BMC Geriatrics

RESEARCH Open Access

Care home managers' perspectives on domiciliary dental care: a qualitative study

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Abstract

Background Domiciliary dental care (DDC) is an established, safe and cost-effective alternative to standard care which can increase accessibility to professional dental care for care-dependent individuals. Qualitative research with care home managers has explored current practices and specific barriers to accessing dental care services: this has highlighted problems with dentist availability, accessibility and financial concerns. No research has explored reported experiences of DCC implementation in care home settings.

Purpose This study aimed to explore care home manager's perspectives and preferences on DDC following its wider implementation.

Methods The study used a qualitative approach in a constructivist paradigm. Six semi-structured face-to-face interviews were conducted with ten care home managers from a purposive sample of care homes participating in DDC. Interviews were audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis.

Results Five major themes were defined. Care home managers preferred DDC to avoid logistical challenges and stress for residents, highlighting the need for on-site dental services. While they wished for reliable partnerships with locally based oral health professionals, this was seen as unrealistic due to their limited willingness to treat care home residents. DDC was valued for its accessibility and support, yet financial concerns were raised due to increasing costs associated with DDC. Managers also emphasized the importance of stable oral care teams within the care home; they noted, however, that this was difficult to achieve due to high staff turnover in long-term care.

Conclusion Domiciliary dental care was widely accepted and appreciated by the care home managers in this study, but increasing costs presented a significant threat to its sustainability.

Keywords Dental care provision, Care home, Qualitative research, Domiciliary dental care, Care home managers

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Introduction

Care home residents often experience poor oral health [1]. Poor oral health can negatively impact the quality of life of older adults and can affect their ability to eat, speak, and interact socially. It is also a risk factor for several systemic diseases such as aspiration pneumonia [2–5]. Therefore, it is important that older adults receive regular oral health screenings by dental professionals to allow timely detection of oral health problems. However, access to oral health services for care-dependent older adults is often hindered by mobility impairments, physical disabilities, cognitive deterioration and other comorbidities [6–10]; in addition, dental professionals may be reluctant or cautious to provide care to such groups [11, 12]. Due to the distinct context and characteristics of care-dependent individuals, conventional dental services may not be well-suited to meet their needs.

Domiciliary dental care (DDC), described as dental care provided outside a dental office, usually in the patient's place of residence, is an established safe and cost-effective alternative to standard care and increases accessibility to professional oral care [11, 13–17]. This form of care is predominantly provided to care-dependent older adults (in a care home or home dwelling) when their physical or cognitive condition prevents them from visiting a dental practice [10].

DCC has not been heavily researched. Survey studies on DDC revealed that dentists often lacked confidence or willingness to provide dental care in a care home setting [18], a concern also echoed by care home managers [19–21]. Commonly reported challenges for dental care provision in care homes included accessibility issues, insufficient portable equipment, and the need for formal collaborations [19–22]. However, no quantitative studies reported specifically on DDC implementation. Previous qualitative studies on DDC are even more limited. A Canadian case study mainly focused on the experiences of dentists and patients [23], while research from the UK's National Health Service (NHS) highlighted that care home managers' preferred having access to DDC whilst acknowledging its inherent limitations like treatment scope and availability [24, 25]. In various contexts, including the NHS and New Zealand, care home managers expressed a desire for mobile dental services, but financial limitations remained a key barrier [24, 26, 27].

To date, no qualitative research has examined the perspectives of care home managers on a DDC programme that has actually been implemented. Therefore, this study aimed to explore perceptions and experiences of DCC in a setting where it had been successfully implemented for a prolonged period.

Methods

Design

The research questions for this study were addressed with a qualitative approach, within a constructivism paradigm. When presenting constructivism, Charmaz states that 'we interpret [research] participants' meanings and actions and they interpret ours' [28]. A constructivist epistemological perspective proposes that our subjective interpretation of experience is formed by a worldview and conscious construction [29]. Reflexive thematic analysis (RTA) was chosen as method for analysis [30, 31]. A key principle in the RTA methodology was to account for the first authors' own reflexive influence on her interpretations as both a researcher and a clinician. By accounting for the unique position of the first author as a practicing dentist for DDC, as well as a qualitative researcher, RTA seeks to acknowledge and embrace this, rather than trying to objectify its influence. This paper adheres to the criteria for reporting qualitative research from the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Additional file 1) [32].

