Response ID ANON-7EJJ-84Z2-8

Submitted to **Aged Care Workforce Strategy**
Submitted on **2018-03-16 11:40:48**

PART A: Demographics

1 Do you give consent for your submission to be published in whole or in part?Please select one item (required):

Yes

2 What is your name?

Name:
Fiona Taylor

3 What is your email address?

Email:
fiona.taylor@ada.org.au

4 Are you answering on behalf of an organisation and have authorisation to do so?

Yes

5 If you answered yes to the question above, please provide your organisation's name.

Organisation:
Australian Dental Association

6 Where do you live or where is your organisation based?

Not Answered

(Optional) Indicate your City/Town::
The ADA is a Federation with branches across Australia

Details about your organisation

7 What role best describes your organisation? Please select all that apply:

Peak body – professional

If other, add in text box below:

8 Does your organisation provide support or services to any people with diverse characteristics or life experiences? Please select all that apply.

Care-leavers*, Lesbian, gay, bisexual, transgender and intersex people, Parents separated from their children by forced adoption or removal, People from Aboriginal and/or Torres Strait Islander communities, People from culturally and linguistically diverse backgrounds, People who live in rural or remote areas, People who are financially or socially disadvantaged, People who are homeless, or at risk of becoming homeless, People with mental health problems and mental illnesses, People with a disability, Veterans

9 In which states/territories does your organisation deliver services? Please select all that apply:

NSW, Victoria, Queensland, WA, SA, Tasmania, ACT, NT

(Optional) What is the name of the towns/towns that your organisation delivers services to?:

More details about you

10 What role best describes you? Please select one item:

Other

If other, please specify::
Oral health advocate responding on behalf of Australian Dental Association

11 Do you identify with any of the following groups with diverse characteristics and life experiences? Please select all that apply:

For aged care providers only

12 What types of care does your service deliver? Please select all that apply.

If other, please specify::

PART B: Shaping the Aged Care Workforce Strategy

1 Why does an aged care workforce strategy matter?

Why does an aged care workforce strategy matter?:
The reasons that an aged care workforce strategy is urgently required are well documented in the Senate Community Affairs Aged Care Workforce Inquiry report and Legislated Review of Aged Care Report (henceforth the "Tune Report") published in quick succession in mid-2017.

The ADA is chiefly concerned with the negative impact that current workforce arrangements are having on the quality of oral and dental health care received by aged care consumers with high dependency needs, particularly within residential aged care facilities (RACFs).

Successive studies (see bibliography and links at Q.11) have found that the prevalence of "generally inadequate" oral health care provision in such facilities is acknowledged as a significant concern by many care staff who work or have worked within the sector. Many residents unable to brush their own teeth might only have their teeth brushed by staff once a week, and those who are less able or willing to participate in the process can go for weeks or months without having their oral hygiene attended to.

Aged care staff and academic research studies into oral health provision in aged care settings have indicated that workforce-related issues are amongst the key reason for this. These issues include:

- Reliance on non-dental professionals for oral health status assessment and care planning on intake, with the result that many aged care residents enter care with undiagnosed oral or dental disease, discomfort or treatment and care needs that often go unnoticed and untreated unless they result in systemic infection.

- Lack of clinical leadership or oversight of oral and dental health care by management and overloaded senior nursing staff, with the result that junior staff responsible for day-to-day oral hygiene care provision see it as being less "essential" than other types of personal care.

- Inadequate staff-to-resident ratios in many facilities that leave personal care workers insufficient time for the oral care of residents with more complex needs.

- Lack of entry-level qualification requirements for personal care workers in relation to areas such as oral health or dementia care, and

- Lack of regular and sufficient on-the-job training to ensure that new or existing staff develop and retain skills to provide oral care to residents with complex health conditions, cognitive/communication difficulties, or behavioural and psychological symptoms of dementia (BPSD).

2 What practical difference do you hope a strategy will make?

What practical difference do you hope a strategy will make?:
In the ADA's view, an Aged Care Workforce Strategy should have a major focus on how aged care services can better fulfil their responsibilities to provide high quality care, particularly to the most vulnerable amongst the aged population who are unable to advocate for their own needs or perform daily preventative health care routines for themselves.

