General dentists’ attitudes and perceived barriers in providing domiciliary dental care to older adults in long-term care facilities or their homes in Northern Ireland: A descriptive qualitative study

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Abstract
Objective: Many older patients, housebound or living in long-term care facilities (LTCFs) have limited access to dental care. This descriptive qualitative study aimed to understand general dental practitioners (GDPS) attitudes and perceived barriers to undertaking Domiciliary Dental Care (DDC) for those patients in Northern Ireland (NI).

Methods: Semi-structured telephone interviews were conducted with a purposive sample of 12 GDPS in Northern Ireland. Interviews were digitally recorded and transcribed verbatim. An iterative coding process using theme-analytic methods was used.

Results: The data were characterised into four major themes—risk of professional litigation, remuneration for those undertaking DDC, complexity of treatment, and the overall framework of the dental care system in NI. Two minor themes identified were practice culture and reasons for undertaking DDC. The GDPS in the study identified a number of barriers to undertaking DDC including a legal requirement to transport oxygen, lack of organisation and limited oral hygiene care provision in LTCFs, and confusion around their responsibilities for provision of DDC. Those GDPS who were providing DDC indicated that they did so out of kindness and a sense of loyalty to their long-standing patients.

Conclusion: The GDPS in this study identified a number of significant barriers to provision of DDC at organisational, structural and clinical levels. The GDPS indicated that they required clarification of their responsibilities around DDC with clear guidelines necessary given the increase in demand for this service.

KEYWORDS
barriers, dental health, domiciliary care, elderly, qualitative research
1 | INTRODUCTION

Dental domiciliary care (DDC) describes dental care delivered for a patient in an environment outside clinical dental practice, usually in the patient’s place of residence. DDC is most often provided for older dependent adults in either a long-term care facility (LTCF) or in the patient’s own home as due to illness, disability or frailty they are physically unable to come to the dental practice. General dental practitioners (GDPs) in Northern Ireland (NI) are responsible for the oral health of all their registered patients whether they are able to attend the surgery or not, and receive additional remuneration for travelling to the patient’s residence. Figures show the number of patients treated by GDPs via a domiciliary visit has remained around 3000 per year from 2015 to 2020. This figure is low when compared to the 35 000 registered care home residents, and that is not including the elderly housebound. It suggests around 32 000 care home residents do not receive any dental health care in NI. Less GDP domiciliary visits leave the elderly without dental care and places more pressure on the Community Dental Service (CDS), whose main purpose is special care dentistry, usually on a referral basis, but who often have to provide routine DDC when GDPs are unavailable.

As people retain more of their teeth into older age, they are more likely to suffer from chronic dental diseases including dental caries and periodontal disease. These conditions can impact on a number of systemic diseases including diabetes, respiratory, and cardiovascular disease, as well as negatively impacting on quality of life. Amongst older adults, 40% of the 75-84 age group and 33% of the 85+ age group have dental caries, while periodontal disease affects 69% of those over 65 years of age. The oral health of LTCF residents is much worse than their community living peers with 73% of residents experiencing caries. With increasing age, the ability to self-care deteriorates, poly-pharmacy leads to dry mouth, and diets become rich in sugars. All these factors significantly increase their disease burden and the risk of future problems.

A previous postal survey of GDPs carried out in Northern Ireland in 2008, recorded decreasing levels of DDC provision and reported barriers to DDC including a lack of time and equipment, and a view in 2008, recorded decreasing levels of DDC provision and reported barriers to DDC including a lack of time and equipment, and a view that the patients were too difficult to manage in this environment. These obstacles were mirrored in multiple studies which also cite low remuneration as a barrier to DDC provision. These studies also suggest that a lack of preventative care from LTCF staff is a significant cause of dental decay in residents.

No study of this kind has previously been carried out in NI. It aimed to gather qualitative information on GDPs attitudes to undertaking DDC for dependent older adults and perceived barriers to providing this care, to potentially address and reduce oral health inequalities amongst the elderly.

2 | METHODS

A descriptive qualitative study was conducted. The consolidated criteria for reporting qualitative studies (COREQ) was used as a guide throughout data collection and analysis. Full ethical approval was obtained from the School of Medicine, Dentistry and Biomedical Sciences Research Ethics Committee at Queen's University Belfast (QUB) in September, 2019 (Ref: 19.37).

