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RESEARCH ARTICLE

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Views of homecare staff and carers on oral needs and dental care for people living with dementia: A qualitative study

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Abstract

Objective: People living with dementia are at risk of mouth and dental problems. Many receive help with this aspect of personal care from family carers or homecare workers. We explored the views of homecare providers and carers on how this aspect of personal care is addressed and implemented.

Materials and methods: In this qualitative study we conducted semi-structured interviews with carers (all family members), homecare workers and managers providing support to people living with dementia in their own homes. Interview questions focused on daily care practices, exploring barriers and facilitators to oral care. Interviews were recorded online or over the telephone, transcribed, and thematically analysed.

Results: Carers ($n = 8$), homecare workers ($n = 9$) and homecare managers ($n = 15$) were recruited from across England in 2021–2022. Across interviews, two main themes were identified: (i) Missed opportunities to address oral care, which is not always seen as a priority despite the importance and potential risk of neglect. (ii) Challenges in delivering oral care, including factors related to the person living with dementia (such as cognitive and physical decline) and factors related to the care infrastructure and policies such as training, perception of roles, allocated time, and consistency of care.

Discussion: More emphasis could be given to the training and skills of homecare providers to identify and prevent dental problems and to assist carers. Several strategies and tools (oral care checklists, greater detail around oral care in care assessments and care plans) could be used to enhance this aspect of personal care for people living with dementia.

KEYWORDS
dementia, home care, oral care, qualitative

Key points

- Mouth and teeth care is important for people living with dementia in their own homes because they are at higher risk of dental problems than the general population. However,

this aspect of personal care can be overlooked and information may not be shared or recorded.
- Mouth and teeth care and the risks of poor oral hygiene in dementia could be more consistently addressed and more integrated in assessment and care planning.
- There are barriers to addressing oral care. The practitioners could utilise available resources or checklists as reminders to have these assessments in place.
- Oral health care guidelines and skills training in homecare may be timely.

1 | INTRODUCTION

As dementia progresses it is hard to maintain personal hygiene so carers and/or homecare workers may help with such tasks.[1] Living with dementia becomes a risk for oral (mouth and dental) health deterioration even at early stages.[2,3] People living with dementia often have more dental plaque, higher levels of tooth decay and more mouth problems than older people without dementia[4,5];. Poor oral health not only influences physical health but also impacts on self-esteem, dignity, social integration, nutrition and quality of life.[6] Kc et al[3] found that people living with dementia relied highly on carers for support due to lack of dexterity and reduced capacity to care for their teeth. Their review also suggested possible difficulty in identifying and communicating their needs. Additionally, a Swedish study found declining use of dental services after dementia diagnosis.[7]

For people living with dementia who have publicly funded homecare or domiciliary services in England, an assessment and/or an individualised care plan is routinely developed to outline what will be needed to help promote their wellbeing.[8] Such care plans are typically drafted after an initial assessment with a practitioner (e.g. social worker, homecare manager or co-ordinator), who discusses the condition, abilities to carry out daily tasks and unmet needs with the client. Together they agree on a care plan (outlining components of the care package) which is generally reviewed (and if necessary revised) in 6–8 weeks initially. The professional undertaking the assessment may contact family and the General Practitioner (GP) to inform the assessment and produce a mutually agreed care and support plan that covers the needs, support to be provided, and desired outcomes. Such assessments and care plans are often general descriptions of the activities to be undertaken (e.g. 'undertake personal care'), or lack detail[9]. There are no oral health guidelines for people living with dementia at home, so not all care assessments and plans will include conversations around the oral care and may not elicit information about the person's dental history and regular dentist, if any. Curtis et al[10] found that oral health was not a primary concern of carers who had other worries on their minds, for example, medication, especially in the context of dementia's progression and other long-term conditions. In this context, access to dental services was reactive, instead of preventive, putting the person living with dementia at greater risk of overall poor health.[10]