Setting and participants

This study was conducted in care homes, where domiciliary dental care had been in place for 8 to 12 years prior to data collection. This project is part of a broader research programme that also includes interviews with residents, informal caregivers, and ward staff in the participating care homes. The DDC programme (called Gerodent) is active in 62 care homes in the regions East- and West-Flanders, offering DDC in around 17% of long-term care organisations in these regions. In this programme, curative and preventive on-site oral care for residents is combined with a preventive implementation plan at the care home level and education for the care staff. The oral care is provided under a fee-for-service (FFS) system, with partial coverage provided through mandatory health insurance. The programme adheres to a fixed fee-guide, provided by federal government. Residents eligible for increased reimbursement (50 to 70% of residents) incur minimal out-of-pocket expenses for basic care under this system, supported by a third-party payment mechanism. To cover the additional costs of DDC, participating care organizations contribute with an annual fee alongside the FFS income.

To obtain a broad range of preferences and experiences, variation was pursued based on the perceived smoothness of the on-site collaboration between with the care home staff during DDC provision and the perceived daily oral care. This was discussed with both dentists and dental assistants during the recruitment phase of care homes. Following each DDC visit, an evaluation document was completed, assessing key criteria such as the suitability of the location, the availability of care staff

to assist residents, the perceived quality of daily oral care, and the fulfilment of administrative requirements. These evaluation documents complemented the dental team's reported experiences. Furthermore, heterogeneity was sought on the location, size, financing type and years of experience with DDC of the care home. Following the purposive selection of care homes, managers and coordinators were invited to participate in the study.

Data collection

A topic guide was developed, reviewed and used by the research team (LJ, BJ, and IP) (Table 1) and focused on following key areas: experiences regarding the functioning of DDC, preferences regarding professional oral health care for care home residents, and the impact of DDC on the daily care processes of the organisation. The semi-structured interviews with the care home managers were held between November 2021 and June 2023, in meeting rooms or office rooms in the participating organisation. Four interviews were conducted with dual participants, as the general manager and care coordinator possessed complementary expertise and routinely worked in tandem. Interviews resemble regular conversations, yet the interviewer and interviewee use much more energy and active thought in this process than in everyday conversations [33]. Semi-structured interviewing involves using a topic guide to explore key themes while allowing flexibility for the interviewer to probe deeper into responses and adapt questions based on the participant's answers. This reflects the active construction of meaning that occurs by both parties during the process. The interviews were conducted by the principal researcher, LJ (Master of Science in Dentistry, PhD), who was trained in conducting qualitative research. All discussions were audio-recorded and, when possible, field notes were taken. After recording, the audio-data was transferred to the university's General Data Protection Regulation-safe cloud service (GDPR). Audio-data was immediately removed from the recording device. In contrast to what the COREQ-guidelines ask, data collection was not ended when 'data saturation' was invoked. For RTA, ''meaning resides at the intersection of the data and the researcher's contextual and theoretically embedded interpretative practices". On this basis, new meanings are always (theoretically) possible [34]. Instead, the researcher made a judgement, based on the interpretation of the meanings generated, the breadth and focus of the research questions and on pragmatic considerations (e.g. time). All interview recordings were transcribed verbatim in Word (Microsoft) by the principal researcher (LJ) and two undergraduate dental students.

Table 1 Topic guide for the interviews

Experiences regarding functioning of DDC	- Can you tell me about how you encountered the DDC service? - Can you tell me how you experienced the implementation process? - What expectations did you have beforehand? - What expectations do you have now? Can you tell me about your expectations for the future? - How do you experience the administrative preparation for a DDC visit? How do you approach this? - What's the impact of a DDC visit on the organisation? - What's the impact of DDC on the care processes?
Preferences for professional oral health care for the residents	- What is the ideal scenario for care homes if you want to make professional oral care accessible to residents? Are there multiple scenarios possible?