2.1 | Recruitment of participants

The main participant inclusion criterion was to be a GDP working in NHS and/or private practice in NI. Any GDP not currently working in NI was excluded. An invitation to take part in this study was included in a weekly news bulletin emailed to all (approximately 300) members of the NI branch of the British Dental Association (BDA) at the beginning of June 2020. Ten dentists responded citing their interest in taking part. They were emailed a standardised cover letter with the participant information sheet (PIS) and the consent form. The voluntary and anonymous nature of the study was emphasised in the PIS and six dentists returned the written consent form. Four dentists showed initial interest but did not reply after the PIS was emailed. This was during a time of extreme professional stress within dentistry as a result of the SARS-CoV-2 pandemic so it was assumed they did not want to were not able to take part and were not followed up.

As the study continued, purposeful-iterative snowball sampling was used to identify six more participants. Via direct email, eight GDPs were approached by another member of the research team. To ensure a more representative sample, they were chosen based on their practice location, principal (worked in their own practice) or associate (did not own the practice they worked in) status, and whether participants undertook DDC. These dentists were known to the research team through previous work and research links. Seven dentists responded but one was rejected as he had not practised dentistry in over three years.

At no point were participants offered any type of incentive for taking part in the study.

2.2 | Topic guide

A topic guide for the interviews was developed by the research team which included the following subjects:

- Background career information.
- DDC provision by the participant and/or their practice and how that has changed over time.
- Views and perceptions of current DDC services for dependent older adults including barriers to DDC.
- How to encourage GDPs to undertake more DDC.

The topic guide was pilot tested with two dentists known to the interviewer (Appendix 2).

2.3 | Data collection

Twelve in-depth, semi-structured, open-ended telephone interviews were conducted. The interviewer was a female dentist working in...
general practice who conducted the research as part of a Masters in Public Health (MPH) postgraduate course.

Allowing 30 minutes for each interview gave adequate time for in-depth responses and follow-up questions, but if participants had more to say they were allowed to continue. Two interviews lasted over 50 minutes. Participants were alone while being interviewed either at home or in their practice. Interviews were audio-recorded and transcribed verbatim. Only one interview per participant was conducted, no field notes were made and transcripts were not returned to participants. After approximately eight interviews, no new categories of data emerged but four more were carried out to ensure data saturation.

2.4 Data analysis

Theoretical thematic analysis using Braun and Clarke’s framework was conducted on the transcripts to code relevant data. Open coding was used to attribute different codes to related script. Coding was completed by hand using hard copies of the transcripts. No computer software was used in coding. One data coder, the interviewer, coded all the data. Recoding was performed 10 days after initial coding to increase dependability of the analysis. The codes were grouped into 15 categories and these were further consolidated to develop four major and two minor themes. Four participants were emailed the themes as a form of member-checking. Three replied, and all agreed the themes were appropriate.

3 RESULTS

Table 1 summarises the main characteristics of the sample of 12 GDPs recruited to the study. All were working as dentists in Northern Ireland, in predominantly National Health Service (NHS) practices. 33% (n = 4/12) of the participants were female, 67% (n = 8/12) worked as associate dentists and 83% (n = 10/12) worked in independent practices (not part of a larger group practice). The number of years qualified ranged from 5 to 36 with a median of five visits per year. There was a wide range of DDC activity reported by each dentist during the previous year, from zero to one hundred DDC visits. The research team endeavoured to interview dentists from all over NI and Figure 1 shows where each participant worked. Four participants worked in Belfast city which reflects the area of highest population density. The only other city represented is Derry/Londonderry while the remaining participants worked in towns that service the surrounding rural areas. Fermanagh and Down are not accounted for. The dental healthcare system is the same throughout NI and no pattern in opinion was linked to the dentist’s gender nor to geography, whether the practice was in an urban or rural area.

