Royal Commission into Aged Care Quality and Safety

Statement of Kathleen Ann Matthews

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Date of birth:	Known to the Royal Commission
Address:	**Known to the Royal Commission**
Date:	17/03/2020

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

   The views I express in this statement are my own based on my education, training and experience and represent the views of The Australian Dental Association, NSW.

Professional background

I am currently employed as a senior dentist and clinical lead, Wagga Wagga cluster at Murrumbidgee Local Health District (NSW Health). I have been in this role since 07/09/2011. I am a general dentist with a Bachelor of Dental Surgery from the University of Sydney and a Graduate Certificate in Clinical Education. I have worked as a community-based dentist in regional NSW since 1989, both as an employed dentist (public and private) and as a dental practice owner from 1995-2009. I have been an ADA NSW member since 1987, ADA NSW Board member 2014-present and currently serve as the President of ADA NSW.

Prior to working at the Wagga Wagga Base Hospital Dental clinic, I worked for myself as a dental practice owner at Peter St Dental Practice.

2. Provide an overview of the Australian Dental Association – NSW branch, including its membership profile.

The Australian Dental Association NSW branch (ADA NSW)

ADA NSW is the peak body representing the dentistry profession in NSW and the ACT. Our mission is to advance dentistry to improve the health of every Australian. Our membership comprises 70% of dentists and 79% of dental specialists. Our purpose is to have the best dentists in the world in a nation with the best oral health (OH). We are proud of our legacy of advancing dentistry since 1929 and we are honoured to represent a profession that aims to improve the health of every Australian.

Dental and oral health care needs of older Australians

Signature		Witness	

3. Outline the dental and oral health care needs of Australians accessing aged care services, and the implications for dental and oral health care service provision. Consider both older Australians who receive aged care in their homes and older Australians in residential aged care.

Older Australians have been identified as a priority population group by the NSW Ministry of Health.[1] As the number of older Australians continues to rise, so does the number of natural teeth that they maintain. This results in a significant amount of unmet OH need as they become more frail and less able to maintain good OH for themselves and become reliant on others for daily OH care. At this stage of frailty, OH most often undergoes a rapid decline due to deficient oral hygiene practices, changes in diet to softer and often more decay-causing foods and decreased saliva production as a result of medication side-effects, dehydration and the ageing process. This rapid decline occurs similarly in older Australians receiving aged care services in the community as well as those in residential aged care facilities (RACF).

4. Comment on the adequacy of dental and oral health care services for Australians receiving aged care services in the community and any barriers to accessing services. In your response, consider addressing the following:

The inadequacy of access to dental and oral health services:

a. Oral health assessment

Oral health assessments by a registered dental professional must form the basis of all oral care service provision by informing prevention and early intervention, daily OH care needs and ongoing professional management. Currently there is no requirement for or funding of professional OH assessments except for those older Australians who are eligible for OH services through the public system. This leaves a large gap between those who are not eligible for public services but still cannot afford to access private dental care.

b. Prevention and early intervention

This is currently almost non-existent because OH assessments are not routinely conducted. Without OH assessments that lead to preventive and early intervention measures being embedded as a requirement within the Aged Care quality Standards[2] and being supported with adequate funding that allows carers to assist with daily oral hygiene practices this cannot be improved.

[1] NSW Ministry of Health. Oral Health 2020: A strategic framework for dental health in NSW. Sydney: NSW Ministry of Health. 2013

[2] Aged Care Quality Standards (1 January 2020). https://www.agedcarequality.gov.au/providers/standards

c. Daily oral health care needs

The interim report of the Royal Commission into Aged Quality and Safety[3] has highlighted that in the majority of cases this basic right is not being met. Aged care providers in the community must be mandated to meet oral care standards. This would best be included as a mandatory requirement under Standard 3, Requirement 3b. *Personal Care and Clinical Care*, where oral care would be identified as one of the high prevalence risks associated with the care of consumers (page 65).[4]

d. Dental and oral health care treatments from low intervention to high intervention

The type of dental and OH care treatments currently provided are dependent on identification of treatment need, access and barriers to treatment provision and factors specific to individuals such as ability to be transported to OH clinics, ability to cope with treatment and medical co-morbidities. As independence reduces and frailty increases, the likelihood that treatment needs are met decreases. For example, as cognitive levels decline and where routine oral care is neglected, medically-necessary OH care needs may go unnoticed. The importance of regular, routine OH assessments by registered dental practitioners with appropriate management when indicated, cannot be emphasized enough in addressing the unmet needs that currently exist.