Ethical considerations

Ethical approval was obtained from the ethics committee of Ghent University Hospital (B6702021000251). Participants were provided with written and oral information on the study, and informed consent was obtained. The study adheres to the ethical principles of the Declaration of Helsinki.

Context of the principal researcher

The principal researcher (LJ) had a dual role both as an active clinician (dentist) in the participating care homes and as a qualitative researcher conducting the interviews and performing the analysis. This dual role was disclosed at the start of each conversation, with an emphasis on the fact that the information shared in the focus groups or interviews would have no effect on the care relationship that LJ might have with the care home and its residents. As most care home managers were used to seeing a dentist in professional attire, wearing everyday clothes made LJ less recognizable as a clinician. LJ is a white woman in her early thirties, born in Flanders. The language used by the interviewer was informal spoken Flemish. Interviewees responded in a similar informal Flemish, or in their local regional dialect. A reflexivity account can be found in Additional file 2.

Data analysis

A reflexive thematic approach was used to analyse the data [30, 31]. First, transcripts were read thoroughly by LJ to gain familiarization with the data. All transcripts were imported into NVivo 13–14 software and coded inductively [35]. Most coding was semantic (e.g. close to the explicit meaning 'need for direction by the manager'), though latent, more implicit meanings (e.g. 'resignation concerning dentist's interest in older adults') were also included. Around 130 initial codes were created at the end of this phase. Next, candidate themes were constructed by 'using codes as building blocks', into clusters of meaning. A constant comparative approach was used throughout this process to revise and define the themes,

