

Opinions of administrators and health authority inspectors on implementing and monitoring the oral health regulation in long-term care facilities in British Columbia

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ABSTRACT

Objective: To explore how a government regulation on oral health care in long-term care (LTC) facilities has been implemented in British Columbia (BC). **Introduction:** In 2009, the Government of BC enacted a regulation confirming the joint responsibility of dental professionals and administrators of LTC facilities for the oral health care of LTC residents. This regulation was intended to direct attention to the apparent widespread neglect of oral health of the residents and to improve oral health care in the facilities. **Methods:** Open-ended interviews with two health authority inspectors and five LTC administrators were conducted to determine how the regulation has been implemented in the facilities. Observational notes were made before and after each interview, and participants were selected purposefully to obtain a range of experiences and opinions on the implementation process. The relationships among the various perspectives were analyzed thematically by a constant comparison of responses. **Results:** Two major themes emerged from the interviews: 1) inspection by government officials; and 2) the administrators' perception of oral health care. Inspectors explained that government wanted LTC residents to be examined at least annually by dental professionals. For the most part, however, inspectors do not assess oral health care unless there are complaints from dental professionals or a formal complaint to government. Administrators generally seemed unfamiliar with the regulation, and did not expect that oral health care would be part of the government inspection. **Conclusions:** The regulation on oral health care in LTC facilities in at least two health authorities in BC is not achieving its objectives because health authority inspectors do not usually inspect the specific oral health care practices of the facilities.

RÉSUMÉ

Objet : Examen de la réglementation des modalités d'application des soins de santé buccodentaire de longue durée (SLD) en Colombie-Britannique (C.-B). **Introduction :** En 2009, le gouvernement promulguait une réglementation confirmant la responsabilité conjointe des professionnels et des administrateurs de la prestation des SLD en matière de santé buccodentaire chez les résidents en SLD. Cette réglementation avait pour objet de porter attention à l'apparente évidence de la négligence concernant la santé buccodentaire des résidents et l'amélioration des modalités de prestation des soins buccodentaires. **Méthodes :** Des entrevues à questions ouvertes avec deux inspecteurs en autorité et cinq personnes administratrices de SLD ont cherché à déterminer les modalités d'application de la réglementation. Des notes d'observation ont été retenues avant et après chaque entrevue et les personnes participantes ont été choisies délibérément pour obtenir une gamme d'expériences et d'opinions sur l'application de la procédure. Les relations entre les diverses perspectives ont fait l'objet d'une analyse thématique par comparaison constante des réponses. **Résultats :** Deux thèmes majeurs ont émergé des entrevues : 1) l'inspection par les représentants du gouvernement et 2) la perception des administrateurs de la santé buccodentaire. Les inspecteurs ont expliqué que le gouvernement voulait que les résidents des SLD soient examinés au moins annuellement par les professionnels dentaires. Toutefois, la plupart des inspecteurs n'évaluent pas la santé buccodentaire à moins de recevoir une plainte des professionnels ou si une plainte officielle est présentée au gouvernement. Les administrateurs ne sont généralement pas familiers avec la réglementation et ne s'attendent pas à ce que les soins buccodentaires soient inclus dans l'inspection gouvernementale. **Conclusion :** Pour au moins deux autorités de la santé de la C.-B., la réglementation des soins buccodentaires dans les services de SLD n'atteint pas ses objectifs parce que les inspecteurs des autorités de la santé n'inspectent pas de façon particulière la pratique des soins buccodentaires dans établissements concernés.

Key words: oral health, government regulation, long-term care, frail elders

INTRODUCTION

Long-term care (LTC) facilities, known also as residential, complex or extended care facilities, and nursing homes provide medical, rehabilitative, custodial, social, and residential services to people with chronic cognitive and/or physical disabilities.^{1,2} Although little attention seems to be given to mouth care in most facilities, and oral diseases are rampant among the residents,³⁻⁷ administrators generally

believe that oral health care is provided satisfactorily.⁸⁻¹¹ However, there is little agreement on how care should be regulated in LTC facilities,¹² and there are significant gaps in policy, education, and clinical standards to guide oral care.¹³ So, apart from the possibilities that administrators are overwhelmed by conflicting priorities of care¹⁰ or that some are disengaged from the daily needs