While some research has recommended that carers (family and friends) and care workers should receive mandatory training in practical oral health hygiene strategies for people living with dementia who may resist help with oral hygiene and denture care or be unable to self-care,[6] this is not implemented in England. Currently, guidelines and training are available for care home staff providing mouth care,[11] although challenges in implementing are reported, such as lack of time, resistance or refusal by residents and balancing their daily oral care needs with other needs.[12] However, there are no similar guidelines for oral care at home. In England, there is no mandatory training in social care overall, with the basic Care Certificate being only voluntary.[13]

2 | MATERIALS AND METHODS

2.1 | Study design

The overall aim of this study was to explore ways of improving social care practice in integrating mouth and dental care into personal care for people living with dementia at home (SORTED study). We conducted a qualitative study as we wanted to explore participants' views around oral care and how this is supported in individual assessments and care plans. We aimed to interview (a) people living with dementia, (b) family carers, (c) homecare providers, and (d) social care practitioners responsible for assessments. Participants were recruited and invited to individual semi-structured interviews, which enabled participants to share their opinions and experiences. This paper reports the findings from interviews with family carers and homecare providers only (findings from the practitioners' interviews are reported elsewhere (Soilemezi et al, in press). Despite our best efforts and use of multiple recruitment channels we were unable to recruit participants living with dementia, likely influenced by the prevailing pandemic at the time.

The project was guided by Kitwood's framework of person-centre care (Kitwood, 1997).[14] This framework is relevant to dementia research as the person is placed at the centre and the focus is on what they can do, and on their needs and unique circumstances as well barriers to their wellbeing.

2.2 | Ethics

The study was approved by the Health Research Authority Social Care Research Ethics Committee (SCREC—ref: 21/IEC08/0032). Participants were informed about the study aims and signed an informed consent form before the interview.

2.3 | Study setting and participants

Interviews were conducted in England from November 2021 to August 2022. Recruitment was based on purposeful sampling with

maximum variation to capture diverse experiences and views from carers and practitioners from different ethnic backgrounds, years of experience/caring, location, gender, and so on. To achieve this, we liaised with several national and local organisations, sending them an information sheet requesting they promote our study and help us identify participants. Study posters were displayed in public spaces (library, carers' centre) and shared via social media. Participants were asked to contact the main researcher, who then arranged a mutually convenient time for an interview. We offered a face-to-face, telephone, or online interview.

2.4 | Data collection

A semi-structured interview guide was developed based on the study's research questions and study advisory group's input. A preliminary guide was pilot-tested ($n = 3$), consequently some questions were combined and the order changed. The topic guide was iteratively revised covering questions around care assessments, care plans and care practices around oral care, and recommendations for better practice, allowing participants to add more topics. All participants were aware that questions around oral care would be asked from the study recruitment leaflet, which explained the aim and focus of the interviews. In addition, we collected brief sociodemographic characteristics (age, gender, ethnicity, years of caring, etc). Participants were able to ask questions and clarifications about the study before the interviews.

Interviews were conducted by DS, whose background is in health psychology, with training and experience in interviewing carers and practitioners. Interviews were audio/video recorded and then transcribed verbatim by an external company under a confidentiality agreement.

2.5 | Data analysis

Thematic analysis followed the Framework approach following seven steps: transcription, familiarisation, coding, developing an analytical framework, applying the framework, charting data into the framework matrix, and interpretation of data,[15] DS independently read and re-read all transcripts and then started coding the data on a preliminary coding/theme which was developed after each transcript had been read during the familiarisation stage. After coding seven interviews, the framework was iteratively developed and finalised (no additional codes emerged). A spreadsheet was used to generate a matrix where the interview data were charted, summarizing the data from each transcript but retaining the original meanings and interesting ideas. Remaining data were subsequently entered on the final framework and the preliminary themes were developed, based on recurring codes/patterns, and after condensing similar codes. In order to facilitate the charting process and using the same framework, data were entered in different spreadsheet according to the participant group (which enabled us to add more codes if needed specifically to each group) and also helped to compare similarities and differences across groups. DS and JM then met to examine the framework, discuss and refine the preliminary themes and reached consensus. JM read a sample of transcripts and brought social care and caregiving perspectives to the analysis. The final themes were also discussed and validated by three carers (members of the study's Public Engagement group). They confirmed the lack of clarity over responsibility for oral health and difficulties for them of high turnover in homecare agencies, meaning information kept needing to be repeated and lack of continuity of care.