In particular, it is important that an aged care workforce strategy improves the capacity of aged care providers to deliver best practice oral and dental health care to this group.
Australia's National Oral Health Plan (COAG Health Council 2015) notes that older Australians—and most particularly those on low incomes—have high rates of periodontal disease and tooth decay, which often goes untreated because of a range of access barriers including transport, physical access and cost. Many suffer frequent toothache, but affordability issues mean that they put off going to the dentist until there is an urgent problem. Long waiting lists for anything but emergency dental treatment through the public system reportedly leave many aged people suffering "immense pain and diminished quality of life" for significant periods of time (Lewis et al. 2015: 97, 9).

In addition to compromising the capacity to eat and speak, the undiagnosed or untreated dental disease, pain and discomfort found to be so common amongst the residential aged care population has many other under-recognised and adverse consequences for general health. These include increased risk of for bacterial infections of the blood, aspiration pneumonia (a major cause of mortality in this age group), exacerbation of cardiovascular disease and diabetes, and preventable hospitalisations for treatment of dental disease or its complications.

Dental disease, pain and discomfort that goes unnoticed, undiagnosed or untreated in aged care can significantly reduce quality of life and emotional/psychological well-being. Often, it is implicated as a causal factor behind the escalation of BPSD amongst dementia sufferers.

These consequences can be avoided. Aged care providers should ensure that a dentist examine and treat any oral or dental problems aged people have when they enter residential or high needs home care and formulate a preventive and treatment oral care plan that informs provision of preventive oral hygiene care by aged care staff thereafter. Risks to health and wellbeing posed by poor oral health are best minimised by ensuring that any dental disease or dental maintenance requirements are addressed prior to any further deterioration in mobility, physical health, or cognitive/communicative capacity.

3 How do you think a strategy can contribute to meeting future needs in aged care?

How do you think a strategy can contribute to meeting future needs in aged care?:
An aged care workforce strategy that results in better oral and dental health for the aged care population can help to reduce the significant indirect costs to government health budgets of poor oral health in this age group, which have been estimated to run into hundreds of millions of dollars per annum.

Less strain on government health budgets from preventable oral and dental disease and its complications will increase fiscal capacity to fund other services for the aged, including aged care services.

It is important to recognise that even if an Aged Care Workforce Strategy results in aged care staff having the time and the training they need to provide better preventive oral health care, an industry-led workforce strategy will not be sufficient to ensure that aged care consumers actually receive the oral and dental health care that they need.

It is also essential that government acts to:

- Ensure effective monitoring of the quality of oral and dental care provision within aged care

- Increase the affordability of dental treatment for aged care consumers, and

- Provide necessary funding support both to providers, and dental practitioners, to ensure that aged care consumers who are unable to undertake treatment in private or public dental clinics, can access dental treatment outside the private dental clinic setting (see response to Q. 4).

QUALITY MONITORING

The ADA is concerned that evidence of generally poor oral health care provided within residential care has continued to mount despite an Aged Care Quality Standards Framework that, until now, has been explicit about the quality oral and dental health care outcomes it expects of aged care providers.

In an earlier submission to the Department of Health regarding the new Single Aged Care Quality Framework (see link at Q.11), the ADA has already expressed concern that the removal of explicit, assessable standards in relation oral and dental health care from the new 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.

This is particularly a concern in the light of evidence that the attitudes of some aged consumers and their families towards oral and dental health care are influenced by a perception that oral disease is inevitable in old age, and by a lack of knowledge about the relationship between oral health and general health.

In other words, choices and preferences with respect to the relative importance of oral health care are often formed on the basis of misunderstandings about the extent to which poor oral health compromises general health and wellbeing and quality of life. Other aged care consumers may simply be unable to communicate the fact that they need help with a problem in their mouths that is causing them distress.

