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Royal Commission into Aged Care Quality and Safety
GPO Box 1151
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Via email: Sarah.Bohmer@royalcommission.gov.au

Dear Commissioners,

Re: ADA comment on Counsel Assisting's draft oral health, health system/aged care interface and aged care workforce propositions

Thank you for providing the Australian Dental Association (ADA) with the opportunity to provide feedback on the Adelaide Hearing 5 draft oral health propositions, Canberra Hearing health system/ aged care interface propositions, and Counsel Assisting's Adelaide Hearing 3 submissions on the aged care workforce.

As you are aware, the Australian Dental Association (ADA) lodged its main submission to the Royal Commission[1] on 7 June 2019.

Although this supplementary submission focusses primarily on the draft oral health propositions, it first touches briefly on relevant submissions by Counsel Assisting on the aged care workforce, and on Canberra Hearing Propositions CH3 and CH6.

Counsel Assisting's submissions on the aged care workforce

The ADA supports the recommendations made in Counsel Assisting's submissions on the aged care workforce,[2] many of which are closely aligned with recommendations or points made by the ADA in its first submission to the Commission lodged in June 2019.

Workforce Recommendation 1 which recommends the establishment of mandatory case-mix-based staff-to-resident ratios is particularly welcomed, because if implemented, it will require most aged care providers to substantially increase both the overall number of care staff rostered on per shift, and the proportion of those staff with registered and enrolled nursing qualifications.

This is clearly critical to improve the quality and safety of clinical care in aged care settings. The ADA is also pleased to note Counsel Assisting's explicit recognition that increased staffing is one of many systemic changes required to ensure that staff have time to attend to providing daily oral hygiene care to those who need it 'as part of the core care they deliver'.[3]

However, the ADA shares many of the concerns of other witnesses with the methodology used to develop the minimum staffing ratio measure recommended by Counsel (that measure being staff levels that appear to be sufficient to produce 4 star quality ratings for nursing homes in the USA under the

[1] https://www.ada.org.au/News-Media/News-and-Release/Submissions/Submissionto-the-Royal-Commission-into-Aged-Care/ADA-Submission-to-the-Royal-Commission-into-Aged-C
[2] Royal Commission into Aged Care Quality and Safety. *Counsel assisting's submissions on workforce*, 21 February 2020. https://agedcare.royalcommission.gov.au/hearings/Documents/submissions-by-counsel-assisting.pdf
[3] Ibid. p.26 [104].

current CMS[4] rating system).[5] The ADA believes that minimum staffing ratios should be developed on the basis of a careful analysis of what the need for staff of different types will be in Australian RACFs with different case mixes into the foreseeable future, taking into account both demographic projections, and the impact on staff workloads of the Commission's other recommendations to improve the quality and safety of care.

For example, the Commission has heard evidence that personal care workers are currently being required to perform duties like pain management, medication management and wound care (with sometimes disastrous results). What would staffing needs be if responsibility for such duties was returned to nursing staff who are properly qualified to do them? What would the staffing requirements be if registered nurses were to have time to adequately supervise and mentor students on work placements, and to check the work of enrolled nurse and personal care staff to be sure that they are providing safe, high quality care?

The ADA is aware that in many RACFs, even when in-house training opportunities are offered to personal care and nursing staff by interested organisations, staff are immediately concerned that they will not be able to get all their regular duties done if they take up the training opportunity.[6] What will the staffing requirements be if personal care staff are to be given the opportunity for proper inductions and ongoing training during work time – a change for which the Commission has already indicated support?

Likewise, while the Canberra Hearing propositions advocate a significant expansion to multi-disciplinary health outreach services to bring care into RACFs, the reality is that some health services will not be able to be provided within RACFs. Currently, RACF staff and facility managers are often concerned about arranging such appointments because of the time that getting residents ready and accompanying them takes away from other care duties. What extra staffing would be sufficient to ensure that where a resident is willing and able to travel, their access to health services like this is not compromised by inadequate RACF staffing?

Only a needs-based determination of minimum staffing ratios can adequately answer these questions.

The ADA supports ***Workforce Recommendation 3,*** with respect to the Certificate III in Individual Support (Ageing) becoming the minimum mandatory qualification required for paid personal/home care workers in aged care settings. This was recommended in the ADA's own submission.

Workforce Recommendation 9**,** recommending the establishment of a registration scheme for personal care workers including this mandatory minimum qualification requirement, and mandatory ongoing training and continuing professional development requirements is also supported.

The question of how best to increase the oral health content of personal care workers education and training is addressed below in the context of discussion of the Adelaide Hearing 5 draft oral health propositions (***Proposition D2.***)

Workforce Recommendation 7 – Education and training in geriatric medicine for medical practitioners, registered nurses and enrolled nurses

In Recommendation 7, Counsel Assisting recommends the incorporation of an introductory module/subject on geriatric medicine and gerontology care into the Registered Nurse Accreditation Standards and the Enrolled Nurse Accreditation Standards.

The ADA strongly supports these recommendations.