3 | FINDINGS

We interviewed 8 carers, 9 homecare workers and 15 senior homecare staff (see Table 1; pseudonyms used). Overall, interviews lasted on average 27 min (between 17 and 44 min), which reflects the range of different experiences and views on the topic, with some participants providing examples and several opinions to share and others' limited input. We tried to keep the interviews flexible but focused acknowledging that some participants had limited time to talk away from their busy work schedules.

Homecare providers ($n = 15$) were registered homecare managers ($n = 8$), homecare coordinators ($n = 4$), a clinical lead ($n = 1$), a deputy manager ($n = 1$) and a quality assurance officer ($n = 1$). Fourteen were female, with average age of 43 years (range 26–56 years). Homecare workers' average age was 44 (range 26–66) years old, and all were female. Carers were all female: adult children ($n = 5$), a niece ($n = 1$), a partner ($n = 1$) and a wife ($n = 1$). Their average age was 62 (range 51–81 years). One homecare worker spoke from both her work and family experiences.

The thematic analysis produced two main themes, each with subthemes (Table 2).

3.1 | THEME 1: Missed opportunities due to conflicting priorities

Across interviews, both homecare staff and carers commonly declared mouth and teeth care as important aspects of care but at times it could be missed.

3.1.1 | Importance of oral care

All carers and homecare workers discussed the importance of keeping mouth, teeth and dentures healthy and gave examples of the benefits of good oral hygiene. They shared their experiences and examples of bad oral care and possible severe consequences:

> You have to be serious about the mouth because mouth disease or if it's getting worse, it's hard to

TABLE 1 Participants' characteristics (pseudonymised).

No	Gender	ID	Location (England)	Ethnicity	Age
1	F	Anna–carer	Midlands	White British	52
2	F	Eve-carer	South West	White British	52
3	F	Paulette-carer	Midlands	Mixed other	58
4	F	Lynne-carer	East	White British	51
5	F	Alex-carer	East	White British	72
6	F	Martha-carer	South	White British	62
7	F	Sandra-carer	South	White British	73
8	F	Wendy-carer	East	White British	81
9	F	Rekha-homecare worker	South	Asian other	52
10	F	Kate-homecare worker	East	White British	26
11	F	Sarah-homecare worker	East	White British	66
12	F	Amanda-homecare worker	South	Black African	29
13	F	Christine-homecare worker	South	Black African	34
14	F	Helen-homecare worker	South	White British	64
15	F	Amy-homecare worker	South	White British	47
16	F	Sonia-homecare worker	South	White other	48
17	F	Natasha-homecare worker	London	Black British	32
18	F	Pat-clinical lead	East	White British	34
19	F	Anne-registered homecare manager	East	White British	52
20	F	Carla-registered homecare manager	East	White British	43
21	M	Matt-registered homecare manager	East	White British	37
22	F	Jill-registered homecare manager	East	White British	48
23	F	Charlotte–registered homecare manager	East	White British	51
24	F	Elsa-registered homecare manager	South England	White British	56
25	F	Sandy-care coordinator	South	White British	40
26	F	Ruth-care coordinator	South	White British	30
27	F	Sheila-registered homecare manager	Kent	White British	49
28	F	Valma-registered homecare manager	South	Asian	39
29	F	Victoria-care coordinator	South	White British	26
30	F	Gail-care coordinator	South	White British	54
31	F	Mary-deputy homecare manager	East	White British	51
32	F	Fearne-quality assurance officer	East	White British	37

TABLE 2 Overview of main and subthemes.