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of residents,¹¹ it is not clear why this apparent neglect and misunderstanding occur. There have been reports that many care-aides lack the skills to clean the mouths of residents with complex oral conditions.^{10,14-16} A survey of and interviews with the staff and administrators of a facility in British Columbia (BC) some years ago found that “issues such as time, increased workload, limited staff, and the lack of an accountability structure are disabling factors for provision of daily mouth care” in the facility.¹⁷ In addition, the cultural divide between dentistry and medicine has effectively excluded dentistry from the interprofessional teams that organize and deliver health care in most LTC facilities.¹⁸ Professional segregation of dentistry from medicine almost everywhere frequently precludes oral care as an integral part of geriatric care,^{12,19} and in-house training of care-staff for mouth care rarely translates into sustainable improvements in care to residents.²⁰⁻²²

The neglect of mouth care in LTC facilities is compounded certainly by the limited education of dental professionals in dental geriatrics,^{23,24} and by the concerns of clinicians that they are not paid adequately for their domiciliary services when compared to in-office services.²⁵ Furthermore, outside of BC, Alberta, Saskatchewan, Manitoba, Ontario, and Nova Scotia, dental hygienists in Canada can provide clinical care only under the supervision of a dentist.¹²

Moreover, publicly and privately funded LTC facilities in Canada operate under various health care policies and payment systems.^{12,26} Two-thirds of the facilities in BC are licensed by municipal health authorities under the provincial *Community Care and Assisted Living Act* (CCALA) (SBC 2002, c75), while the others are licensed either as private hospitals or extended-care units of public hospitals and regulated by the provincial *Hospital Act* (RSBC 1996, c200). Nonetheless, all of the facilities, no matter how they are licensed, are “subject to the regulations” of the CCALA (*Hospital Act*, RSBC 1996, c200, part 1, 4[3]). Oral health care is identified in the most recently amended CCALA as a Residential Care Regulation (BC Reg 96/2009), which states in section 54 (3) that a licensee must

1. encourage persons in care to be examined by a dental health care professional at least once every year; and
2. assist persons in care to
 - i. maintain daily oral health;
 - ii. obtain professional dental services as required; and
 - iii. follow a recommendation or order for dental treatment made by a dental health care professional.

This regulation (henceforth referred to as the “Regulation”) applies to the six health authorities in the province, and is supposed to form part of the annual inspection of LTC facilities by health authority inspectors or licensing officers.²⁷ However, in BC this legislation, like similar legislation in Sweden and elsewhere in Canada, is vague on how it should be implemented and monitored.^{15,28} Aka et al.²⁹ contend that the legislation does little to ensure that administrators are accountable for providing a uniform standard of care. Consequently, the research questions underlying our qualitative investigation were

as follows: a) What was the intent of the Residential Care Regulation (BC Reg 96/2009) in BC? b) How has it been implemented? and c) How has it been monitored over the past two years?

METHODS

Consistent with the methodological principles of grounded theory as interpreted by Corbin and Strauss,³⁰ we conducted open-ended personal interviews with two health authority inspectors and five LTC facility administrators in BC (Table 1). All interviews were audio recorded. Approval for the investigation was granted by the Providence Health Care Research Ethics Board (H10-02941).

Based on existing information about conflicting priorities of care,¹⁰ we selected participants on the principle of theoretical sampling from the roughly 200 LTC facilities for seniors in BC to document a range of opinions and experiences related to the Regulation.^{27,30} We used a snowball approach to extend the scope of the investigation by soliciting from each participating administrator the names of colleagues who might have additional information or different perspectives on the Regulation.³¹ Three administrators were selected from

Table 1. Characteristics of the facilities and their administrators

Facilities			Administrators	
Identification	Regulation	Number of residents	Education	Years of experience
A1	Hospital Act*	100	Nursing	0.5
A2	Hospital Act*	150	Social Work	1.5
A3	Hospital Act*	80	Nursing	10
A4	CCALA**	117	Nursing	3
A5	CCALA**	90	Business	8

*Hospital Act (RSBC 1996, c200)

**Community Care and Assisted Living Act (SBS 2002, c75)

facilities licensed under the *Hospital Act*, whereas the other two were from facilities licensed under the CCALA. Both before and after each interview, and with informed consent, we made field observations on the daily operation of each of the five facilities in order to provide a context to the analysis of each interview.³¹

Telephone calls to each of the five health authorities in the province revealed that these authorities employ about 150 health inspectors who are responsible for monitoring a range of services including child care, food safety, and LTC facilities, but only about 12 of them inspect the LTC facilities. Written requests and follow-up telephone calls to each authority yielded only two inspectors (a nurse [#1] and a dental hygienist [#2]) who were willing to participate in our study. Each inspector represented one health authority and offered insights into regional variations in enforcement policies and practices.