[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS

[5] Eagar K et al. (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks*. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong,

[6] see, for example, pp. 25-26. https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/14-october/exhibit-11-1-melbourne-3-general-tender-bundle/AHS.0001.0001.0001.pdf

Nevertheless, the ADA is aware that the Commission has also received evidence that the oral health content of entry-level nursing courses is *also* far from comprehensive,[7] and should be boosted to include education in relation to:

- the impacts of diseases and health conditions common in older people (e.g. arthritis, diabetes, dementia, cardiovascular disease, dysphagia) and their diet, medications and daily hygiene practices on their oral health and capacities to perform oral hygiene self-care
- the impact of poor oral health in older people on their general health
- how to screen for poor oral health in older people (including training in the use of the internationally recognised Oral Health Assessment Tool designed for use by non-dental practitioners) and
- evidence-based recommendations for the day-to-day oral health maintenance of RACF residents and high-needs home-based age care consumers.

One suggestion is to incorporate the learning and teaching resources developed under the government-funded *Better Oral Health Communities program* during 2012-14.[8] A 2016 evaluation study that incorporated these reference and video resources into units of study in Bachelor of Nursing, Diploma of Nursing and Certificate III Aged Care courses as prescribed study materials found that both students and teachers reported a high level of satisfaction with the resources, and significant improvements in oral health knowledge and skills.[9]

Canberra Hearing Aged care/health system interface propositions

Proposition CH3 Physical Infrastructure and Staffing Support touches on issues of concerns to dentists that are the subject of a recommendation in the ADA's original submission to the Commission.

Proposition CH3 states that:

The Quality of Care Principles 2014 (and any subsequent instrument) should include a requirement for approved providers of residential aged care to provide a room with sufficient lighting and privacy for consultations (which could be the resident's room), access to necessary equipment, and the necessary levels of clinical support staff to visiting primary health practitioners to ensure residents have timely and quality access to primary health care services. Visiting health practitioners may also include non-primary health care practitioners, such as geriatricians.

The ADA believes the section on treatment rooms should be expanded and reworded to clarify that there is a requirement for dedicated treatment rooms that can be used by visiting health practitioners, and that more detail should be provided about the kinds of facilities, equipment and clinical support that should be provided to these practitioners.

The Australian Government's position that resident's rooms are adequate locations for the delivery of primary care to RACF residents and that a requirement for treatment rooms would force RACFs to incur large costs for an investment 'which may not necessarily have high utility'[10] is extraordinary given all the evidence the Commission has heard about residents' limited mobility and health practitioner concerns about the occupational health and safety aspects of current treatment arrangements within RACFs.

[7] Exhibit. Cairns Hearing. Statement of Adrienne Alexis Lewis. https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/16-july/WIT.0246.0001.0001.pdf

[8] see, for example, SA Dental Service. (2008). *Better Oral Health in Residential Aged Care Staff Portfolio Education and Training Program.* https://www.sahealth.sa.gov.au/wps/wcm/connect/09fa99004358886a979df72835153af6/BOHRC_Staff_Portfolio_Full_Version%5B1%5D.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-09fa99004358886a979df72835153af6-n5hOC7k

[9] Lewis, A. et al. (2018). 'Evaluating students learning outcomes in oral health knowledge and skills', *Journal of Clinical Nursing*, 27 (11-12), pp. 2438-2449.

[10] https://agedcare.royalcommission.gov.au/hearings/Documents/post-hearing-submissions/canberra/RCD.0012.0058.0001.pdf, p.9.

As the ADA states in its original submission, it supports the position on treatment spaces in RACFs articulated in *Australia's National Oral Health Plan 2015-24*[11] published under the auspices of Australian Government and state/territory health ministers a few years ago.

That is to say that where possible, dental treatment in smaller RACFs should be provided in a dedicated treatment room that meets minimum infection control requirements, which could be shared by visiting dental, medical and allied healthcare providers. Larger aged care facilities should ideally establish dedicated dental surgeries, with funding assistance from the Australian government if necessary.

The ADA concurs with Dr Peter Foltyn's evidence[12] that at a minimum, very small facilities that cannot provide dedicated treatment rooms should ensure that bottles of medical air are available so that visiting oral health professionals who use air-driven equipment can provide services in residents rooms.

As Dr Adrienne Lewis has suggested to the Commission in evidence, if RACFs want more dental professionals to provide on-site treatment at their facilities, then RACF management need to treat oral health and the time of visiting dental practitioners with respect, provide clean appropriate treatment areas, timely clinical support (signed consents, medical records and medication lists) and staff support so that residents are ready to be seen by the dentist and that any assistance required during the appointment is available.[13]

As medical practitioners who gave evidence at the Canberra hearing expressed essentially similar concerns and needs, these requirements should be specified more clearly in this proposition.

Proposition CH6: Responsive funding for comprehensive health assessments

This draft proposition is that

The Medicare Benefits Schedule (MBS) items 224, 225, 226, 227, 701, 703, 705 and 707 should be revised to support comprehensive health assessment and team care arrangements on entry to aged care and then every 6 months or as needed. They could also be amended to allow nurse practitioners to carry out health assessments in particular circumstances.

The Commonwealth appears unlikely to support this recommendation, given its expressed opposition to fundamental changes to the Medicare GP fee for service model, particularly if such changes are proposed only for RACF residents.[14]

However, one recommendation that the Commonwealth may be willing to accept, and which the ADA requested that the Commission consider in its original submission to the Inquiry, is that health assessment item numbers applying to Australians 75 years and over, Aboriginal and Torres Strait Islanders 55 years and over, and residents of aged care facilities should include a mandatory and reportable requirement that oral health be assessed, along with the other domains of physical, psychological and social functioning that are included as mandatory.