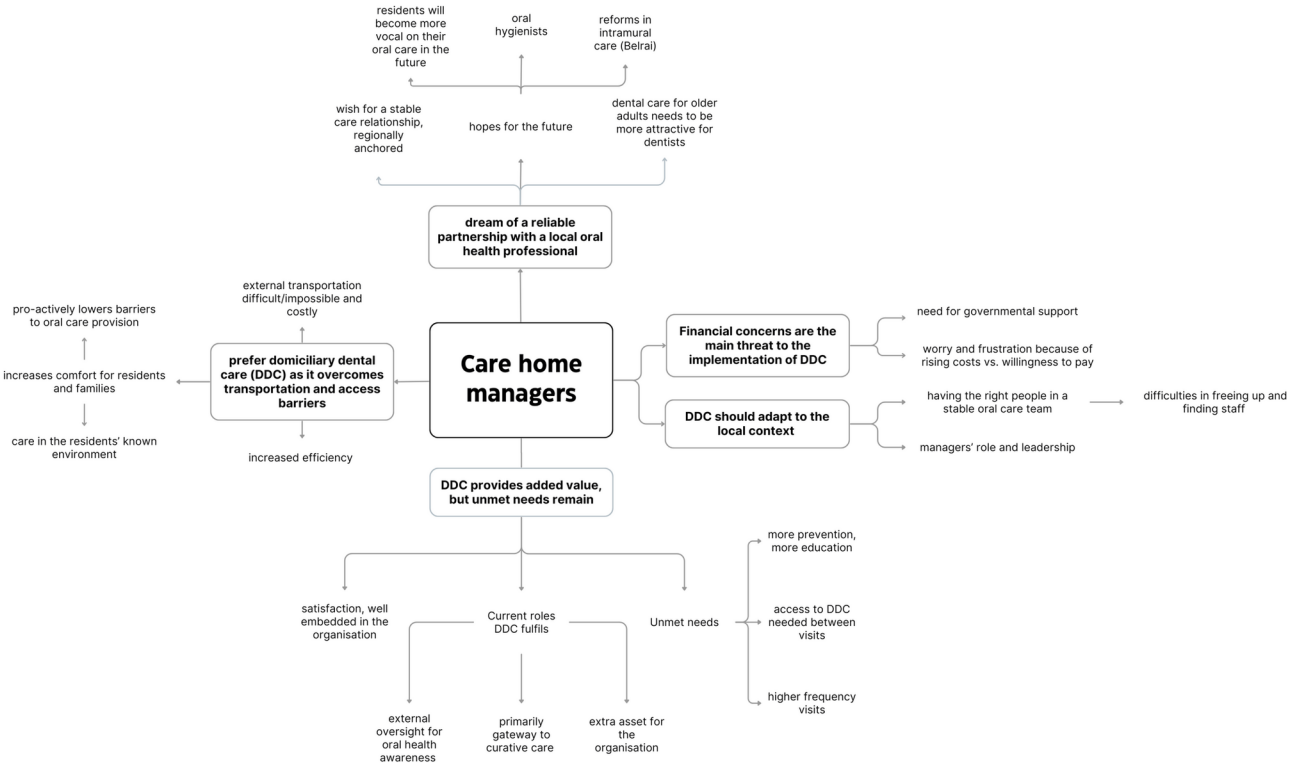

Fig. 1 Coding tree

Table 2 Characteristics of participating care homes

	Care home					
	1	**3[a]**	**4**	**5**	**6**	**7**
Interview number	1 (*n* = 2)	2 (*n* = 1)	3 (*n* = 2)	4 (*n* = 1)	5 (*n* = 2)	6 (*n* = 2)
Size						
<120 beds			X			X
>120 beds	X	X		X	X	
Rural/urban	Rural	Urban	Rural	Urban	Rural	Urban
Type of financing	Social profit	Public	Social profit	Social profit	Social profit	Public
Number of years working with DDC						
5–10			X			X
10–15	X	X		X	X	

[a] Care home 2 is not included. Although residents, informal caregivers and staff were interviewed within the context of a larger study, the care home manager of CH2 was not available

[b] Three financing models of long-term residential care exist in Belgium: public, private or social profit. The latter being non-profit organisations, without shareholders

going back to the data to build understanding [30, 36]. The interpretation of the candidate themes was discussed within the research team (BJ, IP). Illustrative quotes were selected and translated into English for the purposes of publication using the large language model ChatGTP4. Quotes in native language and their English translations are shown in Additional file 3. The coding tree can be found in Fig. 1.

Results

Ten care home managers from 6 care homes participated in 6 semi-structured interviews. The care home characteristics are described in Table 2, while participants' characteristics are displayed in Table 3. When recruiting, three care homes declined to participate in the study, stating problems with staffing, work pressure and/or difficult timing. There was heterogeneity in professional background and seniority of care home managers. The interview duration ranged between 40 and 90 min, with an average length of 54 min.

Table 3 Participant characteristics

	Care home						
	1	**3**[a]	**4**	**5**	**6**	**7**	**Total**
Interview number	1 (*n* = 2)	2 (*n* = 1)	3 (*n* = 2)	4 (*n* = 1)	5 (*n* = 2)	6 (*n* = 2)	*n* = 10
Age							
40–49	1	0	1	0	1	0	3
50–59	1	1	0	1	1	2	6
60+	0	0	1	0	0	0	1
Function							
Care home manager	1	0	1	1	1	1	5
Coordinator I&D[b]	1	0	1	0	0	0	2
Care coordinator	0	1	0	0	1	1	3
Seniority in long-term care for older adults							
0–10	0	0	0	0	1	0	1
10–20	1	0	2	0	0	1	4
20+	1	1	0	1	1	1	5
Seniority current function							
0–10	1	0	1	1	2	1	6
10–20	1	1	1	0	0	1	4

[a] Care home 2 is not included. Although residents, informal caregivers and staff were interviewed within the context of a larger study, the care home manager of CH2 was not available

[b] Coordinator innovation and development

Five themes were generated from the iterative reflexive review of qualitative data:

1. Care home managers prefer DDC as it overcomes transportation and access barriers.
2. Care home managers dream of a reliable partnership with a local oral health professional.
3. DDC provides added value to the care organisation, but unmet needs remain.
4. Financial concerns are the main threat to the implementation of DDC.
5. DDC should adapt to the local context.