5. Comment on the adequacy of dental and oral health care services for Australians in residential aged care services and any barriers to accessing services. In your response, consider addressing the following:

Research shows that the OH status of the elderly receiving either home-care or residential aged care services is equally poor.[5] When reviewing the data, however, it shows that of those living in RACF, whilst having similar DMFT (decayed, missing, filled teeth index) rates, the severity of their disease is greater (more untreated decay and missing teeth) than their community-dwelling counterparts.[6] This results from the inadequacy of access to dental and OH care services for Australians in RACF being even more pronounced than in the community for all types of care from OH assessments (a) through to treatment (d). Without the mandated provision of suitable resources for OH care services within RACF, there is simply no impetus for this often unnoticed and unmet need to be addressed.

[3] Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect. October 2019. https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

[4] Aged Care Quality Standards (1 January 2020). https://www.agedcarequality.gov.au/providers/standards

[5] Chalmers J. Geriatric Oral Health Issues in Australia. Int Dent J 2001. 51:188-99.

[6] *Ibid*.

Roles, responsibilities and capabilities

6. Outline what you believe the dental and oral health care roles should be for the following groups in respect of older Australians living in residential aged care and those who receive aged care in their homes, including consideration of location of service provision and frequency of service:

   a) personal care workers – Perform daily routine oral hygiene procedures including toothbrushing and denture cleaning. Assess for any obvious oral abnormalities or pain. Ensure regular OH assessments by a registered dental practitioner are arranged and undertaken.

   b) registered nurses – Monitor that oral hygiene procedures are being performed. Facilitate referrals for OH assessment.

   c) Dentists and d) other dental professions – The registered dental practitioners work cooperatively in a team. The practitioners who carry out the various types of OH services will depend on several factors including location, availability of practitioners etc. Models of care and utilization of the different practitioner types to the top of their scopes of practice will determine these roles.

7. Outline what you believe the necessary dental and oral health training needs are for the following groups in respect of older Australians living in residential aged care and those who receive aged care in their homes:

   a) personal care workers and b) registered nurses – The Better Oral Health in Residential Care[7] (BOHRC) training package is the most appropriate model for training and is available for immediate use. Training for these two categories of staff must be mandated.

   c) dentists and d) other dental professions – University training programs must be supported to maintain and broaden the experience of dental practitioners in the aged care sector. The professional associations have a role in the ongoing continuing professional development of their members.

8. Outline the types of equipment and facilities that would be required at a residential aged care facility to best meet the care needs of residents in light of your answer to item 6 above.

   In order to provide flipped treatment that comes to the resident and avoids them having to be transported to an OH service, RACF must be required to provide a suitable area for all types of OH care service provision, ranging from daily oral hygiene routines to OH assessments and treatment. These requirements are not onerous. Portable dental equipment is available to facilitate all treatment requirements.

[7] Better oral health in residential care model. https://agedcare.health.gov.au/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training

For larger RACFs it would be practicable to have such equipment on hand, whereas smaller RACFs, especially regional/rural/remote facilities benefit from the portability of the newer units. Apart from this equipment requirement, the other resources are not extensive. These include but are not limited to personal protective equipment (eg. masks, gloves etc.), basic consumable items and basic dental instruments. Many basic services can be provided in-house for very immobile patients in their own wheelchair or bed, whilst more mobile patients benefit from receiving treatment in a dedicated treatment room with appropriate space, infection prevention design and lighting.

Outreach oral hygienists and dental and oral health therapists

Please note that the recommendation is for outreach services to be provided by a dental team including all dental practitioner types working cooperatively to the top of their scope where-ever practicable. As such the responses to the next 3 Questions (9,10 and 11) and the following questions on Outreach Dental Services (12, 13 and 14) have been combined.

9. Outline your views on the value of a dedicated funding stream for dental practitioners other than dentists to provide services in situ in residential aged care facilities. In your response, consider addressing the following:

a) any benefits and drawbacks of the proposal

The funding stream for the provision of services in RACF must be for all registered dental practitioners. Dental practitioners should work collaboratively in a team[8] where individual practitioners provide service within their individual scope of practice. This means that it is impossible to create funding streams directly at one practitioner type. Instead the most appropriate type of funding allows for mixed service provision amongst different registered dental practitioner types – including Dental Therapists, Dental Hygienists, Oral Health Therapists, Dental Prosthetists and Dentists.

b) the services that should be provided

- Regular Oral Health Assessments - by a registered dental practitioner for **all** people over 75 years and be mandated for those undergoing ACAT assessments, those in geriatric wards of hospitals and those receiving care services both in the community and within RACF.
- Preventive and primary care (relief of pain and acute infection) services.
- Medically-necessary dental treatment including management of the oral soft tissues, restorations and provision and maintenance of existing prosthetic work (fixed and removable). This would **not** include cosmetic dental procedures, implants or other complex prostheses (eg. crowns and bridges).

