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Dental Public Health in Action

Stakeholder involvement in designing an oral care training package for care home staff

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This paper describes the principles applied and the challenges met while seeking user and other stakeholder perspectives before designing an oral care training package for carers in nursing and residential care facilities. The public health competencies it illustrates include the application of appropriate leadership styles, strategic management, collaborative working and knowledge of research methodology.

Key words: *caregiver, nursing staff, residential facility, dental care for elderly, proprietary health facilities, training activities*

Initial impetus for action

In the United Kingdom, 2009 mid-year population estimates by the Office of National Statistics showed there were 1.7 million more people over the age of 65 years compared with 25 years previously. Within this group, the fastest growth has been seen in the number of people aged 85 and over, which has more than doubled in the last 25 years and is predicted to reach 5% of the total population by 2034 (Office for National Statistics, 2012). The increase in the number of older people, with various needs and self-care abilities has serious implications for the provision of health and social care in the UK. As a greater proportion of the population survives to very old ages, the public health impact of the burden of disease, disability and related utilisation of medical care and the need for supportive and long-term care has become an important concern.

The combination of frequent sugar intake, poor oral care and medications that affect salivary flow, means that older people in care homes are at higher risk of dental disease (Steele *et al*., 2001). In addition, older people living in long term care are often dependent on others for their diet, personal care and access to healthcare. Carers are frequently unaware of the importance of oral health care within holistic care, and are not often provided with professional instruction on how to deliver oral care effectively (Fitzpatrick, 2000). In addition, psychological barriers to working in another person's mouth are widespread among caregivers (Fitzpatrick, 2000; Frenkel *et al*., 2000).

Oral health education for older people in care has focused mainly on the oral health training of care home staff. A cluster randomised controlled trial undertaken in the South West of England showed that oral health training of carers had a positive effect in reducing the plaque scores and improving denture hygiene of residents in nursing homes (Frenkel *et al*., 2001) A more recent study showed that oral health training of care home staff improved oral health knowledge although attitudinal barriers still existed towards oral care (Reed *et al*., 2006). Barriers to providing oral care from carers' perspectives include complex communication difficulties, behavioural problems of residents, work place constraints, lack of time and the low priority of oral health (Chalmers and Pearson, 2005). Although this research demonstrates the effectiveness of oral health training, in all cases members of the community dental services or oral health improvement team delivered this to carers face to face, which has significant resource implications for the universal delivery of training in care homes.

Carers' training needs

A 2012 questionnaire survey of care home managers and carers in five areas in the West of England identified a need for oral care training in care homes. Questionnaire data from 404 carers across 123 care homes was collected (28% of all care homes in the region from CQC registers). It should be noted in the absence of a definitive list of all carers in the region, there is no way to identify what proportion of carers were sampled. The questionnaire included a series of questions on attitudes and perceived barriers to delivering oral care and the level of oral care training. Overall the data were positive, with 85% of carers stating they felt confident about cleaning their clients' natural teeth, and a clear majority feeling that time (79%), support (74%) or equipment (79%) were not barriers to providing care. Interestingly, only 38% had undertaken any oral care training and 59% requested further training (Figure 1).

Current level of training

The oral health improvement team covering the West of England had developed direct training with care homes, which was adapted from the Caring for Smiles programme in Scotland (NHS Health Scotland, 2010). This entailed face-to-face training over a maximum of three hours to a group of carers. The purpose was to develop oral health

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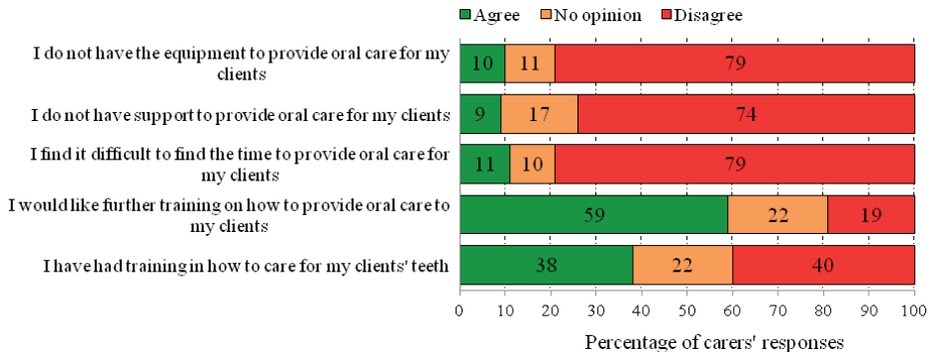