No	Theme	Subtheme
1	Missed opportunities due to conflicting priorities	Importance of oral care Not a priority Assumptions around oral care and expectations around tasks and responsibilities Risk of neglect
2	Challenges in delivering oral care	Living with dementia Care infrastructure and policies

manage because of dementia… a care worker has to know how oral hygiene is important for dementia people

-Rekha, Care worker

It is important… if you have pain, it can affect other parts of your body like diabetes or other parts of your body

-Anna, Carer

Homecare workers and managers also highlighted the importance of a healthy mouth for diet and wellbeing. One homecare worker shared the example of a client with new dentures and how *"he was smiling at everyone, and it had really lifted his confidence"* (Amy, Homecare worker).

3.1.2 | Not a priority

One of the most discussed topics, particularly by care providers, centred on missed opportunities to address oral care. Although part of personal care routines, many participants acknowledged that "*we forget about a lot of the time*" (Elsa, Care Manager) or that oral care was not always possible amidst completing demands and limited time.

Many carers wanted homecare workers to concentrate on more pressing needs. However, homecare workers sometimes suspected dental or mouth problems when a client seemed in pain or discomfort:

> And it's funny because if carers report into me they're [clients are] not right, or they're not eating, it's actually one of the first questions I ask—is there anything wrong with their teeth, when did they last see a dentist?
>
> -Gail, Care Coordinator

Interestingly one care manager and two carers thought that denture care received more attention because the presence of dentures was generally recorded in the care plan. Notwithstanding, difficulties could still arise:

> I find that a lot of people with dementia, it's a funny one, they're quite protective over their dentures, they don't want to take them out and they tend to want to sleep with them and you have to be actively encouraging them to ensure they're looking after them and they're fitting correctly.
>
> -Fearne, Quality Assurance Officer

3.1.3 | Assumptions around oral care and expectations around tasks and responsibilities

Many participants discussed their assumptions around oral care. For example, one carer had wrongly assumed that the homecare worker was helping her mother with tooth brushing daily. Another carer discussed a common assumption that old people do not their teeth. Three homecare managers thought that in general "*old people don't seem to brush their teeth twice a day*" (Sandy, Care Coordinator) and furthermore that "*oral health is just not important to them, until they get toothache*" (Anne, Homecare Manager). Some of these views stemmed from combined professional and family experiences.

Another manager talked about the false assumption that *"everybody knows how to brush somebody's teeth, but we don't"* (Jill, Homecare Manager). There was also an expectation that care workers would check and provide dental products (e.g. toothpaste) but it was not always clear if this was included in their clients' care plan and their own task list.

Some carers and managers mentioned the need for closer supervision or assistance by homecare workers. Although homecare workers said they would prompt clients to brush their teeth, prompting was not always effective and regular checks were not always done, especially for clients who were (or seemed to be) more independent, as this carer noted:

> Just because they say they'll do it, doesn't mean they are going to do it, and you just need to kind of check back on that don't you to make sure it's been done because otherwise he could go for weeks saying that he'd done it.
>
> -Eve, Carer.

Homecare workers and managers also noted that not all families expected them to provide oral care while in other instances there could be miscommunication or different expectations:

> Sometimes the family don't help… if I'm meant to spend 30 minutes to get a few things done and the family expects you to come, hoover the house, do everything and then you hardly have time to get the important things done just because you want them to be happy. It makes it difficult sometimes
>
> -Christine, Homecare Worker

3.1.4 | Risk of neglect

A small number of homecare managers and workers mentioned that some clients were *"neglecting to look after themselves"* (Amy, Homecare Worker). Different procedures were then put in place in their companies, ranging from alerting homecare staff to pay attention to bad breath, or more systematically undertaking regular oral hygiene checks, or making oral health a specific heading to address in the care plan:

> It can become like a safeguarding concern if we're not, you know, looking after their oral health
>
> -Anne, Homecare Manager

3.2 | THEME 2 Challenges in delivering oral care

Participants described several potential factors affecting the delivery of oral care by homecare staff.