For these reasons, the ADA supports the recommendation of the recent Review of National Aged Care Quality Regulatory Processes that the Aged Care Quality Agency must take steps to boost the capacity of its assessment teams to accurately monitor the quality of clinical care being provided in aged care.

AFFORDABILITY OF DENTAL TREATMENT

Another critical current and future need in aged care that requires urgent government action is the declining affordability of dental treatment for aged care consumers. This issue, and the ADA's proposals to address it, are discussed in more detail in the ADA's 2018—19 Prebudget Submission (see link at Q.11).

Aged care staff report that it is often affordability concerns that prevent aged care consumers or their representatives from seeking required dental treatment. Affordability barriers to treatment may increase for aged care consumers if, as foreshadowed in the Tune Report, the Federal Government will require aged care providers to recoup a greater proportion of the total costs of care (and accommodation where applicable) from consumers than they are required to contribute now.

The ADA has proposed that the Federal Government introduce an Aged Pensioner Dental Benefit Schedule (APDBS) in the 2018–19 Budget, along the same lines as the existing Child Dental Benefits Schedule. This would allow aged pensioners to obtain all services included in the ADA Schedule and Glossary, up to an annual or bi-annual monetary cap, from either private or public dental practitioners.

By supporting access to private dental services for the purposes of oral health assessments and care planning on admission to residential aged care, the APDBS will also support the individually-tailored planning and delivery of daily oral health care that has been found to be so important to the oral and general health trajectories of residents.

Furthermore, the ADPBS will also support affordable access to dental care for aged consumers who live independently in the community, or with the support of government-funded Community/Home Care services.

4 Tell us what you see as the changes on the horizon that aged care needs to be ready for, and how you think the workforce strategy can contribute to meeting these future needs (in the context of an ageing population calling on aged care services in a variety of settings)?

Please tell us what you see as the changes on the horizon that aged care needs to be ready for, and how you think a strategy can contribute to meeting these future needs?:
In addition to accommodating the forecast rapid growth in demand for aged care places, aged care providers need to be able to adjust the quality of the oral health care they deliver to accommodate the trend to an increasingly dentate aged population, which brings about some new challenges. Despite the functional benefits of a natural dentition, dentures are often easier for the frail aged and their carers to look after than natural teeth, and an increasing proportion of aged care consumers who retain some or all their natural teeth may have had complex restorative treatment that requires a higher level of maintenance by experienced

dental providers. Older people with complex health conditions are often on equally complex medication (“polypharmacy”) regimens. Some of these medications reduce the flow of saliva which this significantly increases the risk of dental caries, infective episodes and periodontal (gum) disease unless daily attention is given to oral hygiene.

As a corollary of increasing longevity, the proportion of aged care consumers with dementia, mild cognitive impairment and communication disorders will also increase into the future. This population may not only require assistance to maintain their oral health but also have difficulties communicating that an oral health problem is causing them discomfort or distress. Taken together, these factors mean that provision of high-quality oral care will become an increasingly complex and challenging responsibility for residential and home/community aged care workers.

Rapid expansion of an increasingly dentate aged population receiving care in residential facilities, in their home, and in rural and remote communities where it is not sustainable to have a dental clinic, will increase the need for dental practitioners to provide treatment in locations outside a dental clinic.

Lack of full facilities available when providing treatment outside a dental clinic can compromise the provision of care, so dental practitioners strongly prefer to provide treatment in their clinics.

Aged care staff often report that a lack of suitable and affordable transport services pose significant barriers to aged care residents who wish to seek treatment within private dental clinics. Government should provide funding support to ensure that such services are readily available to aged care consumers who are able and willing to travel to receive treatment in the normal dental clinic setting.

Private dental practitioners also face both financial disincentives and logistical barriers to working on-site in RACFs, particularly in rural and remote locations. Financial disincentives arise through the potential income earning time lost in travelling to and from facilities, and logistical barriers arise because even larger RACFs tend not to have well-equipped dental surgeries on the premises.

Many RACFs do not even have suitable treatment rooms for use by visiting health professionals. Even where they do, and where mobile dental equipment can be obtained by the dental practitioner, he or she may face the logistical problem of collecting and transporting it to the facility and returning it.