Figure 1. *Carers' questionnaire responses to training and barrier questions (n=123)*

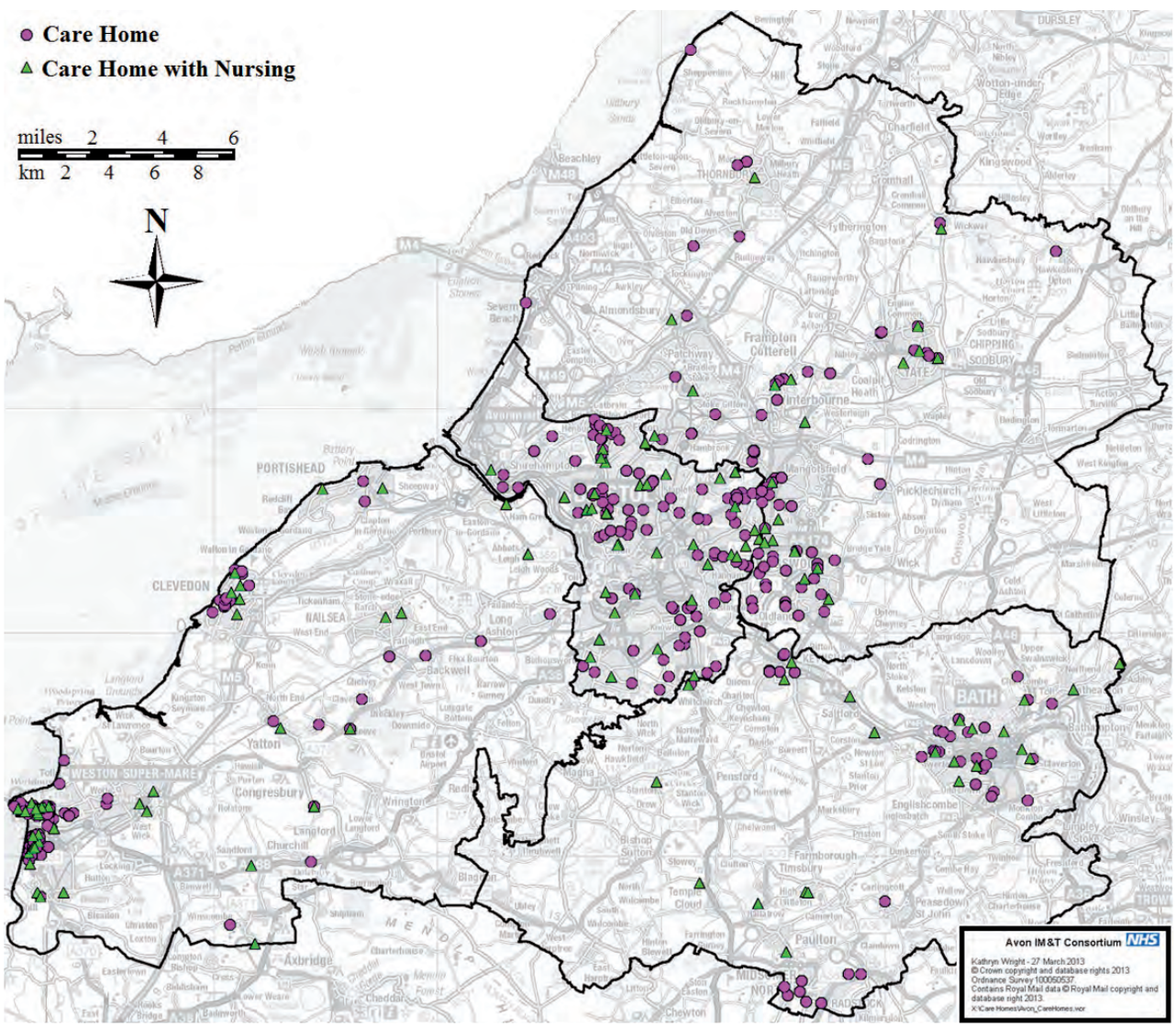

Figure 2. *Map showing the distribution of care homes in Bristol, North Somerset, South Gloucestershire and Bath and North-east Somerset, March 2013*

training leads within the homes, whose staff could then cascade the information to other members of the care team. This programme had been running for a year, and 28 homes had been approached. On discussion with the oral health improvement team, we considered the issues faced and long-term feasibility of delivering a direct face-to-face training model. The issues raised were as follows.

- Large geographical areas with a large number of care homes covered by the salaried dental services' oral health improvement team. The region covers approximately 1,343km^2 and has 443 care home providers (Figure 2).
- Limited community dental service (CDS) resources: The oral health promotion services have been working within the CDS (and its forerunners) for many years. This service had been in a state of flux for some time, and is still significantly understaffed, with 3 members of staff (1.4 whole time equivalent) who also have clinical roles.
- Care home perspective: Based on the small number of carers attending previous training sessions, the OHP team reported the initial availability of staff to undertake direct training at point of delivery and the high staff turnover impacts negatively on ease of arranging training, the certainty of encompassing all carers and the long term benefits which might be achieved.

With these issues in mind, we planned to develop more practical, pragmatic and cost effective training.

Solution suggested

We considered it was important to step back and involve stakeholders to establish the best method of delivering training. By including the recipients of the training and their managers, we could ensure that the training developed and mode of delivery were viable for the care homes, their staff and the oral health improvement team.

In the context of our project, stakeholders were considered to be any who would have a direct interest in the development, delivery and evaluation of an oral care training programme. Stakeholders could provide insights, which would then inform the planning of the timing, method and content of the training besides their personal involvement at this stage potentially increasing commitment to and adoption of the resulting training. We decided that stakeholders would include care home business teams, care home managers and carers.