An interview guide was constructed prior to the first

interview from the results of previous interactions with administrators of LTC facilities in BC,^{10,32} and focused on how the administrator felt about the implementation of the Regulation. All interviews used a nonjudgmental approach, with questions such as “What do you know about mouth care regulations?” and “How have you been involved with the licensing inspections?” which were designed to allow participants to respond freely. After analyzing the verbatim transcript of the first interview, we identified issues needing clarification or further development, and modified the interview guide accordingly for the next interview using the principles of constant comparison.³³ The transcripts were imported to a computer program (NVivo 9, Burlington, MA: QSR International Inc. USA) that helped us to manage the iterative process of the analysis. Relevant units of text were coded openly, axially, and selectively by the two authors to produce categories of information that most aptly explained the beliefs and behaviours of the participants relevant to our research questions.^{31(p462–468),33,34}

The credibility of each interview was determined by comparing the responses against the web-posted results of each facility’s inspection by the regional health authority and by cross-checking them against the results of the other interviews. The participants received our summary of their interview and were asked to check it for accuracy and clarity.³⁵ This process of constant comparison continued until a saturation of our analysis was achieved. Sampling was discontinued when the new recruits confirmed the information provided by previous participants without adding any new information.^{31(p246)}

RESULTS

Inspectors' perception of the oral health regulation

Regardless of the type of license that a LTC facility has, the municipal health authorities are currently responsible for all inspections. Both of the inspectors explained that, although they inspect facilities regulated by the *Hospital Act*, they had no legal mandate to enforce the requirements in the Residential Care Regulation. Nonetheless, the LTC facilities operated typically from protocol manuals derived from the Residential Care Regulation. Inspector #1 admitted hesitantly that “oral care, to be honest with you, is a very small part in our inspection. We don’t get a lot of things [inspected] when we have two hundred [licensing requirements to inspect].”

Both inspectors explained that oral care would only be inspected if the health authority had received a complaint. Over one-third (40%) of the inspections in one health authority between February and August 2011 included assessments of oral health, and all of the facilities met the oral health care requirement.³⁶ As described by inspector #1, these public reports correspond to a similar trend observed over the previous seven years during which no oral health-related violations were documented. Inspector #2 explained that dental professionals who were dissatisfied with a resident’s oral health often did not complain formally lest they “not [be] welcomed back.” The absence of complaints usually led an inspector to assume that the facility was in compliance with the

Regulation. Furthermore, both inspectors were sensitive to the likelihood that residents who had not seen a dentist regularly before admission were unlikely to seek one after entering the facility. They were aware also that “some residents may only want to receive care from one specific care-aide who may only work part-time,” which made it difficult to provide adequate daily mouth care. Both inspectors also emphasized that, under the Regulation, LTC administrators are only required to “encourage” residents to obtain an annual examination. While the Regulation requires LTC staff to customize oral care plans based on the annual examination and recommendations from dental professionals, LTC staff were absent when dental professionals were examining residents. Moreover, the dental recommendations were written without input from the reviewers of the care plan.

The website for the Ministry of Health describes the general role of a health authority inspector.²⁷ However, both of the inspectors who were interviewed explained that the role of inspectors in each health authority depended on the resources and needs of the local population. For example, inspector #2 was employed specifically to inspect and support the development of oral health care programs within the region and to educate other health inspectors about oral health care. According to inspector #2, this education component meant that

inspectors were then able to understand the complexity of oral health and how it relates to overall health. Thus, they were able to look critically at the oral care plans of the residents with the idea that it was adequate or that improvements were needed. They could call upon the oral inspector if they felt there were inadequacies that needed to be addressed in order to bring the residence into compliance with the regulations.

Although some administrators are aware of the Regulation, Inspector #2 explained that “they weren’t quite clear on how to comply.” She explained further that she looked for evidence that “the administrator [made] oral care... a priority... [with] oral care supplies” and also helped them to establish oral care programs, procure oral care supplies, and find dental professionals to help the residents when necessary. However, she complained that administrators continuously identified a lack of funds as a reason for neglecting oral care even though the

regulations are quite clear... we don’t deal with money, we don’t give them more money if they say they don’t have enough. So that would not be our problem... and we don’t let them use that as an excuse, but they don’t stop using it. They use it all the time.

Inspector #2 did have the authority to intervene on behalf of the residents, and occasionally issued a requirement that residents receive “chlorhexidine twice a day” as a

mouth rinse. Apparently, some administrators resented this intervention while others appreciated the advice and the educational role combined with the regulatory role of the inspector. Inspector #2 told us how she

didn't go in as an inspector saying oh this is what you're doing and this is what you're not doing.... I tried to help them get to where they needed to be... so it was more of an education-support role.