Residential aged care facilities should plan for an increased demand for dental care from residents unable or unwilling to travel, by providing designated areas and equipment for dental treatment. Larger aged care facilities should provide a fully equipped dental surgery, and government should provide any necessary funding assistance to meet establishment costs.

Government should also provide funding support to private dental practitioners to cover any significant travel costs that may be associated with the provision of dental treatment in RACFs.

Further, to meet the needs of aged care consumers in rural and remote areas, government funding support with establishment or travel costs may be required to increase the supply of mobile dental clinic services.

Government action to ensure affordable and timely access to dental treatment under general anaesthetic in hospitals or accredited day facilities is also urgently required to meet the dental treatment needs of aged care consumers who can only be safely treated in these settings. This issue, and the range of government action required to ensure adequate and affordable access to this treatment modality, is discussed in detail in the ADA’s 2018–19 Pre-Budget Submission (linked below).

5 Tell us what is working well in the aged care workforce (across the industry, at provider or service level or through place-based initiatives) and where future opportunities lie.

Tell us what is working well in the aged care workforce (across the industry, at provider or service level or through place-based initiatives) and where future opportunities lie.:
The ADA is aware of a number of dentists who are already providing mobile dental clinic services to RACFs in various states of Australia, including NSW and Victoria.

Several other programs using dental-team based approaches to oral and dental care in RACF’s have been developed systematically and are being researched as they progress. These include the Concord Repatriation General Hospital Oral Health Programme (see Wright et al. 2017) and the Senior Smiles model (see Wallace et al. 2016).

Critical in any programme such as these is the involvement and supervision of a dentist as the clinical team leader to ensure that appropriate diagnosis and treatment planning can occur.

The ADA is also aware of collaborative approaches to the development of resources that can be used as oral health promotion resources and oral healthcare toolkits for health service providers serving the aged care population (see Centre for Oral Health Strategy 2014).

6 What do you think are the key factors the Taskforce needs to consider to attract and retain staff?

What do you think are the key factors the Taskforce needs to consider to attract and retain staff?:
Other organisations may be better placed to advise on what is required to attract and retain appropriately qualified nursing staff, and personal care staff (personal care attendants in RACFs, and community care workers in home/community care) who presently provide the bulk of direct personal care provided in residential aged care facilities and to residents on high-needs home care packages.

However, the ADA notes the widespread concern articulated by NACA, the Senate Committee Aged Care Workforce Report, and the Tune Report that unless pay, contract terms, working conditions, workloads, skills development opportunities, and day-to-day training and support offered by residential aged care providers and management are improved to match those offered in other health care settings (e.g. acute care), or by other employers (e.g. public sector positions,

or disability services providers) the aged care sector will have great difficulty attracting and retaining workers in these categories.

The ADA is also aware that that the ratio of the aged care workforce with clinical qualifications and expertise, such as registered nurses and allied health professionals, to less qualified personal care workers who provide some 90% of direct care is inadequate to ensure the necessary clinical supervision.

As noted earlier, dental practitioners are rarely employed by RACFs, and aged care workers report that dentists and oral health care professionals are rarely consulted for advice on how to overcome barriers to tooth brushing and cleaning experienced with individual residents. One reason for this is that residents and family members often withhold approval for funding the consultation.

Both the Senate Community Affairs Committee and the Tune Report identify a need for aged care providers to better utilise and integrate existing medical, dental, and allied health expertise and resources into the aged care workforce, though not necessarily through direct employment relationships.

The ADA supports the view that to boost the quality of clinical and oral health care, aged care providers should conceive of their clinical care workforce as clinical care teams including both employed staff, and flexible collaborative partnerships with independent private and public practitioners working within their own clinics, in the aged person's home, or on-site at RACFs in suitably equipped examination and treatment facilities.

