CARING FOR OLDER AUSTRALIANS: AN ORAL AND DENTAL HEALTH PERSPECTIVE:

At what age does an Australian become 'older'?
Is older; 50 years +, or 60+, or 70+, or 80+ or is it all of these?

Historically (5000 BC) there were times when being in your late 20s was considered 'old'. That is not the case now. Does age itself really matter?

This submission proposes that what really matters are a person's ability or disability combined with their risk of disease.

Should 'Caring for older Australians' be renamed as 'Caring for disabled Australians regardless of age'?
Some Australians are born with disabilities, most Australians develop some disabilities as we grow older, and very few of us live our entire lives through to death without having developed or acquired some physical health problem or disability. Ageing increases the likelihood of experiencing some type of physical health problems or disabilities. Oral and dental health is just one part of a larger picture, where advancing age increases the chances of acquiring a disability that will adversely affect the quality of your health.

Being 'older' or ageing *per se* is not the problem. In fact the maturity that can be gained over the passage of time is often an advantage that can translate into wisdom. However, when we get older we also have a greater risk of developing physical disabilities that prevent self-maintenance care or the individual's ability to engage in health promoting 'activities of daily living' (ADLs). In addition, when we get older we also have a greater risk of developing health concerns that require an elevated level of self-maintenance care to prevent or to treat. It is the person's level of ability to function and to engage in health promoting 'activities of daily living' that is of central importance, and not the person's specific age.

The importance of the ADLs to well-being
There seems to be very little understanding by able-bodied people of the importance of the ADLs, in maintaining delicate balance of physical, mental, emotional, social health throughout all stages of life. The issue of ADLs is very complex and is unique to each individual. ADLs can change temporarily or permanently.

- When a person is very young (baby and young child) they are unable to; feed themselves, make appropriate food selections, wash themselves, toilet themselves, brushed their own teeth, clothe themselves, make their bed, protect themselves, assess medical care, etc, etc. as the child ages they become able to undertake these ADLs for themselves

- Temporary disabilities, which can occur at any age, can be caused in many ways, for example a depressive episode, a broken limb, seasonal flu, etc. Temporary disabilities can impair a person's ability to perform their ADLs. When the temporary disability passes, ability to engage in all personal ADLs may be, hopefully, fully restored

- As a person ages they may become unable to perform some or all of their ADLs based on their level of ability and the complexity of their personal ADLS. One of the major permanent disabilities that Australia and the world must confront is dementia. Dementia directly and negatively affects an individual's ability to execute their ADLs. As people get older, the chance of developing dementia increases. As their dementia develops the suffers experience diminished capacity to engage in personal ADLs, in the same way that suffers of arthritis, heart disease, vision impairment, deafness, diabetes, etc experience diminished capacity to engage in personal ADLs.

What are Activities of Daily Living?

Every activity, which you do on a regular basis that put you, the reader, into the position where you are reading this document could be said to be your activities of daily living. Some of these ADLs are vital to survival, and some are not. For example most of you reading this document would have been able to feed yourself this morning. There are many other less vital, although very significant ADLs for personal dignity and well being, such as the task of getting dressed

- Washing yourself
- Drying yourself
- Selecting seasonally and socially appropriate clean /ironed clothing in which you feel comfortable
- Being able to put that clothing on by yourself

However, what would have happened if you had damaged either or both of your hands or have developed severe arthritis or one of the many other health changes that reduce our abilities so that you could not wash or dress yourself? If so, you would need access to someone to help you get dressed at a time convenient to you? Alternatively, did you have had to wait for that help so that you were late, or distressed, or both?

Take a moment think of the hundreds of ADLs that you do every day that most able-bodied people take for granted that people who experience disabilities might see very differently. Think for a moment what the loss of these and other ADLs might mean to your physical, mental, emotional and social health.

Getting out of bed on your own	Waiting until your carer or the nurse arrives
Being able to go to the toilet when you need	Soiling yourself because you were unable to 'hold on' until your carer arrived to help you
Wiping your own bottom after going to the toilet	Needing to have someone else wipe your bottom
Washing your hands	Being unable to stand at the basin, look at yourself in the mirror
Brushing your own teeth	Not having your dentures removed by the nursing staff for weeks on end, OR if you still have your teeth not having them brushed adequately so you develop infections
Selecting your own diet	Being forced to eat institutional food for the rest of your life. For example; may be high in sugar promoting tooth decay and other health problems
Going to the local shop for the milk you forgot to buy or to your local doctor, or dentist or hairdresser, etc	You are unable to drive now, and walking any distance is out of the question so you can't get use public transport so all of these visits are major undertakings, so you don't go as often as you want or need
Managing your finances down at the local bank	They have closed the local bank so you now need to do it online. That means buy a computer (you are unable to drive or walk to the public library), become computer competent, maintain virus protection, defend against the hackers, etc, etc

Reduced ability to perform ADLs is a little recognised predicament of living and ageing. To be able to continue to receive the significant benefits from the ADLs that we perform when able-bodied when we are no longer able to do so we will

either need enormous resources or need to accept that not all ADLs are possible to be adequately performed and may need to be forgone.

A key realisation

If we recognise that change in a person's ability to perform their ADLs will occur over their lifetime, it becomes possible to make plans. These plans might include

1. Putting in place strategies and resources to adequately maintain ADLs as performed throughout life and the lifestyle they support, such as home help, Meals on Wheels

OR

2. Developing strategies to relinquish certain ADLs and the lifestyle that these ADLs support.

This second option is largely unexplored by most people and communities. This option requires planning, education and a new way of thinking about the way we prepare for being less able (disabled) in old age.

What is meant by a 'disability'?

Disability is difficult to define but in general terms it can be considered as a condition that in some way hampers or hinders a person in terms of their ability to carry out day to day activities.
Source: Disability Support and Services in Australia, defining disability 2001, http://www.aph.gov.au/library/intguide/sp/disability.htm

"*One of the major innovations in [International Classification of Functioning, Disability and Health] ICF is the presence of an environmental factor classification that makes it possible for the identification of environmental barriers and facilitators for both capacity and performance of actions and tasks in daily living*. … *With this information in hand, it will then be more practical to develop and implement guidelines for universal design and other environmental regulations that extend be functioning levels of persons with disabilities across the range of life activities*."
Source: Towards a common language for functioning, disability and health, World Health Organization, Geneva 2002,

The extent to which a health condition hinders a person will vary from individual to individual and the general range of disabilities varies from conditions that are mild (for example, the need to wear reading glasses) to severe (for example, some forms of cognitive impairment).

Should people be forced to live with significant disability? What place is there for Advanced Health Directives? What place is there for Euthanasia?

I do not want to discuss in detail the following:

- Some people do not want to live their lives with significant disability. Especially if this disability means they must endure constant daily untreatable significant pain and discomfort.
- Some people want the right to control their own life and death, and have personal Advanced Health Directives, which they want, respected, and acted upon.
- Some people want the right to access Euthanasia to be carried out for them by a Legal Guardian, in the event that they permanently loose Mental Capacity.

I do believe these are very important issues, which need to be addressed urgently, although not in this submission.

If as a society we encourage, and legislate people to live and endure life with disability, and to an age where disabilities develop rapidly; then it is our obligation to ensure that we provide care for these people with disability so that they do not suffer and endure pain from lack of care and neglect. This is of course is irrespective of age. It is important to avoid ageism or the tendency to regard older persons as debilitated, unworthy of attention, or unsuitable for normal consideration.

How does this relate to oral and dental health, dentistry, and caring for older Australians?

In recent decades Australians have been encouraged to keep their natural teeth. With the advances in dental science, dentistry, and our understanding of the cause, prevention, and treatment of dental diseases a greater percentage of older Australians have their natural teeth than in years gone by.