Currently MBS Schedule guidance only lists examination of oral and dental health as a mandatory component of health assessments for patients with intellectual disabilities, and Aboriginal and Torres Strait Islanders under (but not over) the age of 55. This makes no sense, given evidence that many older people living in the community on lower incomes have significant needs for dental treatment that

[11] COAG Health Council. (2015). *Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2015-2024*. https://www.coaghealthcouncil.gov.au/Portals/0/Australia%27s%20National%20Oral%20Health%20Plan%202015-2024_uploaded%20170216.pdf, p.67.
[12] https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/14-may/WIT.0121.0001.0001.pdf
[13] https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/16-july/WIT.0246.0001.0001.pdf
[14] https://agedcare.royalcommission.gov.au/hearings/Documents/post-hearing-submissions/canberra/RCD.0012.0058.0001.pdf

they either do not recognise, or cannot attend to as a result of long public dental waiting lists and difficulty according private dental treatment.[15]

One of the reasons that including oral health as a mandatory component of comprehensive GP assessments for people aged 75 and over is critical is to ensure that older people who are not visiting the dentist regularly are identified and managed appropriately. It is particularly important that older people see a dentist regularly for preventive care and oral health management *before* their independence decreases. [16] Once this occurs and their mobility, access to care and capacity to undergo treatment declines, their oral health management becomes extremely difficult. Evidence shows that there is often a rapid decline in their oral health, further complicating their systemic health, ability to obtain adequate nutrition and quality of life.[17]

Likewise, making oral health part of comprehensive assessments for aged care residents on entry and every 12 months is important notwithstanding any other arrangements for oral care in place at the facility, because residents and families who may otherwise be reluctant to consent to professional oral hygiene or dental treatment may be willing to do so if referred by a trusted GP.

Adelaide hearing 5: Draft Oral Health propositions

Proposition D1: Fund public dental to provide outreach services to Australians accessing aged care services in their place of residence

The draft proposition is that:

The Australian and state and territory governments should enter into a new National Partnership Agreement to begin no later than 1 January 2022 to fund public dental services to provide outreach services to aged care recipients in their place of residence (either in the community or in residential care facilities) if they are unable to travel to receive public dental services.

Under the Agreement the Australian government should pay 50% of the Dental Weighted Activity Unit (DWAU) cost of services provided, up to a cap of each jurisdiction's aged care recipient share of $120 million in 2021-22. The national total should be indexed annually for price movements and increases in the eligible population.

Other statements made in relation to this proposition are that:

37. Under this proposition, funding would be provided to public dental services, who could then either directly provide the service or outsource to private providers. This would allow for a systematic approach to service provision, with the state public dental services managing the dental care of older Australians.

38. The waitlist associated with public adult dental services should not affect this older person's outreach service because it would be provided through a separate funding stream.

The ADA believes that Australian government funding support to make quality dental care more accessible for low-income adults of *all ages* is inadequate. In state and territory public dental services, this results in long waiting lists and the imposition of a variety of policies designed to shorten waiting lists by limiting treatment time/cost per patient and artificially suppressing demand. These include failure to authorise full examinations, provision of a very limited range of dental services that may use less

[15] Australian Research Centre for Population Oral Health. (2019). *Australia's Oral Health: National Study of Adult Oral Health 2017–18*, The University of Adelaide, South Australia; Wright et al. (2018). 'Oral health of community-dwelling older Australian men: The Concord Health and Ageing in Men Project (CHAMP)', *Australian Dental Journal*, 63, 55-65.
[16] Pretty, I. et al. (2014). 'The Seattle Care Pathway for securing oral health in older patients', *Gerodontology* 31 (Suppl. 1), pp. 77–87.
[17] van der Maarel-Wierink C. et al. (2013). 'Oral health care and aspiration pneumonia in frail older people: a systematic literature review. *Gerodontology*, 30, pp. 3–9; Wright FAC. et al. (2019). 'Chewing function, general health and the dentition of older Australian men: The Concord Health and Ageing in Men Project,' *Community Dentistry and Oral Epidemiology*, 47, pp.134–41.

durable materials, and compromise aesthetics (e.g. extractions with no tooth replacement), and/or imposition of co-payments that many patients find difficult to afford.

Although some 75% of Australians aged over 65 are eligible for public dental services, the net effect of waiting lists, distance to local public services, 'dissatisfaction with the standards or choice available'[18] and/or the significant co-payments charged in states like South Australia,[19] is that many in this group (and many younger adults) eligible for public dental services choose not to use them.

Given this, the ADA supports the idea that public dental services should be better funded to reduce waiting times and required co-payments, and to reduce restrictions on treatments which vary from state to state. The ADA would also support better public funding for dental services so that eligible aged care recipients who wish to use these services but are too frail to travel to the nearest public or private dental clinic can receive domiciliary care at the aged care facility or private home in which they live.

Provision of additional capital funding to public dental services for the purchase of mobile dental equipment would be useful to both private and public dentists who have patients whose lack of mobility or chronic health conditions mean they cannot travel and need to be treated where they live. As noted by Federal and State Health Ministers in *Australia's National Oral Health Plan 2015-24,*[20]

> *it is not always economically viable for dental practitioners to purchase portable dental equipment for occasional use. However, there are successful examples of the public dental sector making such equipment available to private dentists to use in homes and institutions as needed, and this approach…need[s] to be expanded.*

However, and notwithstanding the ADA's support for better funding of public dental services, there are other aspects of ***Proposition D1*** that require clarification or a re-think.