The ADA also broadly supports the recommendation of the Senate Community Affairs Committee's Future of Australia's Aged Care Sector Workforce report that government should develop scholarship and other support mechanisms to help nurses, doctors, dental practitioners and other allied health staff to undertake specific geriatric and dementia training, and to promote the supply of an adequately skilled workforce in regional and remote areas. It should be noted that despite an oversupply of dental practitioners in Australia, there is a current shortage of Special Needs Dentist in Australia and efforts should be made to support specialist training in this area.

Given the current limited coverage of geriatric dentistry within higher education courses accredited as meeting Australian dentist practitioner registration requirements, the ADA is doing its part to meet future skills demands by offering an expanding suite of continuing professional development courses in geriatric dentistry, covering the full spectrum of relevant issues.

7 What areas of knowledge, skills and capability need to be strengthened within the aged care workforce?

What areas of knowledge, skills and capability need to be strengthened within the aged care workforce? :

The knowledge, skills and capability of the aged care workforce in relation to oral health care needs assessment, oral health care planning and oral health care provision all need to be strengthened.

Given evidence that the oral and dental health of high needs aged care consumers tends to decline rapidly in the year prior to entering care, all aged care consumers should be examined on intake by a dentist practitioner, who can develop an oral health care plan in collaboration with the aged care facility or aged care service staff.

All aged care staff who supervise or provide personal care should receive skills training in provision of oral hygiene maintenance, and dental screening to monitor oral health status, and trigger dental referrals when needed.

In particular, the aged care workforce involved in direct care need greater knowledge and skills in how to manage provision of routine preventive oral hygiene care to aged consumers with more complex needs, including those with dementia, other cognitive or communication related disabilities, or other complex medical conditions.

8 What do you think is needed to improve and better equip the workforce to meet individual needs and expectations?

What do you think is needed to improve and better equip the workforce to meet individual needs and expectations?:
See response to Q.4

9 What is needed for leadership, mindset and accountability to innovate and extend new way of working tailored to the needs of older people who use aged care services, their families, carers and communities?

What is needed for leadership, mindset and accountability to innovate and extend new way of working tailored to the needs of older people who use aged care services, their families, carers and communities?:
As noted in the Review of National Aged Care Quality Regulatory Processes (2017:vi), "effective clinical governance" is "critical to ensuring that residents are well cared for."

This point equally applies in relation to ensuring the quality of oral and dental health care provided to people who require and receive oral health care as part of high-level home care packages, demand for which is expected grow at a faster rate than demand for residential aged care places.

Effective clinical governance of oral and dental health care provision through aged care facilities and home care packages is best achieved through better utilisation of the expertise of registered dentists in private practice. Greater engagement between medical and dental practitioners would assist in the integration of assessment of oral health needs as part of a comprehensive aged-care health plan.

For example, a network of dentists could provide the structured professional framework necessary for dental teams to complete dental examinations on intake and treatment as required. Dental practitioners and allied dental personnel can work with aged care providers and recipients on a part-time basis to provide preventive oral health care training and mentoring to direct care staff, to educate aged care consumers and their families and carers about oral health and ensure timely treatment referral pathways back to dental team leaders.

10 What should aged care providers consider with workforce planning?

What should aged care providers consider with workforce planning?:
The Taskforce should note that Health Workforce Australia's projections in relation to the oral health workforce (see report linked below) suggest that there is a current oversupply of dental practitioners that is likely to persist at least until 2025.

Given this, there is plenty of capacity to better utilise the expertise of dental practitioners within aged care into the future.

When considering how best to integrate this expertise into the aged care workforce, aged care providers must take account of the Dental Board of Australia's scope of practice registration standards (see link below) developed under section 38 of the Health Practitioner Regulation National Law, as in force in each state and territory.

The Board's scope of practice registration standards establish that only dentists can practice all parts of dentistry as independent practitioners. Dental hygienists, dental therapists, and oral health therapists may only practice within their scope of practice as part of a dental team, in the context of a structured professional relationship with a dentist who is the clinical team leader.

Additional comments

11 In undertaking its work, the Taskforce has been asked to have regard to recent submissions to and reports of relevant inquiries on aged care workforce matters, and government responses. If you want the Taskforce to draw on a submission you have made, or evidence or materials you want to draw to our attention, please provide the details in the text box below.