[8] The Dental Board of Australia. Code of Conduct. March 2014. Page 15 Section 4. file:///C:/Users/Sarah.Raphael/Downloads/Dental-Board---Code-of-conduct%20(9).PDF

c) the types of dental practitioners that would most appropriately supply these services

As above, a mix of practitioners from all divisions of registered dental practitioners tailored to each individual patient.

d) the impact on administrative costs

There has been no analysis of the administrative costs that would be incurred to date. However, a review of the impact of the Child Dental Benefits Schedule (CDBS) on the administrative costs to dental practitioners and to the Commonwealth Government would provide some projection on the administrative costs.

e) the adequacy of the current workforce

There is currently adequate workforce to provide the required services if a mix of public and private OH services are utilised. It would be impossible and impracticable to think that all the required OH services could be provided by current state and territory government OH services in the short-to-medium term future. By utilising a model like the CDBS this allows for such a mix of service provision.

f) the value for money of services received

There are 2 cost-evaluated models in the literature,[9,10] the Senior Smiles program and an evaluated model from the UK. Both of these illustrate the enormous cost benefits of providing a funded scheme. Although not cost evaluated, a systematic review of the literature[11] reports that the provision of appropriate oral care within RACF reduces the incidence of aspiration pneumonia, estimating that one in ten cases of pneumonia which would result in death may be prevented by improving oral care. In addition to the benefit of significant improvements in morbidity and mortality rates, the cost savings to the health system by avoidance of hospitalisations are very significant.

g) the applicability in rural and regional locations

A Senior Dental Benefits Scheme would universally cover older Australians in any jurisdiction and could also be utilised across public and private sectors. In rural and regional locations this allows for great flexibility of service provision.

[9] Kent Surrey Sussex, Academic Health Science Network. Senior Smiles: Cost Benefit Analysis. 2019

[10] Frenkel H, Harvey I, Newcombe RG. Oral health care among nursing home residents in Avon. Gerodontology 2000;17(1):33–8.

[11] Sjogren P, et al. A Systematic Review of the Preventive Effect of Oral hygiene on Pneumonia and Respiratory Tract Infection in Elderly People in Hospitals and nursing Homes: Effect Estimates and Methodological Quality of Randomized Controlled Trials. J Am Geriatric Soc 2008; (56) 2124-2130.

h) if applicable, solutions for addressing any perceived drawbacks, and

There is currently only funding for eligible adults (those of Centrelink entitlements) and a great proportion of them are unable to access OH services due to over-stretched, under-resourced government OH services, there are no perceived drawbacks. A dedicated funding stream for the provision of mandated OH services within RACFs would be welcomed.

i) where the funding stream could be/should be directed and why. For example, directly to the residential aged care facility, to health care providers through a national dental scheme, public or private funding, or a combination of both.

To ensure that the funding is used appropriately, it must be directed to health care providers through a national dental scheme where it is utilised by a combination of different registered dental practitioners both public and private. The Australian Dental Health Care Plan[12] outlines a Senior Dental Benefits Schedule that is similar to the Medicare-funded Child Dental Benefits Schedule for this purpose.

10. In relation to the proposal in item 9, outline your views on how the funding recipients should be held accountable for the expenditure of those funds.

This could be managed in the same way as the CDBS, where audits are carried out on treatment provision. Any aberrant expenditure or claiming pattern can be readily identified and dental practitioners would be held accountable. There would be a specific Senior Dental Benefits Schedules with clearly limited items of medically-necessary OH services (assessment, preventive and basic treatment).

11. In relation to the proposal in item 9, outline your views on whether the service could be extended to older Australians receiving high-level home care services, and if so, how it could be implemented.

Whilst this kind of provision is less researched and more difficult, it is possible. The use of mobile dental equipment does allow for this flipped treatment to be provided within the home.

Outreach dental services

Please see the underlined note preceding Question 9. All responses to Questions 13-15 are made above in responses 10-12.