The first of these is the suggestion that state/territory public dental services should 'manage the dental care of older Australians' to ensure a more 'systematic approach' to service provision. Despite the use of the broad term 'older Australians' here, this statement is presumably referring to the dental care of aged care residents, given the context of this proposition.

If so, the idea of establishing a separate funding stream through a National Partnership Agreement (NPA) to eliminate waiting lists for aged care recipients (but not for other eligible older people or younger adults) seems inequitable and divisive. For example, there are many unemployed people in their late 40s, 50s and early 60s trying to survive on the below-poverty level Newstart payment who arguably deserve access to prompt subsidised treatment even more than those in receipt of aged care, because long waiting lists and the extractions that result may destroy their chances of employment.

Counsel Assisting's suggestion that the Australian Government should fund this separate stream to the tune of $120m makes this proposition appear all the more inequitable, given that the Australian Government has only contributed $107.8m for the 2019-2020 NPA on public dental services for *all* eligible Australian adults.[21]

Secondly, the ADA is concerned about the proposed funding mechanism. Under the Federal Financial Relations Act 2009 NPA's are necessarily short-term funding instruments (usually 3 years) which make no promise of ongoing funding, require re-negotiation every few years, and make it notoriously difficult to plan ahead. Yet setting up systems to ensure that all aged care recipients who need domiciliary services can access them will require considerable lead-time.

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[18] Smith, W. and Hetherington, D. (2016). *The adequacy of the aged pension in Australia*, The Benevolent Society, The Longevity Innovation Hub & Per Capital Australia Ltd.
[19] https://www.cotasa.org.au/lib/pdf/submissions/COTA_SA_submission_to_SAOHP.pdf
[20] COAG Health Council. op cit., p. 67.
[21] Australian Government. (2019). *Budget Paper No. 3: Federal Financial Relations 2019-20*, Table 2.3.4, p.27.

NPA's also make release of a large proportion of Commonwealth funding under the Agreements conditional on the meeting of specified performance benchmarks towards the end of each year of the Agreement. Thus they leave the states and territories at risk of substantial budget holes if they cannot meet Commonwealth targets for unforeseen reasons (e.g. greater consumer demand than expected), or if meeting those targets requires more funds than the Commonwealth has agreed to provide. At the same time, one of the key design principles of NPA's is that they should not be prescriptive about how the states deliver the services, meaning that an NPA would not be able to standardise the varying state and territory policies on eligibility, co-payments and dental care that can be provided.[22]

The ADA is opposed to the idea of a system where state public dental services would be required to "manage" dental care for this group, because it would mean private dental practitioners to whom much of the work would have to be outsourced would be subject to restrictions on the services they could provide imposed by state dental policies.

For example, under the NSW Oral Health Fee for Service Scheme, treatment recommended on a voucher issued by the public dental service may not be in line with a participating private dentist's own clinical judgement about the optimal treatment for the specified problem. Alternatively, the treating private dentist may observe that the patient has additional forms of oral disease not covered by treatment specified on the voucher, that could and should be treated at the same appointment in the interests of the patient's health. However, participating dentists can only alter or add to the treatment plan specified on a voucher if they seek approval from the local health district, which will only grant that approval if the proposed changes are in line with state dental policies.

Furthermore, the voucher systems used in such schemes are inherently inefficient; the patient has to be triaged through the public system to get the voucher (rather than being able to see a dentist directly) and then the dentist has to submit the voucher for payment. Dentists and dental prosthetists have often waited up to three months for payment under such schemes, which acts as a deterrent to their participation.[23]

The ADA believes that funding under the Senior Dental Benefits Schedule (SDBS) proposed in its *Australian Dental Health Plan*,[24] the most recent revised version of which is attached, offers a superior mechanism to fund better access to oral health preventive and treatment services for aged care recipients. It would almost immediately remove the problem of waiting lists, and by offering greater choice of dentist and treatments, would also make residents (or their families) more likely to seek treatment.

Like the CDBS, the SDBS would be established and funded by special appropriation under the Dental Benefits Act 2008. It would offer eligible patients 65 years and over an individual entitlement to subsidised treatment up to a cap (which is currently $1000 over every two-year period for the CDBS and would preferably be higher for older people).

The entitlement could be used by patients to fund required dental examinations before or on entry to aged care and regularly thereafter, oral health care planning, and any necessary treatment. Importantly, it would also improve access to affordable and timely dental treatment for those aged 65 and above in the years *before* their health, mobility and capacity to tolerate treatment declines. This would ensure that they enter aged care with a better foundation of oral health – although that oral health is still likely

[22] House of Representatives Standing Committee on Health and Ageing. (2013). *Bridging the dental gap: report on the inquiry into adult dental services*, Commonwealth of Australia, Canberra.
[23] House of Representatives Standing Committee on Health and Ageing, op. cit., p.36; Chu et al. (2013). *Inner West Oral Health Outreach Program Progress Report*, December, http://www.aaainstitute.com.au/funded_research_htm_files/IWOHAC%20ProgressReport%20Final%20Edit%205%20Feb.pdf
[24] https://www.ada.org.au/Dental-Professionals/Australian-Dental-Health-Plan/Download-your-copy-of-the-Dental-Health-Plan/Australian-Dental-Health-Plan-2019.aspx

to undergo a rapid decline unless their aged care provider has a preventive oral health program using the services of registered dental practitioners in place.