3.2.1 | Living with dementia

Many participants commented that the person's cognitive and physical decline, challenging or distressed behaviour and/or changeable mood in combination with the invasive nature of oral health could risk poor oral hygiene. One major challenge was how to overcome clients' perceived resistance to or reluctance to undertake oral care.

Both carers and homecare workers noted clients living with dementia could take longer to clean their teeth or dentures, *'anywhere from a couple of minutes up to 5 or 10 min, it depends on how they are that day'* (Sarah, Homecare Worker). Also, forgetfulness was common, and both carers and homecare workers gave accounts of a person saying that they didn't need to brush or had brushed their teeth (but had not). However, all felt it was important not to challenge this but try to seek co-operation.

Additionally, both physical disabilities and low mood could delay or impede oral care:

> She is living with dementia, and it's quite difficult dependent on how she's feeling, how she's presenting, her mood
>
> -Helen, Homecare Worker

As a result of cognitive decline and/or mood changes some people living with dementia could not follow daily routines and refused help with teeth and mouth care. Both providers and carers considered force inappropriate but also impractical: *"we're mindful we can't be forcing toothbrushes into people's mouths"* (Pat, Clinical Lead).

Lack of consent and resistance to care were also discussed by homecare workers, who explained that sometimes clients *"don't respond well"* (Rekha, Homecare Worker), or do not understand the task (e.g. would bite the toothbrush). In these circumstances staff were unable to complete their care. At an extreme, one worker explained a task might have to be left undone *"so you don't get to injure yourself or the client"* (Amanda, Homecare Worker).

In these circumstances even a minimal amount of care would be considered acceptable, while another discussed the risk management plan their agency has developed for clients who refuse assistance or are proving hard to support adequately.

3.2.2 | Care infrastructure and policies

Many participants commented on how the wider care system helped to address oral care for people living with dementia or frustrated it.

Addressing oral care in the initial assessment

There were mixed reports of whether oral care was discussed in the initial assessment once homecare had been agreed by the funder, the local authority, and a homecare provider then further assessed the client. Two homecare managers mentioned always carrying out an assessment of mouth and teeth, although another acknowledged that "*it's probably something that we should be bringing into our care assessments*" (Carla, Homecare Manager). Two carers reported oral care was not discussed; one thought this was because another pressing problem was being focussed on (a skin condition).

Two homecare managers mentioned using NICE's oral health assessment tool,[16] which they particularly liked, as being short and easy to complete; additionally, they reported it helped discussions with clients and families around this subject. Another manager used a separate section (sub-category) of their assessment template that addresses oral care. However, most providers reported that "*we don't really put it down as specific oral care because that's part of personal care*" (Valma, Homecare Manager). The amount of details and questions raised in the initial assessment also varied; from one or two questions, to more comprehensive assessments. Two managers explained that, if concerns arise, they add another template.

A small number of managers emphasised the importance of holistic assessment to determine the right level of support for oral care. Similarly, two of them mentioned the need for regular reviews and using a checklist to track changes in clients' oral hygiene because of the likelihood of deterioration in self-care.

When asked if oral health history and dentists' details were discussed in the care assessments, two carers remembered that this was discussed, while another three did not, with one recalling *"they've asked me about the doctor but not the dentist"* (Alex, Carer). Homecare agencies' practice varied according to the homecare workers, with two reporting that dentists' information was "*not typically on the support plan*" (Christine, Homecare Worker), while others noted that dental information was usually in clients' records or folders.

Two homecare managers reported taking a client's dental history routinely. However, another three explained that this was only discussed "*if I had anyone who had any tooth problems*" (Sandy, Care Coordinator). Overall, most providers did not seek dentists' details but might contact the GP for this information.

When discussing local authority assessments and care plans that were passed to them, most homecare managers considered them "*very, very basic*" (Mary, Deputy Care Manager). Several collected such detail in their own assessments:

> We need to get that information, and we need to go that little bit further and more detail into personal care and oral care because it's never, no, it's not put down
>
> -Ruth, Care Coordinator

Addressing oral care in care plans

All carers considered detailed care plans helpful as they provided guidance, especially for new clients and new care workers. However,

not all care plans had separate sections or mentions of oral care routines, although families thought mentioning oral care meant if it is "*in the care plan, so that's what they do*" (Anna, Carer). Homecare workers appreciated having detail and family involvement if possible.