Although the potential benefits of involving the stakeholders were expected to be considerable, the reality of their involvement was complex.

Actual outcome

To initiate engagement, contact was first made with the Associate Director of non-acute and social care who provided details of an independent voluntary and community sector organisation called The Care Forum. The Care Forum is host to a number of local health improvement networks and supports communications, consultation and networking with the voluntary and community sector. We attended the Care Services Provider Forum, a meeting that is hosted three times a year and is open to all providers of care including care homes, domiciliary care and supported living providers. We attended this forum to present the idea of oral care training and collaborative working and to develop relationships with the care home community. Parallel to engaging care home providers in meetings, we also liaised with the regional research design service whose staff were able to provide guidance on engaging stakeholders and had links with care homes that had previously engaged in research.

Turning to outcomes, via the research design service and care forum, we were able to engage with three care home providers who owned multiple care homes across the region and set up meetings with the business teams of each provider. The opportunity to discuss the practical aspects of delivering a training programme from a business perspective was valuable to considering delivery options. Other programmes being used and barriers to delivery were explored. The business teams were able to provide links to care home managers and therefore care staff in their homes, and in each case, they made these introductions.

Although contact was made with a number of care home managers, due to time and workforce restraints we were only able to work with three homes. We spent either a morning or an afternoon at each of the three care homes, meeting the managers and carers. Planning was the key to obtaining valuable information from care home staff without disrupting their daily routines. Having previously telephoned the care home managers, meetings with the care home teams were informal and fitted around their work routines. It would have been too disruptive to set up focus groups with staff so we met them in small groups in their work units for up to 15 minutes. We were able to meet with the managers and discuss the project at greater length.