Theme 1: care home managers prefer domiciliary dental care as it overcomes transportation and access barriers

> *"Back then, my main thought was that we would have to send very few care home residents to external dentists. And I definitely saw that as an opportunity, because if you look at the residents, there are very few who can easily go to external dentists anymore, right?" CH3.*

Transferring their residents causes many difficulties for care home managers. It is seen as something very expensive, whether in "costs for the transport, or costs for our workers" (CH7). Often, the organisation does not or cannot receive support or help from the residents' family. For the comfort of their care-dependent residents, they also want to actively avoid stressful transfers. A preference for care in the residents' own environment was reported. It's also a way of increasing efficiency, and they wish to apply this principle to as many care domains as possible in the future. Domiciliary care proactively eliminates barriers towards professional oral care for the residents and their families, who otherwise would just forego this type of care at all.

> *"...getting family members to go along is also not a given. Either we have to find a volunteer, or it ends up being a staff member who has to be taken off their regular duties. And that's not easy nowadays. So, if we can bring that care in-house and do it in a systematic way, it creates a much better flow, both for the staff and for the director. It just works better in-house. I mean, if you send a staff member with someone, you're almost losing half a day, you know?" CH7.*

Theme 2: care home managers dream of a reliable partnership with a local oral health professional

Care home managers want to be integrated in their local community; they seek to see a medical/dental service centre in or next to the care home to provide care, not just for their residents, but also for all the other vulnerable (older) adults in the whole neighbourhood.

> *"... a dentist who just has a practice here, right? Why not? Yeah, as long as our residents can access it, right? That would be ideal...Yeah, you're anchored, I mean, that's our mission too, isn't it? CH5.*

Whilst expressing their preferences, they also acknowledge these are an almost unrealistic dream. Most are resigned that access to oral care will remain a challenge and wish that providing dental care for

vulnerable older adults is made more attractive to oral health professionals.

> *"Yeah, could dental practices specialize in elderly care or oral care for the elderly, maybe?" "There aren't even enough dentists for regular people…" CH7.*

Even though these managers have implemented DDC, they still wished for a solid connection with a local dentist, which proved to be very hard to find:

> *"We also don't have any connection with a local dentist. Residents can't go there, or the dentists aren't open to it. Yeah, but what about residents in pain?" CH6.*

> *"We also tried through him (family connection) to get a dentist to come here on a regular basis, but they said the compensation for that is just insufficient, and they don't have the equipment to do it here. So it's just not up to standard… Yeah, they basically said, forget it, it's never going to work here." CH4.*

In contrast to their awareness of what is not feasible, managers also held hope for the future of long-term care. They envisioned a significant role for oral hygienists, a relatively new profession in Belgium. They believed oral hygienists to be more willing to serve vulnerable groups and are more cost-effective compared to dentists. Moreover, they anticipated future reforms in long-term care, especially with the implementation of BelRAI (Belgian version of InterRAI) which might reveal greater oral health care needs and potentially prompt more governmental action. The interRAI Suite comprises instruments for various care settings, measuring key areas of physical and cognitive functioning, mental and physical health, social support and service use. Recently, the oral health section for InterRAI was optimized [37, 38]. Lastly, they anticipate that future cohorts of residents will express their oral health needs more often, driving cues-to-action for healthcare services at the micro, meso, and macro levels.

> *"Yeah, if it can be done by an oral hygienist, it's ultimately more economical to have it handled by someone with a bachelor's degree, and in that way, preventive oral care can actually be provided…" CH4.*

Theme 3: DDC provides added value to the care organisation, but unmet needs remain

Care home managers were satisfied with DDC, and indicated the process is well embedded in their organisation, having seen a positive evolution over the years.