However, some carers viewed care plans as *"very general in terms of what they do as a visit"* (Lynne, Carer). General references to personal care were also made by six homecare workers who explained that care plan was "*just mainly about getting them fully washed. It says nothing about the teeth in there*" (Kate, Homecare Worker). Those working for agencies where the care tasks were itemised on an app found this prompted oral care even if lacking detail:

> if their assessment states to brush their teeth independently, then it will be a verbal prompt while we're there… On the app, it's oral mouthcare. You click on it, and it would state, "Mr X can clean his teeth independently. Verbal prompt need only," OK? So it isn't just—and it can be that basic; there isn't detailed [information]
>
> -Helen, Homecare Worker

Oral care was therefore not always recorded. Two care workers appreciated being able to use their discretion; we have *"got the freedom to do it as we think [best]"* (Sarah, Homecare Worker) and welcomed "*the flexibility to customise*" (Amanda, Homecare Worker).

Perceptions of role and responsibilities

Most carers assumed responsibility for noticing any dental problems and contacting a dentist. A few considered oral care was homecare workers' and family's joint responsibility. Two managers thought their staff were responsible for noticing any problems and should report their concerns to their seniors, especially if a client lived alone.

In terms of arranging dental appointments and visits, most homecare workers and managers had not done this as they thought this was for family, the GP or the local authority to organise. A few managers were happy to arrange appointments and escorts to the dentist with client's and family's agreement. However, views varied about whether this was desirable, complicated by insurance concerns.

In discussing their roles and responsibilities around dental access, some providers presented themselves as "*fixers*" (Carla, Homecare Manager), while others did not want to "*overstep the mark"* (Amy, Homecare Worker). One carer advocated a balance since homecare workers had to consider their client's wishes and mood and be aware of this '*fine line'* (Lynne, Carer). This fine line between taking over or leaving things alone was also mentioned by others:

> If we overstep the mark, that can be perceived as us trying to takeaway sort of any independence and skills and dignity. So, it's a very fine balance.
>
> -Charlotte, Care Manager

Training, skills and confidence

Many participants mentioned other facilitators of good oral hygiene such as education and training. Carers and a minority of homecare managers acknowledged that brushing someone's teeth requires specific skills and some sensitivity. Some thought that not all care workers were confident or "*trained to do it properly"* (Wendy, Carer). These uncertainties were mentioned by homecare workers and carers, but not all care providers acknowledged this to the same degree. A minority of participants commented on a lack of gentleness among some staff:

> In fact, I don't think she [care worker] would have done her mouth care at all… I didn't think she'd be gentle enough, let's just put it that way'
>
> -Paulette, Carer

Two carers considered their care workers were well trained which reassured them that they "*would be able to spot a difficulty*" (Lynne, Carer) around their relative's teeth and mouth. Five homecare workers and one homecare manager reported having had received specific training in person and online. Another manager considered oral care was covered in dementia awareness training and the Care Certificate. However, at times managers and carers differed on whether homecare workers were prepared to deliver oral care or were knowledgeable and confident enough to spot any difficulties. For many managers this developed with their staff's experience.

A few carers had voiced concerns about some homecare workers' competence which they had raised with the manager and some expressed doubts that they had been trained at all:

> They're not taught to do this, they have no idea
>
> Wendy, Carer

About half the homecare workers and managers interviewed reported that although they received dementia training, they "*didn't have a training for oral hygiene"* (Rekha, Homecare Worker). If the homecare managers or workers had experience of care homes or National Health Service (NHS) work, they seemed more likely to have the skills to deliver good oral care. Some homecare workers had tried to educate themselves, as this one illustrated:

> Obviously, I knew nothing about it really. And obviously now I'm doing this, I'm sort of getting a bit more of an understanding, because I've been looking things up and things like that
>
> -Kate, Homecare Worker

While more training would have been welcomed by most participants generally, those supporting clients at the end of life felt homecare services often lacked the skills or tools to provide this particular care and were not supported by others in these circumstances which could be distressing:

> Sometimes when it's end of life we can only do what we can… So when they're in pain, less movement and that sort of thing, that's the struggle
>
> -Valma, Homecare Manager.