It is envisaged that eligibility for the SDBS would be wider than current public dental eligibility rules affecting those 65 and over in all states other than Queensland and would thus cover more older people and aged care recipients. In addition to health care card and pensioner concession card holders, the scheme would cover Commonwealth Seniors Card holders - self-funded retirees who meet the aged pension income test but are ineligible for it as they just exceed the assets test.

Importantly, the SDBS would offer eligible patients the *choice* of seeing a public or private dental practitioner without the need to be triaged by the public dental service first, and would facilitate and encourage continuity of care for residents who already have a regular dentist. Like the CDBS, the SDBS would offer greater administrative efficiency than public dental fee for service schemes, by allowing electronic claiming for dentists, who can also check patient eligibility for various services and the remaining claiming entitlement through the Medicare provider portal HPOS.

It is envisaged that under the scheme, patients who chose to see a public dental service would be bulk-billed (rather than having co-payments applied as is currently the case in many states). Private dentists could bulk-bill (as the vast majority do already under the CDBS) or charge their customary fees, with the patients who give informed financial consent to treatment under the latter arrangement only paying the difference between the dentist's fee and the dental benefit schedule fee. Ideally, patients with private health insurance would be able to use it to cover some of that difference.

The SDBS would offer access to all procedures in the ADA Schedule (subject to prior approval for more complex procedures) thus offering patients a wider range of treatment options using more aesthetically attractive and long-lasting materials, and reducing the need for major work such as the replacement of dentures or restorations after entry to the aged care system. It is envisaged that fees/rebates would be based on the DVA Dental Schedule.

The ADA Schedule already includes an item number that could be used by dentists who work mostly in their clinics to itemise/claim the cost of travel to and from the patient's RACF or their private residence. Funding under the SDBS also would further encourage the growth of mobile private dental and mobile private denture services, which have already multiplied rapidly across Australia in the past year.[25]

The Commission should note that National Seniors[26] and COTA[27] have recently reaffirmed their support for a scheme along of the lines of the ADA's proposed SDBS. The Australian Labour Party also used it as the model for its Pensioner Dental Scheme policy introduced during the 2019 election.

Importantly, a funding mechanism like the SDBS, if supported by other funding for additional mobile dental equipment as mentioned above, would facilitate innovative partnerships and collaborations between local geriatric and medical health services, public dental services, interested private dental practitioners, and aged care facilities located within the same Local Health District area for provision of domiciliary oral and dental health services to RACF residents. Like the Reach-OHT model operating in Sydney Local Health District, such programs could potentially be coordinated by a public sector dental practitioner working within Local Health District oral health services.

[25] At last count we noted some 20 separate mobile dental providers serving residential aged care facilities, with several of the largest of these practices providing services across several states, or Australia-wide. There is now also an even greater number of mobile prosthetist services that provide denture repair, denture relining and new dentures to patients at their residence.

[26] https://nationalseniors.com.au/news/latest/election-2019-news-update-seniors-matter; https://nationalseniors.com.au/news/media-release/labors-dental-health-care-announcement-welcomed-national-seniors

[27] https://www.cota.org.au/news-items/federal-election-2019-alp-pensioner-dental-plan-welcomed/

However, there is no one-size-fits all model. In addition to the increasing number of private mobile dental/denture services that provide domiciliary services, there are already many private/public partnerships and public dental services providing these services around Australia.

For example, in WA, the public dental service offers domiciliary services to those with health care and pensioner concession cards who have a medical condition that prevents travel to a clinic; the service offers a broader range of dental services than provided by many state public dental services, and subsidises treatment up to 75% of the DVA Dental Schedule cost. There is also a program that offers consenting RACF residents in participating RACFs free dental health assessments and care plans provided by a visiting dental practitioner once a year.

Proposition D2. Increased oral health care training for personal care workers

The proposition is that:

Training for personal care workers should include training on providing routine oral health care and on recognising the symptoms of oral disease that require referral for evaluation and treatment by a dental professional.

Other statements made in respect of this proposition are:

41. Common entry-level qualifications for personal care workers are Certificate III in Individual Support (Ageing) and Certificate IV in Ageing Support. There are no mandatory units in either course that explicitly cover oral health care.

42. There are no requirements for approved providers to ensure their staff have professional development training in oral care (see Proposition D3). However, there are some oral health training programs available to aged care providers and their staff.

43. Consideration should be given both to initial training needs (including components of Certificate III qualifications), and the need for ongoing training. Consideration should also be given to whether ongoing training, if recommended, should be mandated and whether approved providers should be responsible for ensuring it occurs.

44. The Royal Commission has heard evidence that the high turn-over rate among staff working in residential aged care facilities may limit the utility of one-off oral health training.

45. It may also be important to clearly articulate what is expected of personal care workers with respect to oral health care (see Proposition D3: Clarify the responsibility of residential aged care providers for maintaining the oral health of their residents).

As noted earlier in this response, the ADA supports the propositions that the Certificate III in Individual Support should be the minimum qualification for personal care/home care workers, and that a registration scheme prescribing this, and mandatory ongoing training and continuing professional development be established. The registration scheme would need to incorporate recognition of prior learning and grandfathering provisions to ensure that the existing workforce without this qualification could keep working in the industry.