> *"So I think that generally goes quite smoothly. By now, we know what to expect when Gerodent comes, right? Which location, how the space should more or less be set up, and what needs to be available. In the beginning, there was more follow-up on that, but now it's almost fully embedded, so it doesn't require much time or energy anymore. Just scheduling and making sure the space is free at that time. Yeah, I think that's about it." CH3.*

They viewed DDC primarily as a gateway to accessible professional oral care, emphasizing the importance of curative treatment for the comfort of their residents. The services provided were seen as an extra asset the care home can offer to residents and their informal carers, unburdening them concerning oral health.

> *"I notice that a lot of curative work is needed. Especially with new residents, right? These are often people who no longer have a connection with their own dentist, even though that's still supposed to be the first option, right?" CH5.*

DDC also fulfils the role of a partner who can provide some external oversight to keep the topic of oral health alive in the wards.

> *"But I definitely heard… that when someone external comes in, it actually sets things in motion with the colleagues on the floor, with the residents, and I also wanted to mention, with the caregivers."*

However, care home managers also spoke up about their unmet needs. DDC's access is limited to biannual visits, leaving managers and care staff in a difficult position when dental issues arise between appointments as they still face the same challenges. They wanted to be helped in acute situations and see an increased frequency of visits or the availability of preventive screenings for nearly all residents as a solution, ensuring few issues go undetected. Lastly, participants expressed that the educational needs of the care staff were not adequately being met by DDC, wishing for more training possibilities.

> *"If something comes up in between, we still have to keep searching. Just recently, we had a resident with a toothache." "Yeah, that still happens 2 or 3 times a*

year, and we have to postpone it (dental care) then." CH7.

Theme 4: financial concerns are the main threat to the implementation of DDC

Managers expressed significant worry and frustration over increasing annual fees, citing a lack of control and clarity due to insufficient involvement and delayed communication from the hospital management. While there is a willingness to pay a fee and it this is recognised as a good investment, the annual fee must be justifiable. Managers weigh costs against benefits, but rising expenses raise doubts about the feasibility within their organisation. As DDC has grown over the years, decreased flexibility in logistics and planning has led to concerns about receiving less service at higher costs.

"We understand that there are costs involved, and we're also willing to pay for them, but in relation to the number of residents who actually sat in that (dental) chair, that was our concern, right?... Yeah, so that one is really hard to accept, right?"CH5.

Managers unanimously propose that more structured financial support from the regional or federal government would be necessary in the future.

Theme 5: DDC should adapt to the local context

The feasibility of domiciliary dental care is impacted by the time-varying context, such as staff turnover and the level of engagement from both managers and care staff. Managers indicated working actively to provide leadership, putting the topic of oral care on the agenda, coaching the care staff, and evaluating the process after DDC-visits.

"....address the head nurse about that. You have to include her in the briefing, right? Give her a reminder regularly. I mean, that's something you really can't let go of. Yeah, because then you'll lose track of it again... So, I really see my role in this as essential to keeping the process running smoothly, you know?" CH5.

Continuity in the care home's oral care team is a key factor in a smooth and well-integrated oral care process. Managers consider themselves fortunate if their team is composed of permanent, trusted, and reliable members. This stability also enhanced organizational clarity, as these individuals were recognised in their roles and served as a consistent point of contact for all oral care matters, for staff, residents, and their families.

"Ultimately, I find it very important that there is continuity (in the oral care team) and that we have someone internally who takes on that responsibility, because in my role (as manager), I can't manage it myself. But I have complete trust in X, who's always the one taking care of it." CH6.

The continuity of the oral care team, while valuable, is often threatened by the high staff turnover in long-term care. Challenges in finding the right staff can directly impact the logistical process of the DDC visits. Oral care liaisons act as hubs, managing the flow between oral health professionals and the care home, while advocating for residents. Care home managers noted difficulties in identifying suitable candidates and staff shortages further complicated this, leading to a sense of powerlessness among managers who feel they lack leverage due to the already heavy demands on their staff. Mistakes or poor preparations were easily overlooked because there is no luxury of choice in the job market.