12. Outline your views on the value of a dedicated funding stream for outreach dental services in residential aged care facilities for each of the following funding models:

a) funding provided directly to private and public providers, similar to the Child Dental Benefit Scheme

[12] Australian Dental Association. The Australian Dental Health Plan. Achieving Optimal Oral Health. 2019
file://svr-ada-fp01.adansw.local/Common/Communications/Sarah/Current%20Work/Aust-Dental-Health-Plan-2019-FINAL.pdf

b) funding provided directly to state/territory public dental services that could directly provide the service, or outsource to private dental providers

c) some other funding model.

Consider the following in your response:

a) any benefits and drawbacks of the proposal

b) any impact on public dental waiting lists and times

c) any impact on administrative costs

d) the adequacy of current workforce

e) the value for money of services received

f) the applicability in rural and regional locations

g) the services that should be provided

h) the types of dental practitioners that would most appropriately supply these services, and

i) if applicable, solutions for addressing any perceived drawbacks.

13. In relation to the models in item 12, outline your views on how the funding recipients should be held accountable for the expenditure of those funds.

14. In relation to the models in item 12, outline your views on whether these models could be extended to older Australians receiving high-level home care services.

Accountability of aged care providers

15. Outline your views on the adequacy of the Aged Care Quality Standards in respect of dental and oral health care services.

The standards are completely inadequate as there are no mandated requirements specific to dental and OH services.
Aged care providers – both RACF and home care providers must be mandated to meet oral care standards. This would best be included as a mandatory requirement under Standard 3, Requirement 3b. *Personal Care and Clinical Care*, where oral care would be identified as one of the high prevalence risks associated with the care of consumers (page 65).
https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%203.pdf
RACFs must be mandated to provide appropriate OH care as part of the medical health plan not the personal care plan. Oral health assessments and care must be managed by a registered dental practitioner.

16. Outline your views on what aspects of dental and oral health aged care providers should be accountable for in respect of those people in their care. Consider both residential and home care providers.

Whether in RACF or home care, aged care providers should be accountable for:

- Maintaining daily oral care including toothbrushing and denture cleaning
- Communicating with the people in their care and/or assessing the oral cavity to identifying any oral issues requiring attention
- Making timely referrals to registered dental practitioners for oral care assessment and treatment as required

17. Outline your views on whether and if so how dental and oral health care provided by home and residential aged care providers should be measured. In your answer address possible measurement of quality, outcomes, and service activity.

Dental and OH care provision would be managed by registered dental practitioners following appropriate mandatory OH assessment for all recipients of home and residential aged care which is funded through Medicare. The provision of daily oral hygiene care would be embedded into the homecare or residential care plan for each resident and evidence of this care provision would become a routine part of the overall daily care provided. This would best be included as a mandatory requirement under Standard 3, Requirement 3b. *Personal Care and Clinical Care*, where oral care would be identified as one of the high prevalence risks associated with the care of consumers (page 65).
https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%203.pdf
In the RACF setting, by mandating the inclusion of routine daily oral hygiene measures and any other regular preventive strategies into the medical health plan rather than the personal care plan and with the active involvement of a registered dental practitioner in each RACF who provides ongoing training and feedback to RACF staff, it will ensure services are provided which will translate into positive patient outcomes.

Other matters

18. Insofar as it is not addressed in your responses above, outline what should be done to improve the provision of dental and oral health services to Australians who receive aged care in their homes and those in residential aged care. Consider any actions that might be taken by:

a) the Commonwealth government, including statutory bodies such as the Aged Care Quality and Safety Commission

The Commonwealth government needs to make provision for Medicare funding of essential OH assessments by a registered dental practitioner for all adults over 75 years of age.

The Aged Quality and Safety Commission need to mandate both RACF and home care providers, to meet oral care standards. This would best be included as a mandatory requirement under Standard 3, Requirement 3b. Personal Care and Clinical Care, where oral care would be identified as one of the high prevalence risks associated with the care of consumers (page 65)[13].

b) state and territory governments

The state and territory OH services are hampered by the current arrangements of the National partnership agreement that limits the ability to adequate plan for OH services into the medium to long-term. By ensuring adequate and ongoing funding for state and territory OH service, service provision

ADA NSW involvement and collaboration with NSW Health Oral Health Services is good. As most dental services are delivered via small, individual private dental practices, the peak bodies for dental practitioners are the 'point of contact' for this workforce. The collaboration of local, state and federal health services with peak bodies is needed to help coordinate the development and maintenance of dental services for the aged care population.