Although para 41 of ***Proposition D2*** suggests that the current Certificate III in Individual Support (Ageing) and the Certificate IV in Ageing Support do not include any mandatory units that explicitly cover oral health care, this is not the case. Students seeking to graduate from these courses with Ageing or Home and Community Support specialisations must complete not only the core units, but the mandatory elective CHCCCS011 *Meet personal support needs.* This latter unit does at least provide a basic introduction to oral hygiene, and in theory at least, requires that candidates have demonstrated in a relevant workplace that provides personal care that they have been able to support two real

individuals with oral hygiene care (and other forms of personal care) according to requirements set out in individualised care plans.

However, it does appear that students taking either the current or proposed Certificate III in Individual Support (or Care Support as the revised qualification is named) who choose not to select a specialisation can graduate without having to take any units that cover oral care. The ADA believes that this gap in the curriculum should be closed in the revised qualification, so that all those who graduate from this course have been provided with a basic introduction to providing oral care in line with individualised oral care plans, and have had their competence in this skill formally assessed.

Another concern is that it is clear from evidence provided to the Commission that despite successive reviews of the VET sector, the quality and length of these courses as offered by registered private training organisations is widely variable. In part, this is because the Commonwealth has failed to act to ensure that requirements around issues like face-to-face teaching, course duration, teacher credentials, and work placement hours can be enforced by the Australian Skills Quality Authority.[28] The Commission should address this issue in its Final Report.

Whilst there are also five other VET units that are specifically about the oral health care of the aged, one of which is offered as an elective for the Certificate IV course, it does not seem feasible to attempt to 'pack any of them in' as mandatory units to the Certificate III course. Nevertheless, responses to the first and second round consultation on the re-packaged Certificate III currently being considered by the Aged Services IRC would suggest that many stakeholders considered that there was scope to amalgamate the content of some of the existing units to leave more space for additional content or core units, in dementia, in particular.

To improve the oral health knowledge and skills of Certificate III students before they enter the workforce, the ADA strongly recommends the incorporation of the *Better Oral Health in Residential Aged Care* Staff training curriculum and resources into the Certificate III course.[29] It includes three relatively short modules that cover theoretical knowledge, practice in using techniques to overcome common difficulties encountered when providing daily oral hygiene care to aged care residents, and training in how to recognise common oral health problems.

The ADA also strongly supports the idea that ongoing training in provision of oral health maintenance and screening should be mandated, and that approved aged care providers should be held responsible for ensuring that it is provided, preferably using ongoing face-to-face training provided by dental professionals within the aged care facility, as recommended under ***Proposition D4***.

Proposition D3. Greater clarity on the need for RACFs to maintain oral health

This proposition is that:

The *Quality of Care Principles 2014* (Cwth) and any subsequent instrument should include an explicit and measurable requirement that residential aged care providers maintain the oral health of residents.

Key statements made in relation to this proposition were:

49. Expected outcome 2.15 of the former Accreditation Standards explicitly required that residential aged care providers ensure that "Care recipients' oral and dental health is maintained". However, the Royal Commission has heard evidence that the old standards were also insufficient in ensuring evidence-based oral care.

[28] Transcript. Robert Bonner, Deputy Chair, Aged Services Industry Reference Committee, Melbourne 3 Hearing, p. 5870; Health Services Union Submission on the Aged Care Workforce, 21 October 2019, AWF.650.00053.0002_0001

[29] SA Dental Service. (2008). *Better Oral Health in Residential Aged Care Staff Portfolio Education and Training Program.* https://www.sahealth.sa.gov.au/wps/wcm/connect/09fa99004358886a979df72835153af6/BOHRC_Staff_Portfolio_Full_Version%5B1%5D.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-09fa99004358886a979df72835153af6-n5hOC7k

50. One way of ensuring that oral care is core business for residential aged care providers is to introduce an explicit and measurable requirement that approved providers maintain the oral health of residents.

51. Consideration should be given to how the maintenance of oral health of residents could be measured or assessed. One option is measuring particular outcomes, another is measuring the oral health services provided to residents.

In its submission to the Department of Health's 2017 consultation on its then-proposed *Single Aged Care Quality Framework,*[30] the ADA strongly objected to the removal of Expected outcome 2.15 of the former Accreditation Standards ("Care recipients' oral and dental health is maintained") from the new quality framework:

> *The existence of explicit Aged Care Quality standards in relation to personal and clinical care such as those contained in the current standards clearly cannot guarantee high quality care if other aspects of the aged care system, such as inadequate funding and staffing, create conditions that undermine the capacity of the system to provide quality care.*
>
> *Nevertheless, the ADA believes that the removal of explicit, assessable standards in relation to oral and dental health care from the draft Single Aged Care Quality Framework can only exacerbate these problems, by diverting the attention of management further away from them, and reducing the incentive to support and embed good practice.*

The ADA remains of this view, and therefore strongly supports **Proposition D3.**

With respect to Expected outcome 2.15 being insufficient to ensure evidence-based oral care, Counsel Assisting's focus on the need to improve staff-to-resident ratios, staff skills in the provision of oral health care, staff pay and career progression, and funding to facilitate timely resident access to the services of dental professionals will go a long way to improving the quality of the oral care residents receive.

The other main reasons that aged care providers have "gotten away with" neglecting to maintain the oral health of residents in spite of the explicit expectations in the old Accreditation Standards come down to faults in the fragmented and complex design and processes of the regulatory system which have been identified over and over again in a succession of recent inquiries and reviews.[31] Some of the most prominent of these faults such as ineffective complaints mechanisms, and a "tick the box" process-driven approach to accreditation that gave aged care providers advance notice of site visits by assessors are being addressed as a result of such reviews, and could be further improved.