Four major themes emerged from this study:

1. The risk of professional litigation was perceived to be too high to allow dentists to comfortably undertake DDC.

2. Remuneration for dentists undertaking DDC was considered too low to be economically sustainable.

3. Treatment of dependent older patients in DDC was viewed as complex.

4. The organisation of dental services in Northern Ireland was confusing and actually impeding DDC delivery for dependent older adults.

5. The culture within each dental practice dictates provision of DDC.

6. The positive attitudes GDPs have towards DDC.

These themes and the categories which make up each can be summarised in Figure 2. Some of the categories such as transport and time fall into multiple themes. The themes have been outlined below with relevant quotes from participants. Additional quotes linked to each theme are attached (Appendix 1).

3.1 Theme 1

The risk of professional litigation was perceived to be too high to allow dentists to comfortably undertake DDC.

Most dentists fundamental problem comes from..., the fear of being sued because we have a litigious society..., they are the major fears and barriers we have to doing anything

[Participant 10, NHS GDP, Antrim]
A number of participants used a fear of litigation as a barrier to undertaking DDC. They discussed professional indemnity and raised concerns about coverage:

The minute we go out of our practice there is an issue over our insurance and all, does it cover you, does it not cover you? If the patient has a medical emergency can I treat that, can I not. There are just so many questions.

[Participant 1, NHS GDP, Antrim]

Younger dentists spoke at length about the risk of travel to and from appointments and consent issues around patients with cognitive decline and dementia. Those participants who performed more DDC were generally more experienced, practice owners, and voiced less concern around litigation:

If I was a younger dentist and had a lot more of my career in front of me I might have phoned the indemnifier and if they'd told me stop I might have stopped but I was so close to the end of my career I didn't really care.

[Participant 6, NHS GDP, Tyrone]

This was in contrast to the preoccupation less experienced dentists had with regulatory requirements:

It’s not that I don’t want to do it, it’s just that there are so many barriers to it that you have to get in order now to do it properly. I think just our generation is just so afraid of litigation that you wouldn’t do it unless you went knowing you’d done everything your indemnifier told you to, but the list is getting longer and longer.

[Participant 12, private GDP, Belfast]

All dentists agreed the biggest risk was if a domiciliary patient had a medical emergency, they would be exposed to litigation if they did not carry the correct emergency equipment. None of the GDPs had more than one emergency kit in their practice which was a significant problem when travelling to a DDC visit. Only one of the seven dentists who regularly offered DDC reported carrying an oxygen cylinder to visits, despite this being a legal requirement. The majority of GDPs said they would prefer to provide DDC in a LTCF rather than the patient’s own home as they perceived it to have more support from other staff and less risk. Fear of litigation as a barrier to DDC was summarised by one experienced GDP:

I would be more afraid of doing treatment and something happening than not doing it and somebody asking me why I didn’t.

[Participant 5, NHS GDP, Tyrone]

3.2 | Theme 2

Remuneration for dentists undertaking DDC was considered too low to be economically sustainable.

All of the dentists interviewed agreed that the fees offered for undertaking DDC were too low given the time required for a visit:

It’s the same with health service dentistry – trying to make it work and fit into your day without taking up so much time that you can’t get whatever else you need to do done.

[Participant 2, NHS GDP, Derry/Londonderry]

Many of the GDPs considered DDC as a form of “charity work” and expressed their only reason for currently offering DDC was because the number of requests they received was low and so the financial loss was bearable. A number of GDPs identified extra expenses necessitated by DDC including wages for support staff, fuel costs, equipment and motor insurance. All GDPs mentioned the decreasing profitability of all aspects of NHS general dentistry:

You are more doing it because that’s your job..., it’s time consuming..., if you did it all the time it would be economically suicidal but I think something needs to be done, there’s a demand for it and there’s no real supply to it either..., It’s a bit like doing legal aid if you’re a lawyer you’re working for free, pro bono work, that’s really what it is.

[Participant 7, NHS GDP, Belfast]

The majority of GDPs felt that the salaried Community Dental Services should provide DDC completely:
I do think that’s their role (Community Dental Service) and I think because they are salaried they have more time to spend with the patients and it should all be part of their day whereas for us because we’re paid per item it really makes no financial sense for us to do DDC visits

[Participant 1, NHS GDP Antrim]

However, some dentists did recognise the benefit of sharing the service as they felt it was important for the patient to have the option of seeing their own dentist.