Keeping your natural teeth seems like a good idea. So long as you can maintain them daily and access a professional dental care for routine services, natural teeth are not painful, and sources of infection for the rest of the body. The main alternative to maintaining one's own teeth and accessing the dentist regularly, was, and still is, to have all of one's teeth removed and full upper and lower dentures. Many people have lived full, happy, healthy, and successful lives to very old ages whilst wearing full dentures for most of their adult lives.

Activities of Daily Living for Oral Health (ADLOH)

There will be very few of you reading this submission who do not, or can not, perform essential ADLs for your personal dental care or ADLOH, such as rinse your mouth with water, brush/clean your own teeth/gums, use floss, apply a fluoride toothpaste on to your teeth, choose not to eat food with sugar all day long, can get oneself to a dentist when you have tooth or gum pain, or for a six-monthly/yearly check-up. Adequate performance of these ADLs for personal dental care will prevent tooth decay and gum disease.

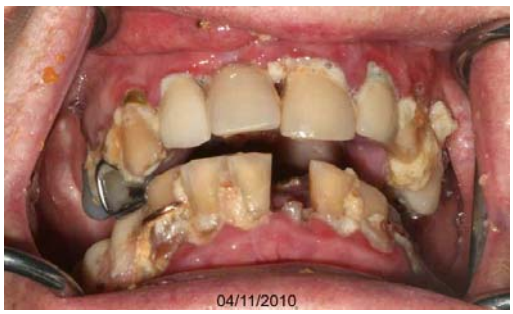
These ADLOH are just some of the activities of daily living that most people take for granted. The human tendency towards the ‘optimism bias’ means that most people think they perform the ADLOH well. However, rates for tooth decay and gum disease show people do these ADLs inadequately or insufficiently to prevent the occurrence of tooth decay and gum disease, however it should be noted that most people do enough ADLOH to stop tooth decay and gum disease becoming continually painful or life-threatening.

What would happen to your teeth and gums if you ceased being able to perform these ADLOH? Within six to twelve months you would develop tooth decay and gum disease that has the potential to become continually painful or life-threatening.

Currently we have a large percentage of the population living in Residential Aged Care Facilities who have developed a disability, of one form or another, which prevents them doing even these ADLOH. A significant proportion of these people have been encouraged to keep their natural teeth as ‘teeth-for-life’. They are now unable to care for these teeth and I contend that they are becoming ‘teeth for infection’, ‘teeth for pain’, and ‘teeth for death’.

When oral health activities of daily living are not done generally a person's mouth will become highly diseased as can be seen in the photographs I enclose. This breakdown has occurred very rapidly within just one to three years after becoming unable perform their own activities of daily living health and entering a Residential Aged Care Facility (RACF) in Australia.

Enclosed is just a sample of the poor oral maintenance, oral disease, and neglect I have collected. Further examples of this are the Appendix.



It is my overwhelming experience as a dentist who has restricted his practice to special needs, geriatric dentistry, and visiting many patients in RACFs that, a person in RACF with a disability receives **inadequate** daily oral and dental maintenance care: that is the basic activities of daily living to maintain oral health are not being provided. Even the relatively simple daily activity of cleaning the residents' dentures is generally not being adequately done. The dentures photographed are covered with stagnate food, which is months old: this is blatant care neglect.

Why are ADLOH not being carried out?

I contend that caring for another person's oral and dental health and taking over their Activities of Daily Living for Oral Health (ADLOH) is difficult. In fact, I will state quite categorically that taking over the oral health activities of daily living is exceedingly challenging, especially for a person with a highly restored (filled) teeth/mouth, regardless of whether that person experiences dementia or other disabilities.

Accuracy of RACF Records

The Oral and Dental Care Standard 2:15 in the Guidelines of the Standards and Guidelines for Residential Aged Care Services Manual requires that the "Residents' oral and dental health is maintained". Source: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-manuals-sgr-contents-gdlstd2c.htm (see appendix)

Regardless of what is written down by the RACF staff in the reporting of daily care, overwhelmingly the residents' mouths are not maintained.

The photographs I have attached of residents mouths/teeth/dentures were all taken in RACFs which the Aged Care Standards and Accreditation Agency (ACSAA) had audited and said COMPLIED with their Oral and Dental Care Standard 2:15. A layperson can see this compliance is FALSE. The auditing of the Oral and Dental Standard in RACFs by the ACSAA to date has been an abject failure and appears is complicit to the neglect, which is shown.

Please note the author has sent records to each of the RACFs, where these residents reside, with a written dental report about all these cases. Several of the residents' immediate oral disease status has been life-threatening.

What needs to change or stop?

The residents, society, and health professionals are not helped by:

- Care staff writing down that they have done oral care, when they have not done the care activity adequately, or at all.
- People pretending to teach oral care activities they are not able do in situ, day-to-day, and in the real world. This is currently happening throughout Australia. See the media release attached.
- Poor auditing of the Standards (in this case the Oral and Dental Standard), and incorrectly acknowledging compliance when it is not actually occurring, and failing to implement investigation to see beyond the falsified records.
- Inaccurate diagnosis/record keeping and acknowledgement of the actual health status means appropriate planning cannot occur for the individual, RACF cohort, and the whole society.

A serious medical and dental health problem exists in Australia now because of the falsification of oral and dental records in RACFs for accreditation, and the failure of the aged care accreditation agency to see past this. We are facing a 'tsunami of dental neglect' in our RACFs. RACF residents are dying from their infected teeth, and poor oral hygiene.

Is having a 'beautiful straight white' smile very important?

I am not going to discuss dental cosmetics in detail; however it needs to be put into perspective. Cosmetic/beauty dentistry could easily be viewed as a fashion issue and possibly a mental health issue, which is subservient to the issues of general health, oral function, infection, and pain.

As an example of the society confusion about cosmetics, physical and mental heath: We have a large percentage of the Australian population who are overweight, which is generally considered; non-beautiful, a general heath risk, and restricts function, however many of these overweight people want for example, perceived 'beautiful hair styles' and perceived 'beautiful teeth'.

Wherever a person wishes to sit within this 'perception of beauty/cosmetics' and the health risks they are prepared to take to have this specific type of beauty may be best discussed in a psycho/social/marketing/mental health setting.

Human Rights and Guardianship.

One significant area of concern for a person without capacity or a person with cognitive disability in a RACF is the issue of human rights and guardianship. Currently there does not exist any formal process for a care-worker or health provider, who detects medically/dentally neglected or abused of a resident of a RACF to:

- Report oral health neglect or abuse
- Institute humanitarian care of the neglected or abused resident
- Initiate thorough investigation of the oral health neglect or abuse
- Refer penalties for neglect or abuse.

If you are not going to look after them why do you keep them? I am referring to teeth!!

Virtually every RACF Clinical Nurse Manager who I have ever met has said that before they become a resident in a nursing home, people should get all of their teeth extracted. The alternative is to suffer years of oral and dental infection.

Having functioning, infection-free, and pain-free teeth is preferable to not having teeth, if you can maintain them. Having no teeth is preferable to having non-functioning, infected, and painful teeth.

Not having teeth is a disability and presents challenges; however people do not actually need natural teeth to live a full healthy life. We do not even really need dentures, however there are times when one thinks that a set of teeth, natural or dentures, look nice. However:

- You do not need teeth, to breath.
- You do not need teeth, to swallow.
- You do not need teeth, to drink water.
- You do not need teeth, to masticate/chew food. Food processors and blenders have been around for a many years now,
- Chewing hard food such as a raw carrot is not essential to survival.
- You do not need teeth, to speak. However, a person generally speaks more clearly with top teeth or top dentures.
- You do not need teeth to kiss.

You do however, not want your teeth, natural or dentures, to be covered in large amounts of stagnant food impregnated with pathogenic and virulent microorganisms shown in the photographs. It becomes very easy to inhale these pathogens. Inhaling this stagnant infective material is a cause of aspiration pneumonia, which is a common cause of death of the elderly especially in RACFs.