For example, the *Results and Processes Guide* (2019) for assessors on how to assess Expected outcome 2.15 (which was made available to RACFs on the www.aacqa.gov.au website prior to the introduction of the new Quality Standards, but has now been removed) said that the focus of assessment should be on 'results for residents'. This was to be measured by (a) management being able to demonstrate that the oral health of residents was maintained, and (b) residents and their representatives confirming they were satisfied with the facility's approach to managing residents' oral care.

However, the bulk of the document was about whether "processes" appeared to be in place to maintain oral health. Given that this cannot be really be verified in the course of a short site visit, it has mostly been assessed by conducting a desktop audit of internal RACF policies and resident records. There is nothing in the document about how to measure oral health outcomes in practice, beyond speaking to residents/representatives. With an increasing proportion of residents with dementia and their families

[30] https://www.ada.org.au/News-Media/News-and-Release/Submissions/Response-to-Single-Aged-Care-Quality-Framework-D/ADA-submission-to-Department-of-Health-consultatio

[31] such as Carnell, K & Paterson, R. (2017). *Review of National Aged Care Quality Regulatory Processes, and* House of Representatives Standing Committee on Health, Aged Care and Sport. (2018). *Report of Inquiry into the Quality of Care in Residential Aged Care Facilities.*

with power of attorney often believing that oral disease inevitable in old age[32] there is a need to do more to measure outcomes effectively.

It should be noted that with a bit of editing to clarify the responsibilities of RACF personal care staff, nurses, management, and dental practitioners who might be engaged by residents/their representatives or the facility, the 'processes' section of the *Results and Processes Guide (2019)* might provide a valuable guide to RACFs as to what they should be doing to maintain the oral health of residents. In this regard, the ADA refers the Commission to the discussion and recommendations on pp.17-20 of its original 2019 submission.

With respect to improving outcomes measurement, the ADA believes that assessors should also be required to speak to a number of dentists who have treated one or more residents recently (but who don't have an employment relationship or other ongoing financial relationship with the facility). They should call these dental practitioners and speak to them briefly to check what *they* think of the facility's approach to managing residents' oral care.

Dentists can tell whether their patient(s) from the facility who need help with cleaning their dentures or brushing their teeth have been receiving that help, and whether or not routine screening for potential oral health problems, appropriate revisions to care plans and timely referrals for treatment are occurring, because if these things have not been happening, it is obvious when they examine the patient(s).

Dentists can also comment on whether the aged care provider and their staff actively support provision of quality professional healthcare, for example, by provision of clean treatment room within the facility, and/or prompt provision of information required to treat the patient safely (which varies in scope depending on whether they have treated the patient before, and how recently that was).

Proposition D4: Fund services delivered by hygienists and dental/oral health therapists to carry out regular oral health assessments and personal care worker education in oral hygiene

This proposition states that:

The Australian government should establish a new mechanism to fund organisations to supply oral hygienists and dental and oral health therapists to residential aged care facilities to carry out regular oral health assessments and personal care worker education in oral hygiene.

Counsel Assisting made these additional statements in relation to the proposition:

52. The Royal Commission has heard evidence about the importance of oral health assessments for older Australians, particularly those living in residential aged care. There is currently no requirement for a formal oral health assessment to be conducted as part of the aged care assessment conducted by a local assessor from ACAT.

53. Ongoing and basic dental services can be provided by oral hygienists and/or dental and oral health therapists in a residential aged care facility with very little in the way of specialised equipment. These services include oral examinations, scale clean and polish, extractions and restorations (not endodontic or prosthodontic).

54. This proposition (D4) suggests that funding be provided to dental and oral health organisations through a national dental scheme to provide ongoing services to residential aged care facilities. In the alternative, funding could be provided directly to residential aged care providers to engage dental health practitioners. Another alternative is that funding could be provided to the public dental services proposed in Proposition D1 to provide these oral hygienists and dental and oral health services.

[32] Chalmers et al, (2009). "Caring for oral health in Australian residential care", *Dental statistics and research series no. 48.* Cat. no. DEN 193. AIHW, Canberra.; Lewis A, Wallace J, Deutsch A & King P. (2015). "Improving the oral health of frail and functionally dependent elderly", *Australian Dental Journal*, 60 (1 – Supplement), pp. 95-105.

55. Other mechanisms for funding could include: an MBS item for oral health assessments for Australians aged over 75 years, inclusion of oral health assessment in the ACAT process (with an appropriate referral pathway), or mandatory oral health assessments upon entry to residential aged care.

56. However, these mechanisms would not necessarily provide ongoing oversight of oral health needs by qualified practitioners and would not contribute to increasing the oral health capability and processes of residential aged care facilities.

With respect to personal care worker education, the ADA concurs that the mechanisms suggested at para 55 would not be sufficient to increase the oral health capability of residential aged care facilities. Instead, we agree that the engagement of dental practitioners to provide this ongoing training is a preferable arrangement. With respect to provision of ongoing oral health assessments within RACFs, the ADA supports the view that dental hygienists and dental/oral health therapists could provide these services, but it would be important that they provided them as part of an integrated dental team.