If you want the Taskforce to draw on a submission you have made, or evidence or materials you want to draw to our attention, please provide the details in the text box below.:
Recent Australian research reports that provide detailed evidence on the changing oral health care needs of the aged care population, and current workforce, attitudinal, financial and logistical barriers that prevent many aged care recipients from receiving appropriate and timely oral and dental health care:

Centre for Oral Health Strategy. (2014). Oral Health Care for Older People in NSW Toolkit, NSW Ministry of Health.
http://www.health.nsw.gov.au/oralhealth/Publications/oral-health-older-people-toolkit.pdf

COAG Health Council. (2015). Healthy Mouths, Healthy Lives: Australian National Oral Health Plan 2015-2024
http://www.coaghealthcouncil.gov.au/Portals/0/Australia%27s%20National%20Oral%20Health%20Plan%202015-2024_uploaded%20170216.pdf

Hilton S, Sheppard JJ & Hemsley B. (2016). 'Feasibility of implementing oral health guidelines in residential care settings: views of nursing staff and residential care workers', Applied Nursing Research, 30, May, pp. 194-203. http://hdl.handle.net/1959.13/1320045

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). http://onlinelibrary.wiley.com/doi/10.1111/adj.12288/epdf

Slack-Smith L, Durey A and Scrine C. (2016). Successful aging and oral health: incorporating dental professionals into aged care facilities, Centre of Research Excellence in Primary Oral Health Care, University of Western Australia.
https://rsph.anu.edu.au/research/projects/successful-ageing-and-oral-health-incorporating-dental-professionals-aged-care

Wright FAC, Chu SK-Y, & Milledge KL et al. (2018). 'Oral health of community-dwelling older Australian men: the Concord Health and Ageing in Men Project (CHAMP)', Australian Dental Journal, 63(1), pp.55–65. http://onlinelibrary.wiley.com/doi/10.1111/adj.12564/full.

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.

Wallace JP, Mohammadi J, Wallace LG & Taylor JA. (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

See also:

Health Workforce Australia. (2014). Australia's future health workforce – oral health detailed report.
https://www.health.gov.au/internet/main/publishing.nsf/Content/3CFAE9DEE7BB7659CA257D9600143C09/$File/AFHW%20-%20Oral%20Health%20Detailed%20report.p

Dental Board of Australia (2014) Scope of practice registration standard.
http://www.dentalboard.gov.au/Registration-Standards/Scope-of-practice-registration-standard.aspx

ADA Policy Statements setting out the ADA's position on the provision of dental and oral health care in residential aged care facilities and people unable to access dental clinics, and associated workforce, training, dental and public education and funding issues:

https://www.ada.org.au/Dental-Professionals/Policies/National-Oral-Health/2-3-3-Aged-Persons/ADAPolicies_2-3-3_AgedPersons_V1

https://www.ada.org.au/Dental-Professionals/Policies/National-Oral-Health/2-3-7-Individuals-Unable-to-Access-Dental-Clinics/ADAPolicies_2-3-7_IndividualsUnabletoAcce

Recent ADA Submissions that include comment on funding and workforce issues affecting access to quality oral and dental health care for aged care recipients,

and links to further evidence supporting claims and suggestions made in this submission:

https://www.ada.org.au/News-Media/News-and-Release/Submissions/Specialist-Dementia-Care-Units-Consultation/ADA_Submission-to-DoH-SDCU-Consultation

https://www.ada.org.au/News-Media/News-and-Release/Submissions/2018-19-Federal-Pre-Budget-Submission/ADA-2018-19-Federal-Pre-Budget-Submission_

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-con

12 Is there anything else that you would like to contribute to inform the Taskforce? Please contribute using the text box below. Alternatively, using the link below, add an attachment in Word or PDF to express your views or ideas more comprehensively.

Please contribute using the text box below.:

Using the link below, add an attachment in Word or PDF to express your views or ideas more comprehensively.:
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