Put simply:

- It is the activities of daily living of oral health, which you do every day, that allow you to keep your teeth and gums disease free or relatively disease free.
- These ADLOHs generally involve cleaning the gums and teeth, using a fluoride toothpaste, avoiding eating/drinking sugar all day long, rinsing in your mouth, however it may also involve taking out, cleaning, storing in water overnight and putting in a partial or full denture, or managing a grinding night-guard/splint, visiting a dentist, or other dental care professional.
- The day you are unable to do these daily tasks, which slow down or prevent oral and dental disease is the day that you will need to have someone do these activities for you, or oral and dental disease in your mouth will develop.
- Currently it is legislated that those residing in RACF have their oral and dental health maintained. This daily maintenance for the disabled elderly is clearly not being done.
- Not providing care when it is need is neglect
- Aged Care Standards and Accreditation Agency is not detecting this oral and dental maintenance care neglect.
- Virtually all RACFs in Australia according to Aged Care Standards and Accreditation Agency 'comply' the Oral and Dental Health Standard 2:15, which is inaccurate and of great concern.
- If we are not going to help people with disability maintained their teeth and gums and dentures surely we need to have the honesty to say that we are not going to do this.
- Falsified and inaccurate records prevent the extent of the problem of care, in this case oral and dental, from being fully understood.
- Without knowing the extent of the problem it is virtually impossible to plan strategically, practically, financially to how to prevent these people with disability from enduring sometimes years of life-threatening infection and associated recurrent acute and chronic pain.

If you went to your dentist right now and said, from today:

- I am not going to brush my teeth or gums'
- I am going to stop using a fluoride toothpaste,
- I'm going to eat and drink sugar regularly throughout the day every day.

Your dentist would probably recommend that you have your teeth taken out and dentures put in place because your teeth will very soon become destroyed, and become sources of infection, pain and have a deleterious effect on your general health. This is a fact. This is happening in our RACFs for the last few decades.

Access to a dental work area, surgery and portable gear surgery

To some degree this is important because obviously fillings do not last forever and need to be repaired or replaced. Even in the well maintained mouth problems will occur that require a dental professional, to repair and this is always better done in a well serviced dental surgery unit, and/or in a specifically designated area with good portable dental equipment. However it is important to remember this is not the primary answer or solution to addressing oral health of residents in RACFs.

It is interesting to note that in most of the RACFs I visit most of the facilities have an area designated for the residents' hair beautification by a beautician/hairdresser, however fail to have even the most rudimentary area for oral and dental care to be used by a dental professional. Recommendations for oral and dental care designated areas have been in place for many years now, however very little has been done.

It is important to reiterate that unfortunately many dentists and health professional bodies do not understand that the fundamental and most important aspect of the oral and dental health for a person with a disability, such as the aged in RACFs, is not their access to a dental surgery or portable gear surgery, or having a trained person who can do dental surgery for this cohort. What is important is the **daily** maintenance care and having a person who is capable and going to do the **daily** maintenance care for another person who then does this care: Daily maintenance

care, which is done every day, efficiently without causing the person with disability discomfort or damage.

Clive Rogers

A short biograph Clive Rogers:

- Registered dentist in WA since 1981
- Member of the ADA WA since 1981.
- Qualified educator
    - Graduate Diploma in Education (Primary) 2003,
    - Nationally Certified Level IV Trainer 2007.
- Guest lecturer in the topic *Special Needs & Care Dentistry*, in the Bachelor of Dentistry degree at The School of Dentistry, University of Western Australia (2004-2009)
- Clinical Tutor at The School of Dentistry for many years
- In 2008 The School of Dentistry conferred title Senior Clinical Lecturer.
- I work mainly as a private domiciliary (visiting) dentist in RACFs, hospitals, and other Special Needs facilities (starting in 1996 and exclusively after 2002 to the present).

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-manuals-sgr-contents-gdlstd2c.htm

Standards and Guidelines for Residential Aged Care Services Manual - Guidelines

Standard 2 Guidelines of the Standards and Guidelines for Residential Aged Care Services Manual

---

Section 3: Guidelines, Last updated 1 May 1998

2.15 Oral and Dental Care

Expected Outcome

Residents' oral and dental health is maintained.

Preamble

This Expected Outcome provides for maintaining residents' oral and dental health and access to professional services to achieve optimum oral and dental care. A dental problem may be the cause of distress or challenging behaviour especially in residents unable to articulate their symptoms.

Staff should understand that oral health has a major influence on residents' quality of life and that continuing dental management assists them as far as possible to eat and talk comfortably, feel happy about their appearance and to stay free of pain from dental causes.

The management of oral conditions and dental diseases is essential to minimise oral sources of pathogens and to alleviate oral side effects of medications, such as dry mouth syndrome.

Considerations

- Procedures for assessing, documenting, treating and regularly reviewing each resident's oral and dental health needs
- Consultation with each resident or their representative in relation to their oral and dental care
- Resident care plan identifies the treatment required to maintain the resident's oral and dental hygiene, including daily oral hygiene and any necessary assistance
- Identification of oral and dental services available to residents
- Resident information on the services available and associated costs
- Documentation of referrals to oral and dental services
- Procedures to encourage and assist residents to maintain their oral and dental health
- Assistance for residents in the care and storage of their dentures
- Residents' dentures discreetly marked
- A system to ensure prompt repair or replacement of dentures
- Staff education addresses oral and dental care, including strategies for residents with dementia and challenging behaviours.

THE VISITING DENTIST
CLIVE ROGERS BDSc (WA), Grad Dip Ed (prim), Cert IV Trainer
SENIOR CLINICAL LECTURER
The School of Dentistry
University of Western Australia
Provider N$^{o:}$ 0579689L

5th March 2009

To Whom It May Concern:

Re: Media Release: The Hon Justine Elliot (Minister for Ageing) Australia's first dental plan for nursing homes. (1 March 2009)

Dr Clive Rogers is delighted that the plight of the dental health of Residential Aged Care Facilities (RACF) residents is being considered. While the Minister's plan sounds as if it will address the problem, in fact there are several major flaws in this plan that will prevent it from solving aged residents' dental needs. Dr Rogers identifies the flaws in the Minister's plan and then proposes a solution that will work.

In summary, the first major flaw is the idea that "dental assessments in the ACAT (Aged Care Assessment Team) process" does not specifically propose that a dentist should conduct these assessments – Oral Examination. The oral and dental care status and care plan needs of the elderly, when they move into institutionalised residential care, is one of the most complex in dental practice. These elderly deserve to be assessed by a dentist, and not a non-dentally qualified health worker as part of the ACAT process.

The second major flaw is the idea that "a staff member from all 2830 aged care homes will be trained in dental hygiene by next year (2010)."

- There is simply not enough time between now and the end of 2010 to train 2830 people to a satisfactory standard in dental hygiene care – unless it is acceptable that the training is superficial, totally inadequate and a complete waste of everyone's time and resources.
- There is effectively only one in-depth and extensive course (with currently only one experienced and qualified trainer) in existence in Australia that could deliver a satisfactory level of training. This course can only train a limited number of people at any one time, until further trainers with sufficient experience can be trained to deliver the course.

The third major flaw is the idea that "The trained staff member will educate other aged care workers to help maintain the teeth of nursing home residents."

- It is unrealistic and unsatisfactory to expect inexperienced and superficially trained carers to be able to adequately train other staff back at their RACF to deliver adequate oral and dental hygiene to their residents.

The delivery of oral and dental daily maintenance care for residents in RACF with high dental needs and low compliance requires considerable knowledge coupled with highly developed hand-skills. To acquire any complex hand-skills that are underpinned by theoretical knowledge, the knowledge must be studied and the hand-skills must be practiced; and practiced before the learner can be assessed as attaining competence to perform adequately.

Teaching or imparting to another any complex hand-skills and related theoretical knowledge is another complex skill-set that must be underpinned by a thorough grounding and practiced accomplishment in the skills to be taught; as well as in the skills and practices of good teaching. Just as a person who has recently learnt how to play tennis is in no way qualified to become a tennis club coach: a person who has for the first time learnt how to deliver adequate dental hygiene to RACF

residents is in no way qualified or experienced enough to be able to "educate other aged care workers to help maintain the teeth of nursing home residents".

