, 2010; Sarin et al., 2008; Singapore Ministry of Health, 2004; Sørensen et al., 2013; SADCM, 2009.
	Dilute hydrogen peroxide	Bassim et al., 2008.
Toothpaste	Unspecified type	Carman et al., 2011; Pear et al., 2010.
	(High) Fluoride (or toothpaste	Carman et al., 2011; Sarin et al., 2008;

	containing additives for mucus and biofilm breakdown)	Singapore Ministry of Health, 2004; SADCM, 2009.
	Toothpaste mentioned	Pear et al., 2010.
Professional Oral Health / Dental Care	Weekly	Van der Maarel-Wierink et al., 2013; Watando et al., 2004
Lip	At least every 6 months	Carman et al., 2011
Moisturising (water-based)	'Frequently'	SADCM, 2009.
Moistening	After oral care	Sarin et al., 2008.
Oral Cavity	At least every 2 hours	Pear et al., 2010.
Suction	At least every 2 hours	Pear et al., 2010.
Flossing / interdental cleaners / WaterPik	Unspecified time	Sørensen et al., 2013.
	Once per day	Bassim et al., 2008; Sarin et al., 2008.
		Carman et al., 2011; Pace & McCullough, 2010; Sarin et al., 2008.

Table 2

Survey Respondent Current Occupation (n = 35)

Occupation	<i>n</i>
Registered Nurse	21
Assistant (e.g. Direct Support Worker, Personal Care Attendant, Paid Carer)	8
Endorsed Enrolled Nurse	2
Enrolled Nurse	1
Care Manager	1
Health Informatics Manager (RN)	1
Clinical Nurse Specialist of Nephrology	1

Table 3

Type of Facility In Which Survey Respondents Undertake the Majority of Their Work

Facility	<i>n</i>
Nursing Home (Aged Care), Skilled Nursing Facility, Care Home, etc.	23
Nursing Home (Aged Care), Skilled Nursing Facility, Care Home, etc. AND Rehabilitation Centre	1
Rehabilitation Centre	1
Large Residential Setting (Not Aged Care)	2
Respite Care	0
Group Home	0
Other (Community Nurse, Hospital, Outpatients, Acute or Subacute)	8

Table 4

Number of Years of Survey Respondents' Work in Current Occupation and Experience in Providing Oral Care to Patients/Residents

	<i>Number of Years of Work in Current Occupation</i>	<i>Number of Years of Experience in Providing Oral Care to Patients/Residents (N = 35)</i>
<1 – 5yrs	18	15
6 – 10yrs	5	10
11 – 15yrs	4	1
16 – 20yrs	4	3
21 – 25yrs	0	1
≥26yrs	3	2
Not answered	1	

Table 5

Health Conditions in Residents Cared for by Survey Respondents in the past 12 months

Health condition	<i>n</i>
Adults with dementia	32
Stroke	31
Cancer	30
Developmental Disability	21
Lack of Consciousness	19
Intellectual Disability	18
Traumatic Brain Injury	13
Motor Neuron Disease	12
Cerebral Palsy	10
Ventilator dependent	8
Autism	7
Physical Trauma to Oral or Laryngeal Structures	6
Anaesthesia	6
Locked in Syndrome	1
dysphagia of unspecified cause	1

Table 6

Age, Years of Experience, and Qualification of Focus Group Participants

Participant number (code)	Age	Number of years experience	Qualification
Participant 1 (P1)	45 years	Declined	Declined
Participant 2 (P2)	37 years	12 years	Certificate IV
Participant 3 (P3)	39 years	8 years	Certificate III Dementia specialist training Palliative care specialist training Studying Certificate IV
Participant 4 (P4)	47 years	7 years	Certificate III Studying Certificate IV
Participant 5 (P5)	44 years	3 years	Certificate IV
Participant 6 (P6)	47 years	11 years	Certificate III

Table 7

Focus Group Content Themes

Theme	Barriers	Facilitators
Access Issues	Lack of equipment / products; Lack of funding for adequate oral care; Lack of family support for oral care	Adequate equipment / products, Family participation/ support, Family willing to pay for services, provide products/equipment
Resident factors	Resident having fixed teeth; Resident having loose dentures; Resident behaviours; Resident dependency/ participation; Resident having dysphagia	Resident compliance, Resident being able to participate in their own oral care (self care abilities); Educating residents on their rights
Staff factors	Oral care is viewed as a low priority; Lack of time; Negative attitude of staff	
Organisational factors	Inadequate staffing; Lack of staff education / training; Systemic errors; Lack of oral care policy education / enforcement	Increased staff; Increased time Specific staff designated responsibility of oral care Staff education / training , Improved organisational systems, Written documentation / orders for each resident, Policy implementation / set oral care program as part of routine