"And we just have to take all of that on, right? We have to find people who are interested, but the pool we can draw from is getting really small, right? And eventually, you keep ending up with the same people, and their load gets too heavy too. Then we're dealing with burnouts, sick leave, and all that, you know?" CH5.

Discussion

The study showed that care home managers prefer and are satisfied with DDC's services but also wished to form a reliable partnership with a local dentist. Financial concerns posed the primary threat to the sustainability of DDC.

The care home managers' avoidance of transportation challenges correlated with the literature, as this is described as logistically complex, costly, and stressful for vulnerable individuals [26, 39, 40]. Providing DDC also created added value in terms of reduced need for staff assistance [41]. Moreover, it was seen as an unburdening of informal caregivers, who can also face serious challenges in transporting the care-dependent person [25]. However, on-site curative care also has its limitations, including restricted capacity and the inability to provide certain complex treatments, which may require referral to specialized settings.

Moreover, care home managers expressed a general sense of resignation regarding the unavailability of dentists to visit care homes or even book appointments for residents. This is a widespread challenge in the context of long-term care, and aligns with other studies with care home managers, both quantitative and qualitative [19–22, 24, 26, 27, 42]. Studies involving dentists have

highlighted numerous barriers or a general disinterest in treating these complex patients, even more so within a DDC-context [11, 23, 43]. Care home managers put their hopes for the future in oral hygienists, who are described in the literature as more cost-effective, more interested in the target population, and more focused on prevention. Previous research has shown that a significant portion of dental care needs in care homes could be effectively addressed by oral hygienists [44, 45]. This also aligned with the WHO Global Oral Health Strategy and Action plan, that pursues an in increase in the number and availability of mid-level oral health care providers, by shifting tasks, competency-based education and updating national policies for licensing and scopes of practice [46].

Another reported challenge in domiciliary dental care was the management of emergency appointments and urgent follow-ups, which are logistically difficult due to the fixed schedules and a limited number of care providers within DDC. Similar challenges were observed in a Canadian DDC case study, where high demand made it challenging to adjust schedules for emergencies. A proposed solution is "proximity dentistry," which involves a close collaboration between fixed and mobile clinics within the vicinity of care homes [25].

Care home managers increasingly struggle to accommodate the increasing costs of domiciliary dental care within their budgets, as annual fees charged to offset the high operational expenses continue to rise. DDC incurs significant logistical costs, with over 35% of work time spent on transporting and setting up equipment. Unlike private dental practices, it generates lower revenues due to the exclusion of high-cost treatments like indirect dental restorations and implant treatments [42]. To obtain financial sustainability for DDC initiatives, either the FFS care must be adapted —potentially with a capitation model for this subgroup of the population—or additional structural government funding would be required.

Belgium's FFS system faces similar challenges to other countries in organizing DDC. In the UK's National Health Service (NHS), although payments for DDC match those for in-clinic care, the time required is 6–8 times greater, making it financially unsustainable. The NHS Community Dental Service, offering salaried dentists, is limited in capacity [11]. In Germany, dental practices generate approximately 50% of their revenue from highly-priced, privately paid services; these are largely incompatible with the services provided by DDC in long-term care facilities [42]. In Canada, a case study suggested DDC could be profitable with strategies such as displacement fees, though combining a fixed clinic with DDC was found to be ineffective. On a positive note, DDC offered non-monetary benefits like flexible work environments, more work-life balance and more meaningful professional experiences for oral health workers [25].

Lastly, when organizing domiciliary care, one must be flexible and adaptable to the diverse environments in which they operate, recognizing that each organization has unique characteristics, strengths, and weaknesses. Managers reported that they played a critical and active role in the effectiveness of oral health interventions, aligning with findings from a qualitative study by Aagaard et al., that emphasized the importance of care home managers' ownership in the success of such interventions [47]. This study highlights that the success of the DDC service is significantly influenced by the stability and continuity of liaisons within the organizations, e.g. the oral care team. While staff shortages in long-term care are well-documented and reported as a barrier to dental care access, previous studies on domiciliary dental care have not emphasized this determining factor [17, 22, 25, 26].