Support from dental and other health services

Several carers declared they did not know where to get information and support from around several aspects of care, including oral care. One felt that "*there's virtually no support, in any area, for people with dementia… unless there's an emergency with my mum… no visit from the dentist or the hygienist*" (Martha, Carer).

Carers had mixed views about healthcare professionals' support with oral care. Community nurses and Admiral Nurses (dementia specialists) were perceived helpful by some homecare staff and two carers. Both reported that some dentists provided excellent care for individuals living with dementia. In addition to treatment, a dentist could influence co-operation in daily oral routines:

> He wants a dentist to show him… Because in his eyes, the dentist is the authority and so he wants a dentist to show him how to do it again
>
> -Amy, Homecare Worker

Homecare managers described a lack of support and feeling disconnected from NHS services:

> Access to information, specifically with dementia, access to past dental health, past medical health history… We have NHS email. We only receive one email a month, which is never relevant. So, we're in the network but we're not in the loop
>
> -Matt, Homecare Manager

Along similar lines, participants discussed difficulties in accessing dental services. Carers worried about treatment costs, practicalities of access and transport. Domiciliary dentists, able to visit people in their own homes, were highly valued when available. Some participants reported difficulty in finding any dentist locally. Unsurprisingly, Covid-19 had compounded some of these problems. Only one homecare manager mentioned dental access was regular and 'hassle-free' for her clients.

Time

Lack of time was widely discussed by all participants as homecare workers had other tasks to complete and oral care could take some time. Sufficient time was thought important *because "you can't rush it, you've just got to do it properly*" (Sonia, Homecare Worker). One manager said that "*in such a short time it can, and is, a rush*" (Victoria, Care Coordinator) while another explained that "*it would just depend on how much encouragement was needed*" (Sandy, Care Coordinator), although two providers admitted that "*we have enough time, truth be told*" (Amanda, Homecare Worker).

Too brief visits meant care could be '*task-led*' (Elsa, Homecare Manager) not person-led. The one exception was from a homecare agency providing 24-h care; here oral care was undertaken at the client's pace.

Consistency of carers

Turnover of homecare workers was a consistent theme. Time to get to know the client, build rapport, understand patterns and behaviours, were mentioned by all carers and highlighted by some homecare workers and managers. One manager considered it important for staff to be able to "*get to know the nuances about that person and all the things that may be the triggers*" (Carla, Homecare Manager).

Mitigation of staffing problems was undertaken by some providers such as building a dementia specialist team of homecare workers. One manager reported that their company's small size fostered more regular contact between homecare workers and clients.

Carers found it easier to explain and demonstrate, if required, how to assist with their relative's teeth and mouth to a small regular team of homecare workers.

4 | DISCUSSION

Although oral healthcare was considered important by all participants, it may be missed in systems of assessment and care delivery, but this is not so in homecare provision overall. Our findings echo Curtis et al's[10] reports that oral health was not a primary concern for carers compared to other pressing needs to be considered in this context of their pressures. Our participants shared their experiences in delivering mouth and teeth care and discussed aspects related to individuals amid the current care infrastructure that could facilitate or impede oral care. Some of the main obstacles reported related to homecare systems with high staff turnover and commercial instability making training and technology hard to implement. The management of dementia symptoms[17] takes time and sensitivity which are not easily provided in the context of homecare staff's time restraints, high turnover and vacancies, and insufficient resources to develop personalised care plans.[18]