Table 8

Quotations Illustrating Barrier Content Themes in Survey and Focus Group

Barrier	Survey Example(s)	Focus Group Example(s)
Lack of equipment / products	“Lack of resources/equipment at our facility”	“...because the family members supply the Sterident... Some family members refuse to pay for it, so [their dentures] just soak in water. We supply toothbrush and toothpaste”
Lack of family support and funding	“Whether the [family member] is willing to pay for it” “Money”	“And it all comes down to the family member if they want [the resident to see the dentist], because it’s coming out of their pocket”
Resident having fixed teeth	“...loose, broken teeth trapping food”	“I think the ones that have got dentures get more dental, like oral care, than the one’s that don’t have dentures”
Resident having poorly fitting dentures	N/A	“How many people have ill-fitting dentures!... Every third resident that’s lost weight, and unless they’re gluing [dentures] in, there’s nobody coming to adjust or anything”
Resident behaviours/ dependency/ participation	“Resistance by aggressive and confused residents” “More dependent residents are difficult to provide oral care for”	“Some residents... don’t, won’t allow you to [deliver oral care]. And you can’t get in [their mouth]. It’s hard. Even they’ll clamp their mouth shut and say, ‘nup, you’re not getting them out’... And they fight you”
Resident having dysphagia	“Concerns regarding aspiration, water, need to spit out contents”	“Cause there’s people... that can’t have thin fluids so they can’t swallow the water too, so that’s a bit...”
Inadequate staffing	“Staffing restrictions mean that carers have little time for the essentials such as showering, feeding, toileting”	N/A
Oral care is viewed as a low priority	“Oral care is down the bottom of tasks to attend” “It is not an ‘obvious’ care need and can go unnoticed and unprioritised”	“It’s just ignored!”

Lack of time	<p>“Time wise it is difficult, as to do this properly you would need extra amount of time and for every resident”</p> <p>“Time limitations when delivering intimate personal care”</p>	<p>Counter view: Time is not a valid barrier</p> <p>“I really don’t understand the time barrier cleaning their teeth, because how hard it is when they get up in the morning, you know, while we’re making their bed, the capable one’s, they clean their teeth, or even if they are bed-bathing, someone’s washing them and the other one’s cleaning their teeth”</p> <p>“You make time”</p>
Negative attitude of staff	<p>“Some staff are lazy and don’t bother with it”</p> <p>“Staff dedication to task”</p>	<p>“[it is] an attitude”</p> <p>“It’s just laziness”</p>
Lack of staff education / training	<p>“Staff not being trained properly in the clinical importance of oral care and its impacts on other areas of residents’ health care”</p>	<p>“education ... it’s not just about brushing their teeth, it’s identifying problems within their mouth, you know, like a lot of thrush goes unidentified, dry mouth, split lips.... So many things... But the staff aren’t really trained to identify and look for those”</p>
Systemic errors	<p>“The amount of poorly trained staff put on the floor to deal with a large amount of residents makes it impossible... Staff are left to their own devices most of the time, and do not complete these essential and simple things”</p>	<p>“Other people’s teeth get put in other people’s mouths”</p>
Lack of oral care policy education / enforcement	<p>“No policy for procedures for oral care accessible for care staff; oral care audits are supposed to be conducted three-monthly by registered nurses but aren’t”</p>	<p>“There is an oral or dental program that’s been sitting downstairs for three years in a box!”</p>

Table 9

Quotations Illustrating Facilitator Content Themes in Survey and Focus Group

Facilitator	Survey Example(s)	Focus Group Example(s)
Adequate equipment / products	“Good supply of correct equipment available, e.g. denture brushes, denture containers, tooth brushes and toothpaste, kidney bowls, etc.”	“I think, if the product was supplied, I think you’d try, and the nurses would try... with education would do the right thing. You might get the odd one that can be bothered and just...” “Have better equipment... more equipment”
Family participation/ support	N/A	“For us to provide better oral care, the families have got to sort of step in and say, ‘yes’... and help us, not be against us all the time. They go ‘Oh well, we can’t afford this, I’m not going to pay’. They always whinge about how much their chemist bill is all the time” “Supply the stuff that we might need”
Resident compliance	“Good behaviour management” “Patient Compliance”	N/A
Resident being able to participate in their own oral care (self care abilities)	“Asking them to help clean their teeth if possible”	“Encourage the able-bodied ones”
Increased staff	“Extra staff to produce better standard of personal care for every resident”	“More staff”
Increased time	“More time ratio to each patient” “More time for personal care for each resident”	N/A
Specific staff designated responsibility of oral care	“Staff specifically designated to oral care” “Perhaps a designated oral care AIN so it takes the pressure off the care AINs. The oral hygiene AIN could perform other tasks in between if there were time”	N/A

Staff education / training	<p>“Education for all staff on the importance of and instructions on proper mouth care”</p> <p>“Education on strategies [for noncompliance]”</p>	<p>“[staff education/training] might not solve the problem, but would create awareness, so that ‘time’ thing... people won’t leave that room and would stop and go, “oh, I could brush their teeth”. You know... if you study feet, you’re observant of people’s feet, if you’re studying their mouth, then you’re looking in their mouth”</p> <p>“Staff could benefit from learning some different procedures... how to prompt them”</p>
Educating residents on their rights	N/A	<p>“I think the actual residents themselves, could do with some, not an education, but an ‘it’s your right to have them brushed’ – don’t let the nurse leave...”</p> <p>“But you can see it every day you know... the little old ladies trying to get into the bathroom after each meal to brush their teeth, because they see the staff zipping around like no one’s really got time. And so they won’t ask”</p>
Improved organisational systems	<p>“Clear guidelines”</p> <p>“A routine of when mouth cares should be attended”</p>	<p>“What about an actual checklist of each resident and so you can actually go through and tick off saying yes, ‘such-and-such’, has had their toothpaste or toothbrush replaced, so we know who’s had it...”</p> <p>“See if you had a checklist, you could put ‘so-and-so’ has got a red toothbrush...”</p>
Written documentation / orders for each resident	<p>“Oral care plan as a section in each resident’s care plan, e.g. specific needs of the resident”</p> <p>“To have it clearly included in... care plans and on monitoring / observation forms”</p>	<p>“That’d be good!”</p> <p>“Yes!”</p>
Policy implementation / set oral care program as part of routine	<p>“A regular routine for everyone”</p> <p>“Care plans to remind staff regarding oral care”</p>	<p>“Enforce the policy... enforce it”</p>