Despite requests from other authorities, it seems that this educational support was limited to facilities in the health authority where Inspector #2 worked. Facilities elsewhere, she said, funded their own educational programs in oral health care or had to "rely on private dental personnel to come in to provide it."

Neither inspector was familiar with the standards of oral health care required by the other four health authorities in BC. The inspection forms used by both inspectors required that "[p]ersons in care [be] assisted in daily oral healthcare and [be] encouraged to have a dental exam once a year." Only one authority specified that "assistance [be] provided to obtain dental services and to maintain recommended or ordered dental treatments."³⁶

Inspector #1 explained that health authority inspectors throughout the province generally check that residents with a toothache are attended to appropriately:

They'd ask what [LTC staff] do if Mrs. Smith has a toothache... [and whether or not] the form gets posted... in the part of the chart that's supposed to be looked at; [and a] three day follow up written down somewhere.

Inspector #1 told us also that he and others would randomly check for compliance with specific care plans and whether or not the records indicated that recommendations or orders from dental professionals were met. They do not, he said, "check whether they have toothbrushes... we just monitor their system... [of] how the oral health[care] is carried out."

Administrators' perception of the regulation

One of the five administrators interviewed was familiar with the Regulation, in part because her facility had obtained funds from the provincial dental association to establish an oral care program for residents. Two of the administrators in facilities regulated by the Hospital Act (RSBC 1996, c200) knew that they were subject to the general Residential Care Regulation but they were unfamiliar with the section on oral health care. Nonetheless all of the administrators interviewed believed that health inspectors "have final authority on everything... [they] look at the residents, talk to them, [check the] environmental situation [and] nursing-related issues ... but [they have] nothing to do with oral care"(interviewee A3). As a result, none was particularly concerned about the standard of oral health care provided

by their staff. Each administrator, at some point during his or her interview, used the terms "guidelines," "protocols," and "policies" interchangeably. Four of them claimed to have a mouth care policy in place but were unaware of the operational details and could not provide a copy because, as one of them explained,

I have my resources and my support people and they tell me what I need to know as I need to know it. So I wouldn't be [familiar with] mouth-care policy [which] is one policy out of thousands of nursing policies (interviewee A2).

Another administrator told us that oral care was similar to other types of care:

[we] don't really have a policy on oral care ... but it's handled with our systems in a "completion of care plan." If a person needs anything out of the ordinary with oral care it would be expected to be put on the care plan (interviewee A4).

"The normal policy," according to another administrator (A4), "ensures that everyday [the residents] brush their teeth... in the morning [and] before they go to bed."

The administrators all shared the belief that accountability for oral health can and should be delegated entirely to dental professionals. One explained that their staff could not "do oral care as well as the professional [since mouth care is not] as high up there as perhaps bathing... because [it] is a more difficult job" (interviewee A1). Yet, she told us that she was willing to coordinate visits by dental professionals whom she expected would identify the need for follow-up treatment. Another showed us a document with, as she pointed out, "a place for the hygienist [to report] any concerns" (interviewee A3), yet we heard also how "we'll encourage people to go see the dentist... [but] we can't fund things we don't have the money for" (interviewee A5).

Difficulties in getting the nursing staff to comply with orders from dental professionals are ongoing. One administrator, for example, explained the challenge of getting her staff to change from "toothettes" to toothbrushes following the recommendation of a dental professional:

It was a big battle to [remove] the little toothettes that had sponges on the ends of them...because [residents] didn't have to have the mouth open... [the care-aides] were ordering them all the time to try to get them back (interviewee A1).

Another administrator explained how similar problems could be overcome by involving the staff in decisions to change because "nothing works better than when people develop [a guideline] themselves and understand it ... and they can work with it" (interviewee A5).

Consequently, all of the administrators assigned to their nurse managers the responsibility for assessing oral health, which in one facility included "chewing problems, mouth pain or swallowing problems ... [or] debris present

in the mouth prior to going to bed at night”(interviewee A3). In addition, they all mentioned that they reviewed the daily care plans for each resident. Two of them used the “Point of Care*” computer program based on the Minimum Data Set† as the protocol for a quarterly audit of the care plans. Daily mouth care in one facility was recorded in a “daily record of events” confirmed by a care-aide’s signature and checked by a nurse. Yet, another administrator acknowledged that this did “not always correspond exactly to what you see in [the resident’s] mouth” (interviewee A4). Two other administrators (A1, A3) explained that they had audits in place, because health authority inspectors reviewed care plans randomly without looking inside the mouths of residents.