Our participants offered various suggestions of how oral care could receive more attention and provided examples of their use of useful tools and strategies. For example, care assessments and care plans could address oral care in greater depth, linking it with other aspects of care (e.g. swallowing or speech problems, nutrition, hydration and pain), documenting and communicating oral care needs to inform providers of homecare, but also possible other services such as day centres. Although there are not currently guidelines specific to care at home, practitioners could utilise available resources aligned to oral care in care homes or checklists, for example, the Oral Health Assessment,[16] the SORTED checklists (Soilemezi et al, in press) as reminders to have these assessments in place. However, care plans may be incomplete or out-of-date and there may be considerable inconsistencies between care plans and the care

delivered.[9] Various practices were reported in the systems of noting potential risks or problems. While most homecare managers saw it as their staff's responsibility to spot problems and report their concerns to the seniors and/or families, they acknowledged that some lacked the skills to notice such problems or the confidence to do so. Carers sometimes felt they too often lacked up-to-date knowledge and thus relied on homecare providers to offer advice and demonstrate good practices. This is consistent with the findings of some studies of NHS professionals[17,19] so perhaps a broader problem in dementia support.

Some homecare providers did not collect or have on record details of their clients' dentists so had to contact a GP or a social worker if dental care is needed, which may not be efficient. Only a few homecare providers offered escorts to dental appointments. Commissioners of homecare services may wish to explore if this could be part of their contracts with homecare agencies. Domiciliary dental visits were thought invaluable but uncommon in the current dental access crisis[20] and dentists may be an under-used resource in shaping dementia services and guidance. Support and information services for carers may wish to highlight ways in which oral health should be integrated into assessments, reviews, and care planning generally. Similarly, primary care services could address oral health in the reviews they undertake with their patients living with dementia as part of quality improvement work.

Overall, our study provides perspectives from both carers and homecare staff. Combined analysis reveals many views in common. For all there are competing priorities, and some uncertainties about skills and knowledge relevant to dementia's progressive symptoms. Situated under the umbrella term of 'personal care', oral care could be overlooked, and information not shared or recorded. We found great variety in homecare providers' systems with some recording oral care provision, offering training beyond the Care Certificate and making detailed assessments. While guidance exists for the provision of mouth care in care homes,[11] the development of this for homecare providers needs to call upon of the sector's existing expertise and specific experiences.

5 | LIMITATIONS

Although we aimed for a variety of participants, we recruited a small sample of carers. Despite efforts, we were unable to recruit people living with dementia, male homecare workers and more participants from diverse backgrounds. Overall, most participants were of White British ethnicity, although the majority of homecare workers (5 out of 9) were not, reflecting the sector's profile. Older age groups in the UK are less ethnically diverse than those working in homecare. Therefore, our findings may not be transferable to other locations where populations are more ethnically diverse. Overall, some themes may chime with many families and practitioners who support someone living with dementia at home. Our findings may be especially relevant to the current cohort of British White older people among whom there are still relatively high proportions with a history of untreated dental problems or delayed access to dental care.

Our sample included carers and homecare managers and front-line homecare workers from a wide geographical area including rural and urban areas and this triangulation of perspectives adds strength and credibility to our findings. In addition, data collection, analysis and reporting were undertaken by the main researcher, a psychologist by background, which may have influenced the themes and data interpretation. To add rigour to the analysis two other researchers were involved in the final stages of the data analysis from different professional backgrounds (social care, dentistry) and emerging findings were discussed with our study's lay advisor (a carer) and the study advisory group. The possible implications of these different perspectives were discussed before refining the final themes and agreeing on the quotations.

6 | CONCLUSIONS

The oral care needs of people living with dementia at home may be overlooked generally but there is a variety of practices and interest in the subject. Mouth and teeth care could be more consistently addressed and more integrated in assessment and care planning. There are now various ways to promote oral care and several tools are being used to facilitate daily oral care routines. Our findings suggest that other professionals should encourage homecare providers and carers to think strategically and practically about oral health care and its place in overall care planning as disabilities develop. The views of people living with dementia about current and future oral healthcare remain under-researched. The development of oral health care guidelines for good practice in homecare may be timely and welcome.

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CONFLICT OF INTEREST STATEMENT

There is no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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