The logistics of training one carer from 2830 separate facilities around Australia "by next year (2010)" make it unlikely that the initial training would be adequate. Complex hand-skills are best taught in small groups of 6-8 people with repeated supervised practice sessions. Imagine how ludicrous it would be to expect to learn to play tennis in a group of 20 or 30 other learners, and then after one block of training expect to be competent enough to be able to play proficiently and also, as is suggested in the Ministers plan, to coach others.

Dr Rogers estimates that will take 24 hours of formal training, over a period of six weeks, to gain the necessary level of knowledge and hand-skills with the opportunity to go back to the workplace and practice the skills learnt and then to return to the training for more instruction and hand-skills development. Past studies and research into the training of carers to perform effective and adequate daily oral and dental maintenance care shows that shorter training courses are ineffective.

A quality-teaching program could not start immediately, as there would need to be several educators in each State to deliver the training. Identifying and training enough suitable people as educators will take time.

There are no 'quick fixes' to solve these significant health concerns. A better solution is one that will lead to an effective and long-term resolution.

Dr Rogers has developed a training program to deliver training in the oral and dental daily maintenance care for residents in RACF with high dental needs and low compliance. This program develops both the necessary technical and theoretical knowledge with the needed hand-skills in a way to maximise the skill acquisition and therefore give benefit to the RACF residents. This Nationally Accredited course is entitled: *Implement Daily Oral Hygiene Care Plan for People with Special Needs* (National Code: 51770).

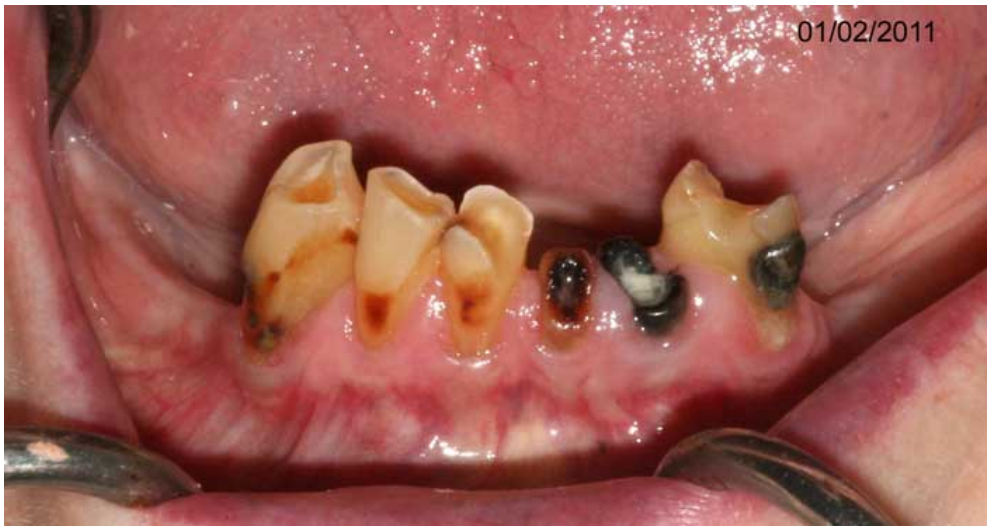
He said "I developed this program because I researched across Australia and the world and found that there is no adequate training or courses for carers in the oral and dental daily maintenance care for residents in RACF with high dental needs and low compliance. And because there is no in-depth and extensive training there are no trainers currently available, other than myself to deliver such a course".

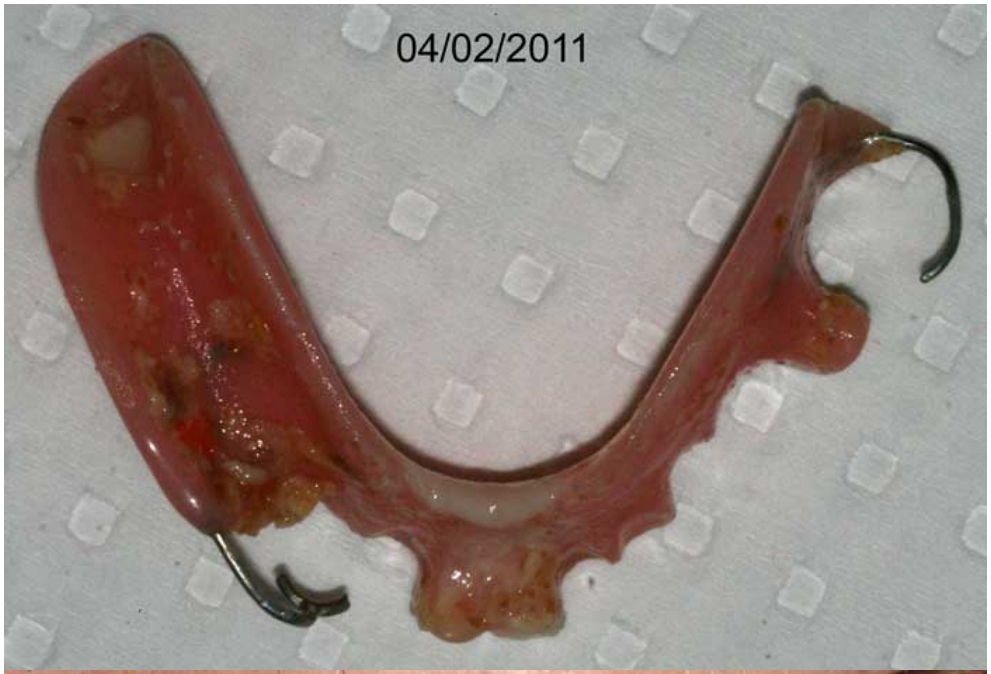
Dr Rogers proposes that he could train suitably qualified trainers with dental experience to deliver the course he has developed. This train-the-trainer would provide adequate training and time to learn, practice and to become competent in the knowledge, hand-skills, and teaching methodology of the above-mentioned course.

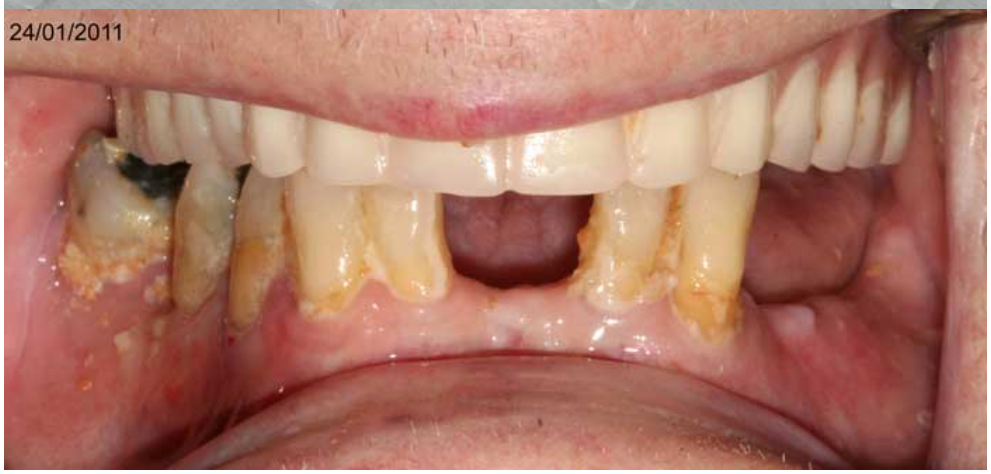
Dr Rogers reiterates that any courses training carers in oral and dental maintenance care need to be conducted by qualified trainers who have developed the specific skills in the subject they are teaching, which in this case is in oral and dental maintenance care for residents in RACF with high dental needs and low compliance.