c) professional associations or organisations such as professional colleges

The professional associations, such as ADA NSW have the responsibility to support their members in the provision of dental and OH services for older Australians. ADA NSW work closely with NSW Health Centre for Oral Health Strategy and all the university training programs (University of Sydney and Charles Sturt University) to support programs and initiatives in the aged care sector. Currently ADA NSW do this by producing resources and offering continuing professional development courses. Further, public advocacy campaigns on the importance and benefits of good OH for the elderly are being developed and conducted.

d) aged care providers

Aged Care Providers must be mandated and commit to facilitating appropriate education and training for all RACF staff and providers of home care. This allows for the provision of appropriate daily oral care for the elderly in their care. The Better Oral Health in Residential Care training package[14] is recommended for carer education. This training must be completed by all carers (RACF staff and homecare providers) and regularly facilitated by a registered dental practitioner.

19. Are you aware of any overseas models of delivering dental and oral health care services to older Australians who receive aged care in their homes and in residential aged care

[13] Aged Care Quality Standards (1 January 2020). https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%203.pdf

[14] Better oral health in residential care model. https://agedcare.health.gov.au/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training

that are working well? If so, explain why they are working well and whether they could be translatable to Australia.

There is limited research from overseas illustrating successful models of OH services within RACF and even fewer detailing programs for community care as this has not traditionally been an area well documented in the literature. However, the models found in the literature over the past two decades are from Japan, Switzerland, Finland, Belgium, Germany, the UK, Canada and the USA. Interestingly, many of these studies have focussed on associations of poor OH with poor general health outcomes such as higher rates of aspiration pneumonia. Research into factors such as pain, inability to maintain an adequate nutritional intake and quality of life measures associated with poor OH are less readily available. With regard to RACF, a Cochrane review[15] of available studies conducted in 2016 concluded that:

> *"Overall, there was a low quality of information from the studies regarding all of the results. We conclude that there is a need for clinical trials to investigate the advantages and harms of oral health educational programmes in nursing homes."*

Despite this, the common threads of all programs showing successful outcomes in both oral and general health are:

- Interdisciplinary approach involving families, carers and RACF, allied health and medical staff has been shown to have the greatest success.
- Education and awareness-raising amongst family, carers and RACF staff of the importance and benefits of good OH for the elderly translates into improvements in OH status for the elderly.
- Long-term involvement of dental practitioners with RACF staff assures routine oral care is maintained and timely referrals for treatment occur.

[15] Albrecht M *et al.* Oral health educational interventions for nursing home staff and residents. Cochrane Database of Systematic Reviews 2016

With regard to the ability to scale up available programs within Australia, some of the most thoroughly researched models have been developed in NSW[16,17] and other parts of Australia[18]. The Senior Smiles program,[19,20] along with one from the UK[21] are the only programs in the literature where cost benefit analysis has been conducted, as part of the overall evaluation. Both of these programs show the considerable cost efficiency of providing structured oral health programs within RACF. In particular, the Senior Smiles program has been evaluated as being able to deliver $2.40 of benefits within the healthcare system and a further $3.18 in social benefits for every $1 invested in the program.

The BOHRC training package[22] is a well-developed and researched model that has been successfully implemented in Australia and should be scaled up to be mandatory requirement of RACF staff.

Signed: 

Date: 17 March 2020

Witness: 

Date: 17 March 2020

[16] Wallace J. *et al.* Senior smiles: Preliminary results for a new model of oral health care utilizing the dental hygienist in residential aged care facilities. International Journal of Dental Hygiene. 2016. 14: 284-8.

[17] Wright F.A. Clive, et al. "Residential age care and domiciliary oral health services: *Reach-OHT* – the development of a metropolitan oral health programme in Sydney, Australia." Gerodontology 2017; 00:1-7. https://doi.org/10.1111/ger.122282.

[18] Lewis, A *et al.* Improving oral health for older people in the home care setting: An exploratory implementation study. Australasian Journal on Ageing, 2016. 35: 273–280.

[19] Wallace J. *et al.* Senior smiles: Preliminary results for a new model of oral health care utilizing the dental hygienist in residential aged care facilities. International Journal of Dental Hygiene. 2016. 14: 284-8.

[20] Kent Surrey Sussex, Academic Health Science Network. Senior Smiles: Cost Benefit Analysis. 2019

[21] Frenkel H, Harvey I, Newcombe RG. Oral health care among nursing home residents in Avon. Gerodontology 2000;17(1):33–8.

[22] Better oral health in residential care model. https://agedcare.health.gov.au/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training