During the recruitment of care homes, the research team aimed to ensure a variety of perspectives by including both care homes where the DDC process was smooth and where challenges were more pronounced. Of the 10 care homes invited, three declined to participate due to time constraints and workforce shortages, two of which were seen as in the 'smooth process' group, and one in the more challenging group.

In Care Home 2, which initially responded positively to the invitation, interviews with residents, informal caregivers and ward staff were conducted as part of a broader study project (not covered in this paper); however, the care home coordinator was unavailable. There was no indication that the care home manager would be available for participation in the study at a later time. In this care home, the responsibility for implementing and managing DDC lay with two highly motivated caregivers, a nurse and a care aid. The absence of these interviews could potentially mean that some views of DDC's process were not captured.

The strength of this qualitative study lies in its ability to provide real-world evidence, as opposed to short-term interventions for research purposes, as the DDC programme has been collaborating with these care homes for over a decade. This long-term engagement offered a unique perspective, with some managers having been present since the implementation of DDC in 2010. However, it is important to recognize that the care home managers' perspectives for residents' access to dental care were expressed within the context of DDC availability, maybe limiting the transferability of these findings to care homes where DDC is not available.

This study findings show that DDC, according to the care home managers, is an acceptable, accessible and accommodating way of providing professional dental care for care-dependent frail older adults. Moreover, DDC aligns well with the World Health Organization's

Global Oral Health Action Plan strategies of both person-centred and integrated care. However, its availability and affordability for care homes remain severely limited due to financial and capacity constraints. Therefore, as the number of care-dependent older adults in both residential and home settings is projected to rise, policy adaptations will be essential to facilitate the expansion of DDC initiatives, while ensuring cost-effectiveness for both society and patients.

Conclusion

Care home managers in this study preferred domiciliary oral care over regular care to avoid logistical challenges and stress for residents, highlighting the need for on-site services to meet the resident's specific needs. While they desire locally integrated oral health professionals, this is seen as unrealistic due to the scarcity of dental specialists willing to serve care-dependent older adults. DDC was valued for its accessible care and support but faces financial sustainability concerns due to rising costs. Care home managers expressed the need for financial support from the government to sustain their collaboration with DDC. Consequently, future policy adjustments will be necessary to organize structured dental care for the growing group of care-dependent older adults.

Abbreviations

Coordinator I&D	Coordinator innovation and development
DDC	Domiciliary dental care
FFS	Fee-for-service
GDPR	General Data Protection Regulation (European Commission)
MSD	Master of Science in Dentistry
NHS	National Health Service
RTA	Reflexive thematic analysis

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12877-025-06005-5.

Supplementary Material 1: Additional file 1: COREQ guideline

Supplementary Material 2: Additional file 2: Reflexivity account

Supplementary Material 3: Additional file 3: Quotes in English and native language (Dutch)

Acknowledgements

The authors would like to thank the care home managers for participating in the interviews. The first author is also indebted to undergraduate students Laurance Marrannes and Chaimae Afkir for transcribing the interviews.

Author contributions

Conception, JB and JL; design, JL, JB, PI; acquisition, analysis, JL, PI; interpretation of the data, JL, PI, GRA; drafting and revision, JL, PI, JB, GRA and PM.

Funding

No funding was received for this study.

Data availability

The qualitative data that support the findings of this study are not openly available due to reasons of sensitivity and are available from the corresponding author upon reasonable request and with permission of HIRUZ (Health Innovation and Research Insitutute, Ghent University Hospital). Data are located in controlled access data storage at Ghent University.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the ethics committee of Ghent University Hospital (B6702021000251). Participants were provided with written and oral information on the study, and informed consent was obtained.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Clinical trial number

Not applicable.

Received: 6 November 2024 / Accepted: 29 April 2025
Published online: 10 May 2025

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