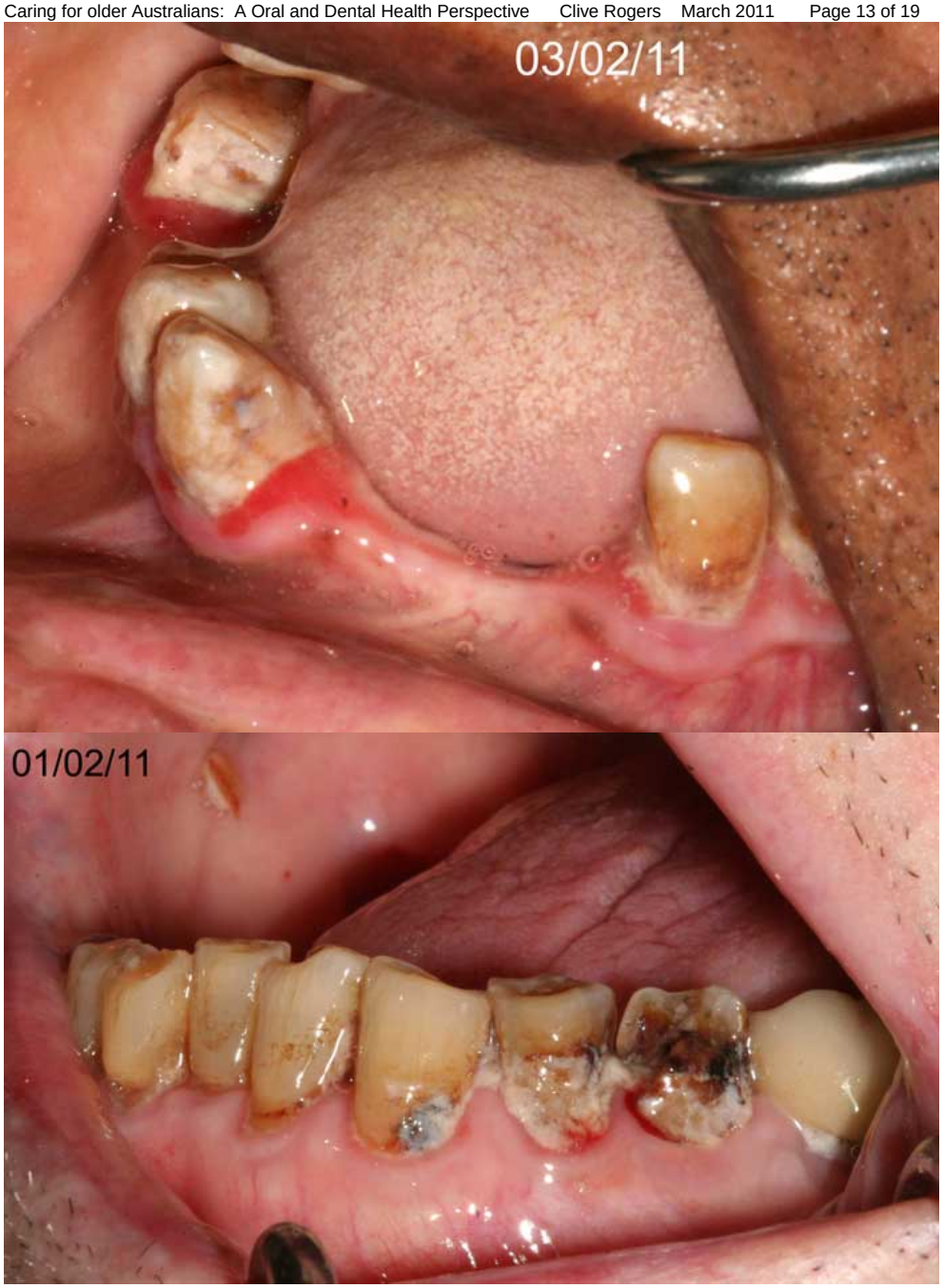
To be successful any plan seeking to address the oral and dental maintenance care needs of our vulnerable RACF residents must adequately address the complex array of issues including assessment, logistics, dental service, and training best practice.

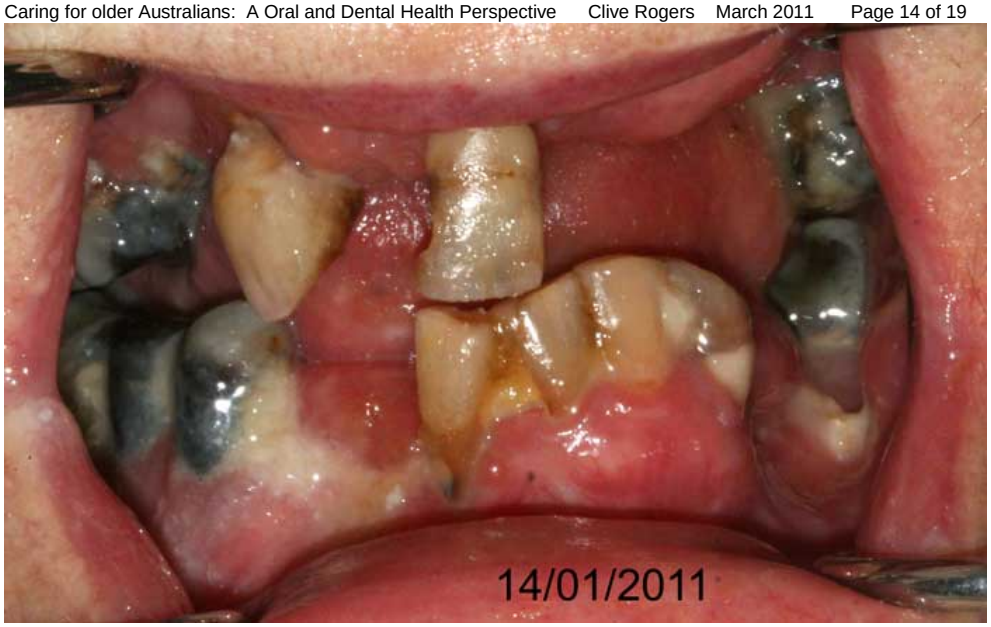
Further photographs of commonly seen oral and dental care neglect in RACFs in Australia.