Other administrators unfamiliar with the Regulation assured us that they provided mouth care supplies to their residents. One believed that “there is some cost-benefit” (interviewee A1) to providing the supplies, although another questioned the cost-benefit of this service because audits of oral care are unusual and the residents’ families rarely complained.

DISCUSSION

The most significant and unsettling finding of this study was that administrators and health inspectors generally make little effort to implement the Regulation. Four of the five participating administrators were unfamiliar with the Regulation, and seemed only mildly concerned about this oversight because they expect dental professionals to address oral health care needs periodically. Perhaps more importantly, they know that health authority inspectors also tend to overlook oral health care. Compliance with a similar regulation in Australia was enhanced by formally auditing and re-auditing the activities of nurses.³⁷ McNally³⁸ and Pruksapong³⁹ suggest that public accountability for oral health care in Canadian LTC facilities would improve if oral health were considered an integral part of the mainstream healthcare system. Aka et al.²⁹ believe that citations by inspectors for non-compliance with health regulations can hold LTC administrators accountable, but that inconsistencies in the enforcement of regulations, as revealed by our study, impede the quality of care.⁴⁰

The developers of the Regulation expected that LTC staff would be mentored in oral health care by the oral health professionals who conducted the annual dental examination.³² Clearly this was not happening in the facilities we visited, nor has it happened in Sweden under similar circumstances,¹⁵ probably because the care staff did not help with the oral examinations or pay much attention to the recommendations of the oral health professionals. Daily mouth care interventions by nurses and care-aides can improve general health,⁴¹ yet our study participants seemed reluctant to attach much significance to the possibility of oral health care enhancing general health,

possibly because they lacked a standard of oral health.⁴²

Administrators should enhance strategies to communicate the recommendations of care plan conferences attended by multiple care providers.⁴⁰ In addition, professional segregation of dental professionals from medicine and nursing requires further study. In Sweden, a study by Andersson et al.,¹⁸ although not extensive, shows quite clearly that some physicians in Sweden believe that the mouth and teeth are the sole responsibility of dental professionals. In our experience, their findings are relevant to BC. A framework for evaluating oral health care in LTC facilities based on a combination of quality assurance and health-program evaluation has been proposed to provide formative evaluations from multiple perspectives,³⁹ and in the hope that it would lead to more morally defensible outcomes in the facilities as a result of increased priority afforded to oral health by administrators.⁴³ Administrators of a facility can distribute workloads to include healthy mouth care for residents,^{44,45} and the care-aides or nurse managers can provide formative and summative feedback on the outcome of this care.⁴⁶ However, only efficient communication among all members of staff will ensure an acceptable quality of care.^{46,47}

This qualitative research focused on understanding the perspectives of a few select experts: administrators and health inspectors of LTC facilities in two regional health authorities in BC. An important limitation of our study is that we were unable to recruit inspectors from the other three health authorities in BC due to caseload conflicts and nonresponsiveness. However, the lack of response in some ways supports our findings by suggesting that interest in oral health care is not a high priority for health inspectors. Like all surveys and selective interviewing, it is uncertain how much can be inferred generally from the opinions and experiences of our participants. There is no doubt that oral health care continues to be managed poorly in LTC facilities globally.^{3-6,17} Consequently, any light cast on the cause of this neglect is helpful. Certainly, the cause is much more complicated than the simple negligence of administrators. Future considerations could be given to the fact that, as the study participants stated and our field observations confirmed, the LTC environment is convoluted, and oral health is but one of many concerns that needs attention.^{10,22,23} Computer software with standardized assessment protocols relating to oral health care might better align dental audits with general care plans and care pathways in LTC.^{3,48-50} A review of electronic documentation might also be revealing in terms of the general health and quality of life of elderly people who are frail and dependent on others for daily mouth care. This study of the perceptions and experiences of administrators and health inspectors is one of the few that explores the problems of oral health and neglect in LTC facilities from the standpoint of experts other than dental professionals.

* "Point of Care (POC)" is a computer program that populates assessments and expedites documentation for nursing staff to monitor the care of residents (PointClickCare POC © 2013 PointClickCare.com).

† Minimum Data Set is a protocol for assessing a resident’s general weaknesses and strengths, and customizing a care plan. (Centers for Medicare & Medicaid Services, United States Department of Health and Human Services).

CONCLUSION

The reasons for the failure to implement the Regulation in BC effectively are as follows:

1. Health authority inspectors assess compliance of facilities in response to complaints from residents, their families, and oral health care professionals. Most inspectors do not assess the specific oral health care practices of the facilities.
2. Administrators are unconcerned about the Regulation because inspectors from the health authorities typically attend only to specific complaints.

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