Challenges addressed

Building an engaged community takes time and a track record of success. By linking in with the Care Forum and RDS, we were able to develop the relationships they had already built with care providers. Care homes can be challenging places to engage with as they host diverse populations, provide a range of services and are businesses. For already stretched care home staff, engaging in service development can be seen as just another pressure. Ultimately, collaboration in developing any services or training is to the benefit of the residents and staff. However, the practicalities of such collaborations need to be carefully thought out. In our case, it was important to understand the care home environment and work within their restraints. This did mean that the ideal approach could not always be followed (such as face to face meetings or focus groups) but it encouraged care homes to engage and showed our willingness to work within their schedules.

This engagement process presented a number of challenges. The main challenge was the time required to undertake the process comprehensively. The whole process spanned longer than we had anticipated at six months, primarily due to the logistics of arranging meetings. Having liaised with the RDS and Care Forum, it was three months before we were able to arrange meetings with Care Home Business Teams. It was another three months before we completed our meetings with these teams. The business

teams worked across many sites, in one case this was the South of England and Ireland, so arranging meetings was difficult. We were only able to meet one local provider in a formal meeting with other discussions being held over the telephone. Scheduling these meetings and discussions required great flexibility and was only possible because of the availability of a trainee to undertake the work. Then it was a difficult to balance achieving our agenda while not imposing on the care home's operations.

Meeting with care home staff was equally challenging. To minimise disruption we were operating on the care home's schedules. Staff were very busy, and at one site we arranged to meet in the morning, which was not practical at all as staff were busy getting residents ready for the day. Consequently, we returned in the afternoon, when the workload reduced somewhat and we were able to speak to staff. We had to accept speaking to only a small proportion of the staff, as they worked shifts and we only met with those daytime staff working that day. There was a cost to this process although no home requested any funding, the RDS did make us aware of guidance on payment for such stakeholder involvement though we felt as the process was so informal, payment would not be necessary. However, travel to sites for meetings and time away from other duties for the trainee meant the process did pose an opportunity cost. Despite these challenges the process was valuable. The temptation at the start of the project was to get into the design of the training pack, but stepping back and linking in with the care home teams, including business and service, was vital to developing sustainable training that was fit for purpose.

Future implications and learning points

Our initial plan had been to consider an online learning system. However, having met with the business teams, care home managers and carers a number of important points were raised which altered our initial training plan. These included the following.

- Accessibility: A key learning point was that although we had presumed that staff would have internet access at work, in reality while staff had access to computers, not every site had internet access.
- Time: All staff appreciated the value of oral care training and were keen to undertake it. However, the business team, managers and carers had concerns over when the staff would undertake this training. It was agreed, this would be within working hours, so the programme would need to be short enough to be accommodated within their working day.
- Cost: Although valuable, the providers were not keen to pay a large premium for the training. We had not considered the programme costs to purchase, so the raising of this issue was useful. It was determined that if there was a cost to the home the product would need to provide long term value for money.
- Language: A large proportion of the carers, probably from overseas, had inadequate English language skills as revealed by their misinterpreting or misunderstanding the questionnaire. Any learning package would need to display the information in an easily understood manner.
- Written support: Carers were keen to have printed as well as electronic support. A reference guide with images was suggested for residents and family members too, so oral care support could be comprehensive.
- Videos: Care home staff were very keen to have video demonstrations of skills that they could apply. They raised the issue of a lack of clarity about the practical techniques of oral care, such as patient positioning.
- Contacts to dental services: A few care home staff felt unsure of how to access emergency or routine dental services and sought clarification on this point, as it was difficult to get immediate access to general dental practice or domiciliary care.

Future Developments:

Having liaised with the stakeholders, we plan to develop an electronic video manual for care home staff. This will run as an oral care tutorial with useful videos and information embedded to ensure it is easily understandable. Contact details for the CDS and OHP teams will be added to the package, to provide a point of contact for dental services, and the importance of communication with care homes fed back to the OHP team. The CDS and DPH departments hope to pilot the pack in the next six months with three of the care homes which participated in the stakeholder involvement.

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