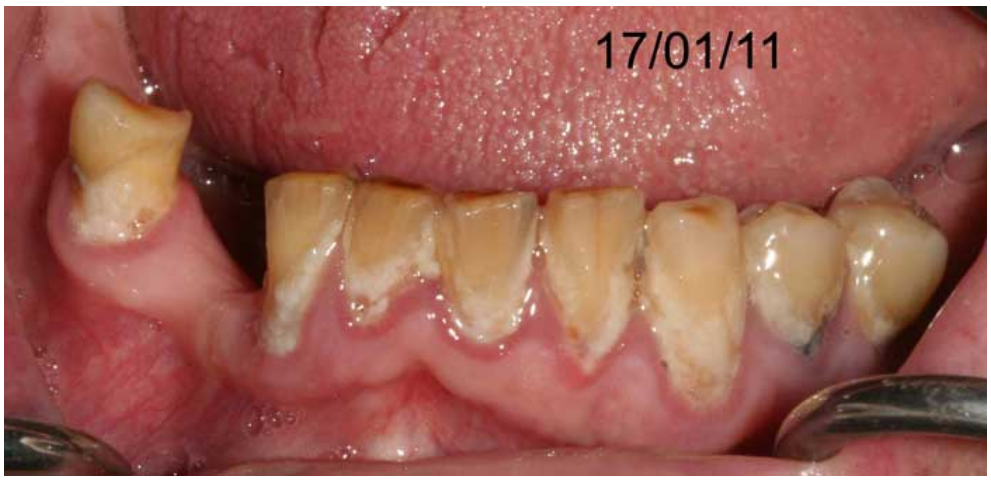


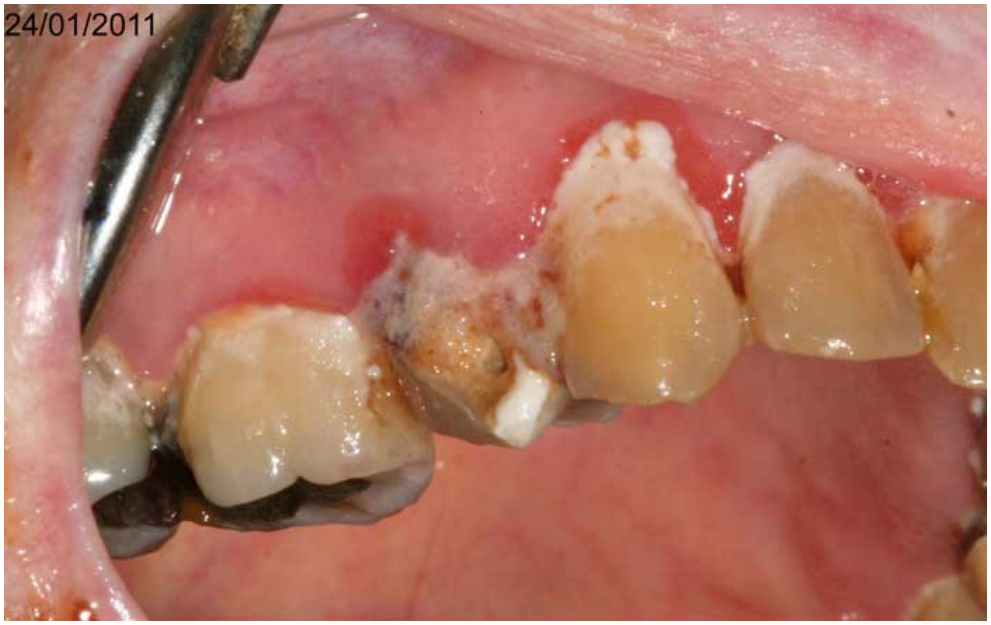




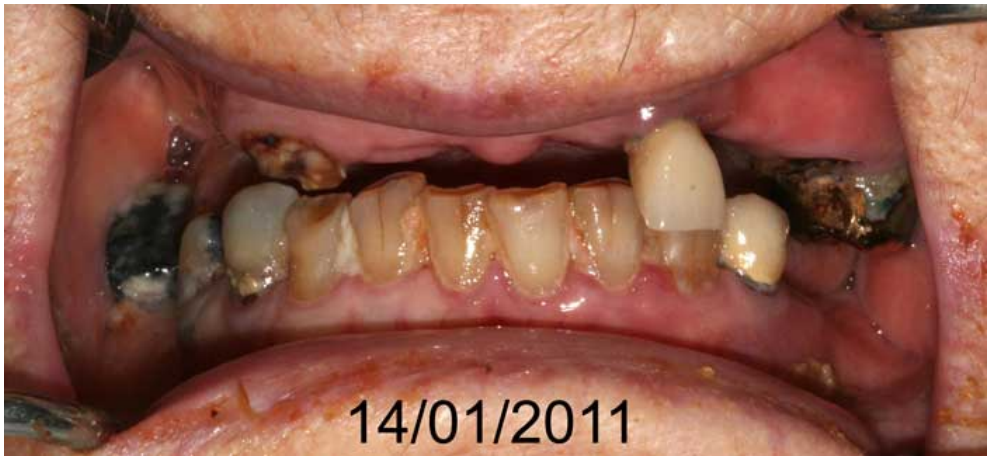

03/02/11
01/02/11

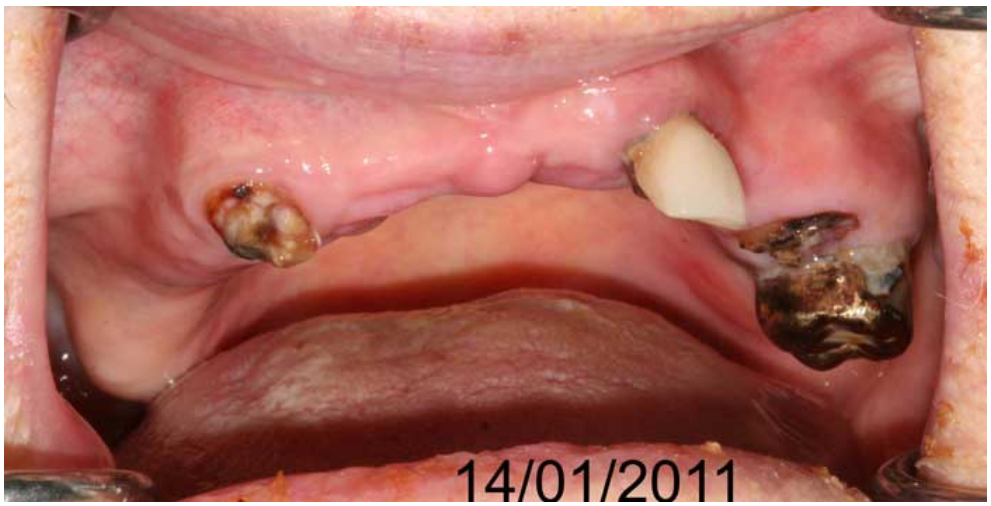

14/01/2011

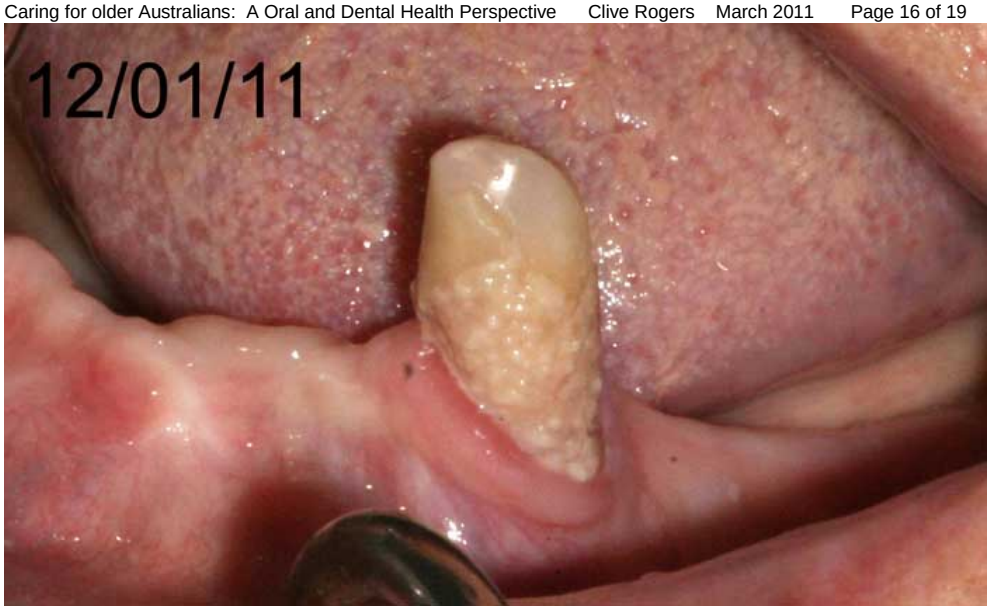