As outlined in the ADA's original submission, two recent NSW examples of innovative, dental team-based approaches to provision of better oral care for aged care recipients that have received support from the ADA, individual ADA members and the ADHF are Concord Repatriation General Hospital's *Reach-OHT* program,[33] and the Senior Smiles program,[34] information on which has already been provided to the Commission.[35]

Another example is provided by a proposal put forward by the South Australian branch of the ADA (ADASA), in response to the South Australian Dental Service's plans to end its existing Residential Aged Care Facility Dental Scheme.[36] A proposal with the needs of frail older people in rural, regional and remote areas in mind, it would involve dental hygienists and oral health therapists working within aged care facilities to provide staff oral health training, oral health promotion to residents and families, preventive hygiene services, as well as screening, potentially taking intra-oral radiographs where clinically justified, and referring patients to dentists. To reduce the need for face-to-face appointments, examinations facilitated by the hygienists/oral health therapists using intra-oral cameras to provide "live feed" video to dentists located offsite could be used, facilitating diagnosis and treatment planning by the dentist, who could then manage treatment needs either using portable dental technology, or, where necessary, treatment in a more traditional clinic setting.

What the ADA does not agree with, however, is the proposition (para 53 above) that dental/oral health therapists should be engaged to provide other dental services such as extractions and restorations in residential aged care facilities. Dentists have a broader knowledge of pharmacology and the complex range of health conditions that affect the frail aged, and are better suited to providing invasive treatment (where necessary) to RACF residents, many of whom are on multiple medications that significantly raise the risks associated with invasive treatment. Dentists are also qualified to provide a wider range of treatments and so offer residents more choices and options.

It is also important to note that such programs are not a panacea that will make up for poor oral hygiene care delivered by personal care staff on a day-to-day basis. The Commission will recall evidence provided by Adrienne Lewis, a nurse who has long been involved in the development of programs to improve the standards of oral care in residential aged care, through her work with the SA Dental Service.

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[33] Wright C, Law G, & Chu S et al. (2017). 'Residential age care and domiciliary oral health services: Reach-OHT- The development of a metropolitan oral health programme in Sydney, Australia', *Gerodontology,* 34(4), pp.420-426. http://onlinelibrary.wiley.com/doi/10.1111/ger.12282/full.

[34] Wallace J.P. et al. (2016). 'Senior smiles: preliminary results for a new model of health care utilizing the dental hygienist in residential aged care facilities', *International Journal of Dental Hygiene* 14(4), pp. 284–288. http://onlinelibrary.wiley.com/doi/10.1111/idh.12187/abstract

[35] http://www.adansw.com.au/getattachment/e618bbcd-16f4-44ff-b99e-0d93adf76289/Model-Scopes-of-Clinical-Practice-Discussion-P-(2).aspx

[36] Papageorgiou, A. (2020). 'SADS Residential Aged Care Emergency (RACE) Dental Service.' *Dental Insights*, The Magazine of the Australian Dental Association, South Australian Branch Inc., 33 (3), pp. 20-21; Papageorgiou, A. (2020). 'SADS Residential Aged Care Emergency (RACE) Dental Service - Part 2', *Dental Insights*, 33(4), p. 10.

In her witness statement, Dr Lewis commented on the South Australian Dental Service's Residential Aged Care Facility Dental Scheme, a program that includes public sector provision of portable dental equipment to a small number of RACFs, and public/private sector dental hygienists and dental/oral health therapists who conduct oral health assessments, provide oral hygiene services, and work as part of a team with private dentists who follow up with any necessary comprehensive examination and treatment on-site. She noted that although initially highly motivated, some of the dental practitioners involved become highly discouraged and even refused to visit some of the participating RACFs because they find that 'rather than dental professionals providing preventative treatments, aged care facilities are essentially using costly Dentists/Hygienists/Oral Therapists to make up for the problems caused by missed daily care.'[37]

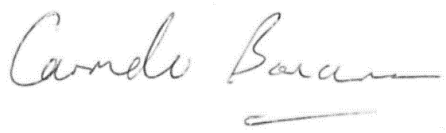
In later oral evidence provided at the Cairns Hearing, Dr Lewis exhibited a picture of a resident's partial dentures covered in a great deal of calculus, because personal care workers had not bothered to provide any daily oral hygiene maintenance and had left the dentures, which should be removed and cleaned at night, in the mouth for weeks. Yet the facility had a dentist and a dental hygienist who attend the facility every four weeks, and who had left this woman's mouth in decent shape following their visit four weeks earlier.

Her conclusion was that the unintended consequence of having this visiting dental program was that care workers felt that care of the mouth was "someone else's problem".[38]

In conclusion, whilst provision of regular professional oral hygiene services to consenting patients is a worthwhile aim that could be funded using the SDBS, improving the oral health of RACF residents will require that all those involved in resident care—particularly the Australian Government which funds and is responsible for regulation of the system, aged care facility management, general practitioners, nursing staff, and personal care staff—are required to take responsibility for it, and are held accountable where it is neglected.

Should you have any further questions concerning this matter, please do not hesitate to contact Dr Fiona Taylor, Senior Policy Officer, on 02 8815 3334 or at fiona.taylor@ada.org.au

Yours sincerely,



Dr Carmelo Bonanno
President

[37] Adrienne Lewis Witness Statement, Cairns Hearing, p.16, https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/16-july/WIT.0246.0001.0001.pdf
[38] Transcript. Cairns Hearing, pp. 3688-3689. https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-16-july-2019.pdf