17/01/11

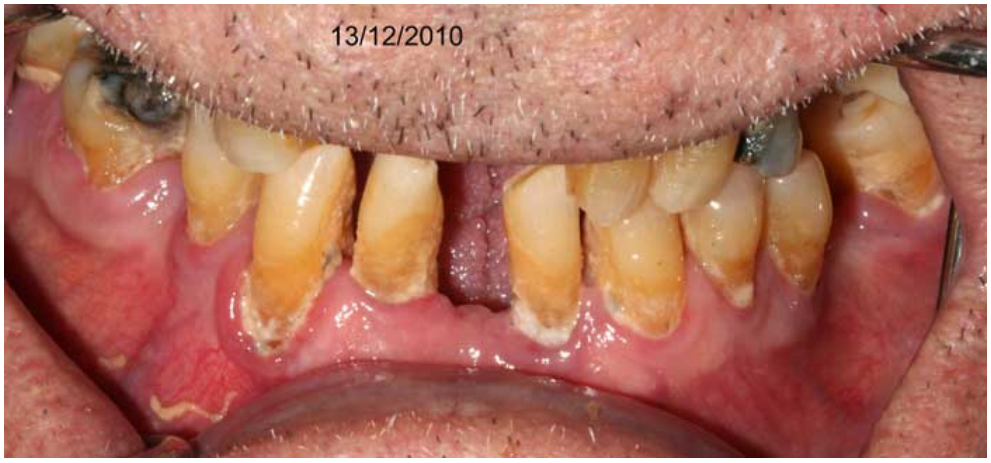

24/01/2011

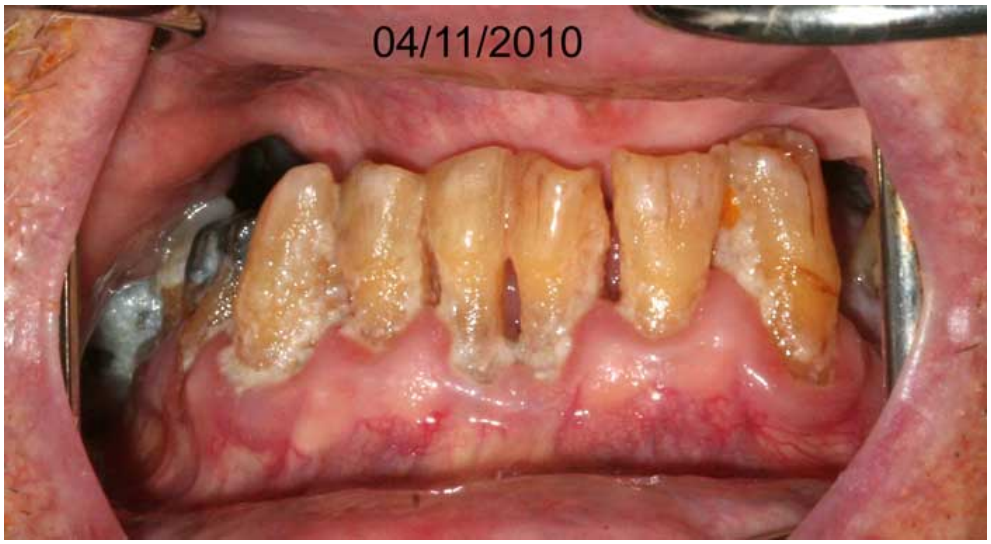

24/01/2011

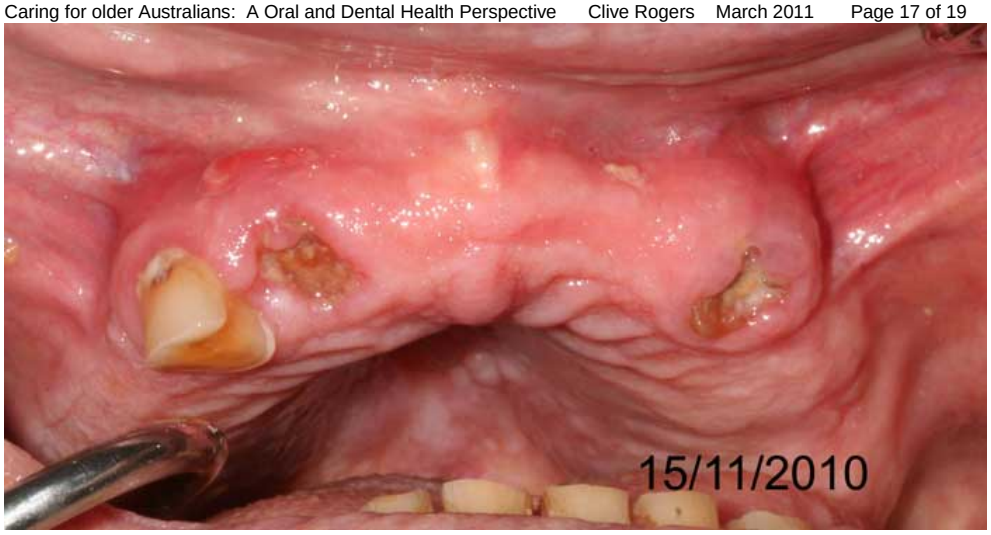

14/01/2011

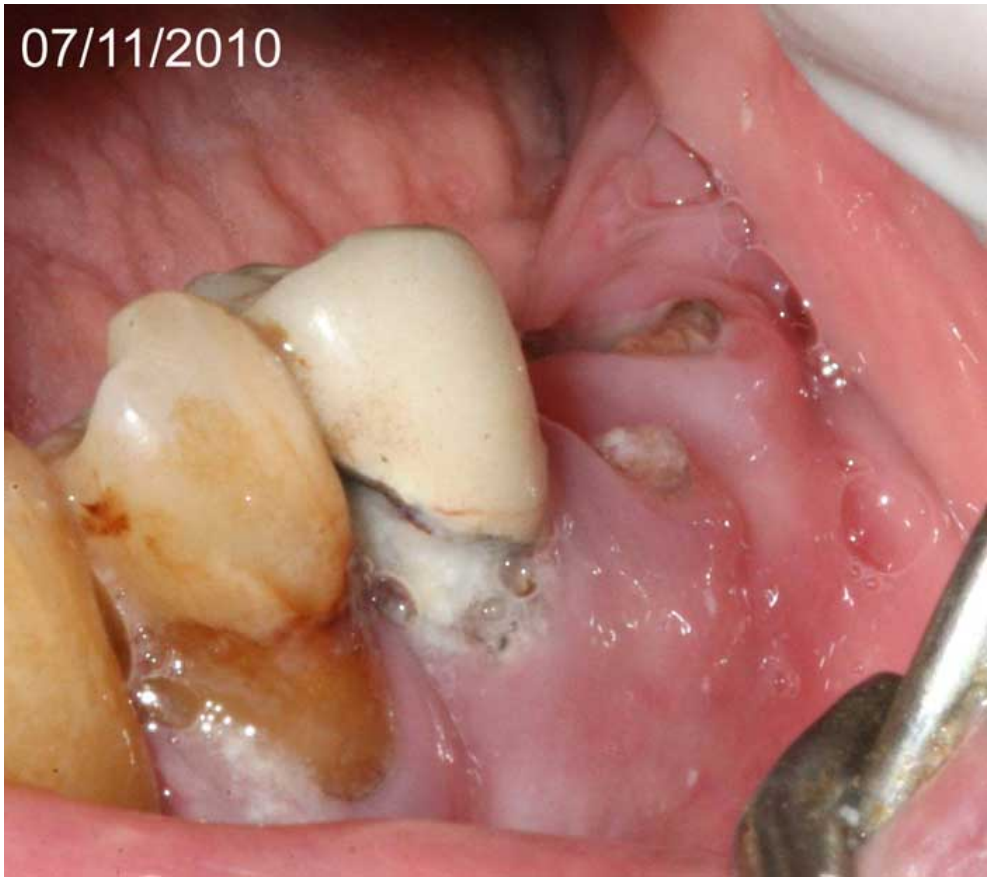

14/01/2011

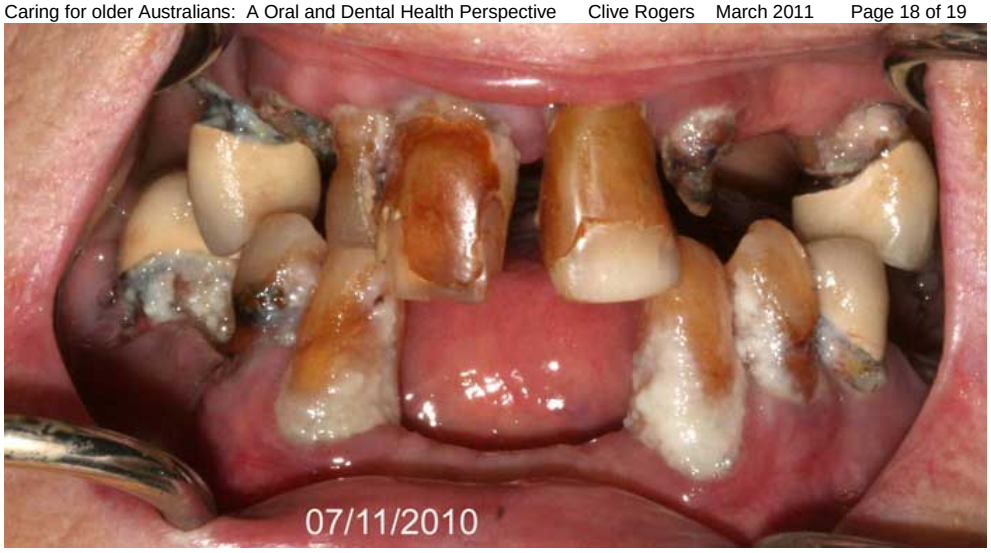

12/01/11

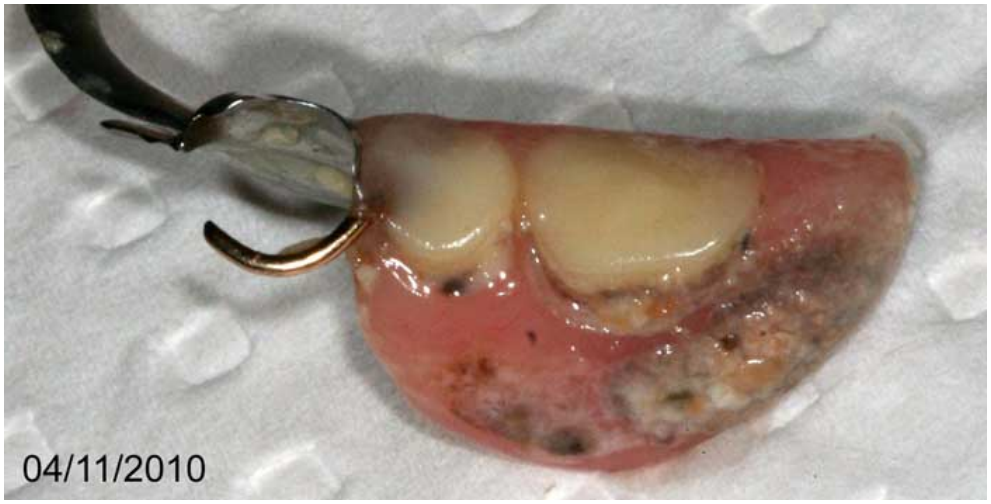

13/12/2010

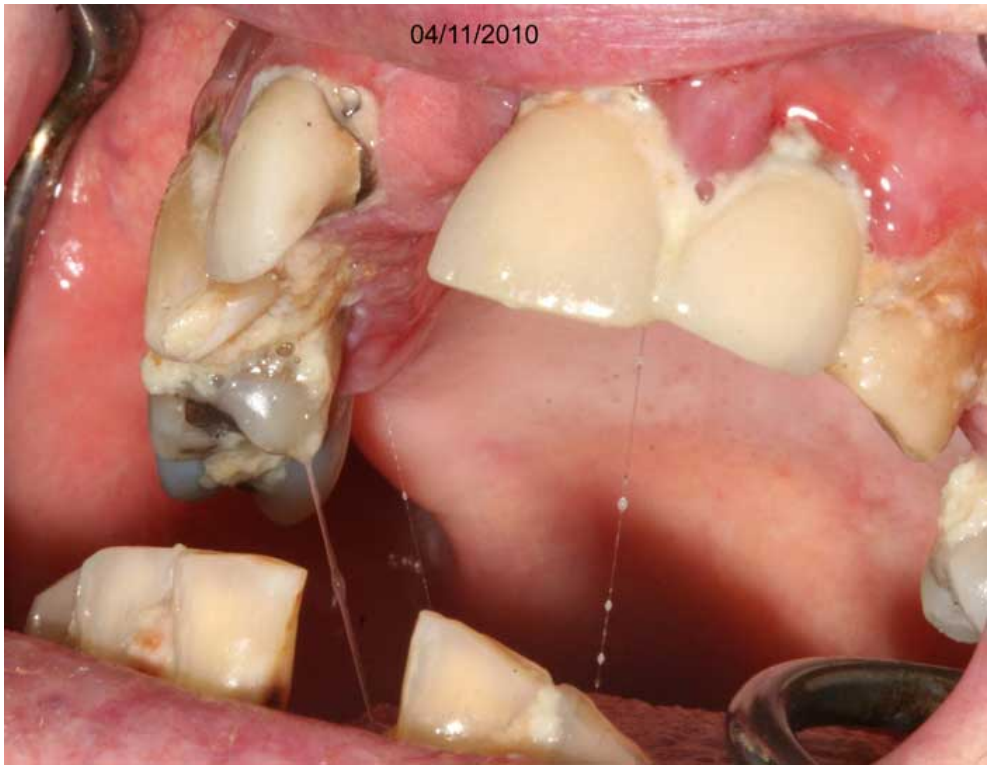

04/11/2010

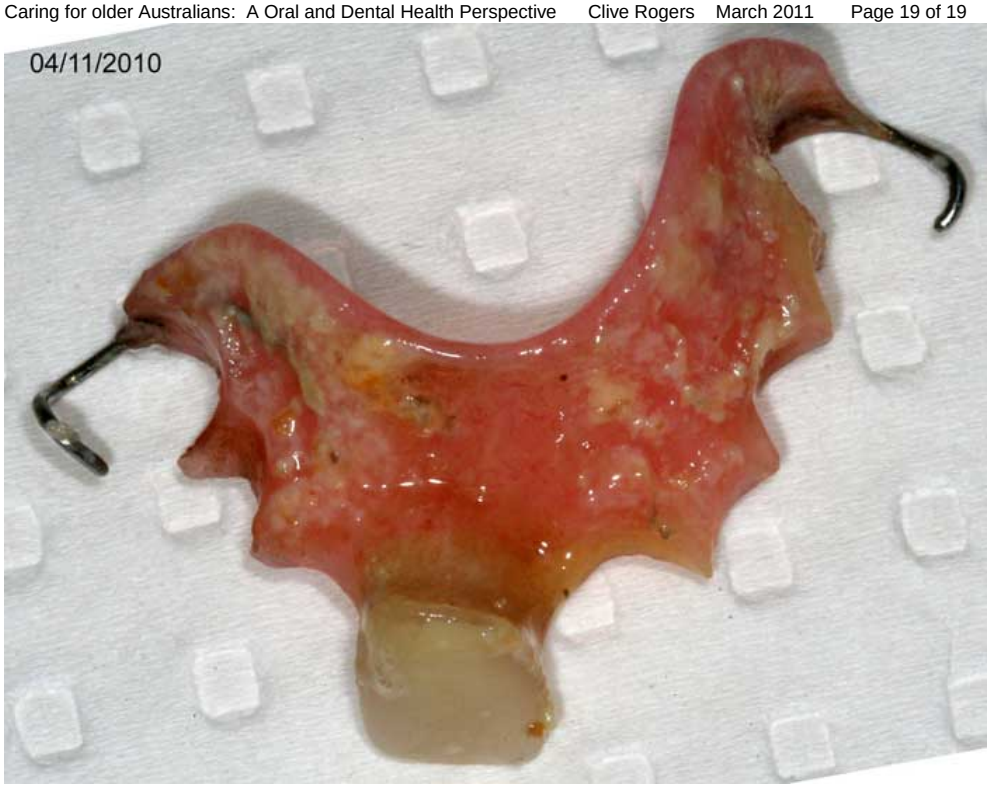

15/11/2010


07/11/2010


07/11/2010


04/11/2010


04/11/2010


04/11/2010