3.3 | Theme 3

Treatment of dependent older patients in DDC was viewed as complex.

This combines all the particulars of treatment from gathering the necessary equipment, to infection control, overcoming the hurdles in a LTCF, to incomplete medical histories. Treatment was considered by all to be physically difficult for patient and practitioner.

It’s not just going there taking impressions and coming back. It’s managing people who have special needs, taking impressions while they are lying in bed, always I get back pain. I can’t move them into a position that I want to, I have to fit myself into their position and stay in that position until it’s done.

[Participant 4, NHS GDP, Belfast]

GDPs reported that they were only asked to visit a patient if there was an acute problem and rarely for routine care including check-ups or for prevention. Participants felt treatment was
unsatisfactory as it was only ever temporary and a lack of preventive measures led to rampant caries, leaving dentists feeling their input was pointless and only ever “fire-fighting.” Participants recognised widespread understaffing and disorganisation in LTCFs. They recommended training of care home staff in preventive oral health but felt they could not spare the time to do it themselves. A majority were concerned about undiagnosed mouth cancer in this patient cohort.

GDPs reported that often LTCF staff were unaware of the DDC appointment or the dental complaint, and rarely was the patient ready when they arrived:

You’ve phoned them that morning and you’ve told them you’re coming at 4 pm and you turn up and you’re patient is in the dining room in the middle of their dinner, that’s happened twice... you either wait for them to finish dinner or they’re wheeling them down to the room and they’ve got a mouth full of dinner

[Participant 12, private GDP, Belfast]

Participants discussed lost dentures as a frequent clinical problem across many LTCFs. In combination with pressure from family members this was seen as a cause of unnecessary treatment, which was widespread:

One lady who had quite advanced dementia, was very difficult to treat, she had lost her dentures, I knew she would not wear new dentures. I explained that to her husband and said look we’ll try and make her something so I made a set of dentures and basically guessed the bite registration because she wouldn’t do anything for me, and got them fitted. The husband was happy, he knew she wasn’t going to wear them, I knew she wasn’t going to wear them but I think he felt he had done his best for her by getting her dentures.

[Participant 3, Private GDP, Belfast]

3.4 Theme 4

The organisation of dental services in Northern Ireland was confusing and actually impeding DDC delivery for dependent older adults.

All of the GDPs in the study reported that they were actually unsure of how DDC was organised and who was responsible for administering the service. GDPs reported confusion about the role of the Community Dental Service and did not know where to ask for information or help:

I don’t know if the community dental service go around nursing homes but there’s maybe a grey area and no one knows where the patients are falling into and maybe they are getting left by the wayside at this stage.

[Participant 9, NHS GDP, Tyrone]

A lack of training was perceived as a barrier especially by younger dentists who would have appreciated some form of instruction either as undergraduates or during vocational training.

At university and even through foundation training there was very little, in fact none probably, no training at all in how to do a domiciliary visit... What is the pathway for us? Do you do a domiciliary? Do you not do a domiciliary? Is it the community dental service’s responsibility or yours?

[Participant 1, NHS GDP, Antrim]

3.5 Theme 5

The culture within each dental practice dictates provision of DDC.

GDPs reported that some practices traditionally offered the service while others did not. Those working as associates felt they could only provide DDC with the practice owner’s approval:

At best it is a free service at worst it costs me money. I can do that because I’m the boss but my associate couldn’t do it or he would be pulled by me.

[Participant 7, NHS GDP, Belfast]

The only participants who reported that their practices did not undertake DDC at all were those working in practices owned by a dental corporate:

The company has meetings at times and it was never mentioned that there is a code for this item of service (payment for DDC). You were the first one to actually mention this.

[Participant 5, NHS GDP, Tyrone]

3.6 Theme 6

The positive attitudes dentists have towards DDC.

Most participants perceived a high need for oral health care amongst dependent older adults. All of the dentists felt it was important to repay years of loyalty shown by the patient and perceived a duty of care to those who were suffering, even if it meant a financial loss:

It’s the same with any dentist, you want to go in and you want to help out and you want to care for the
4 | DISCUSSION

The purpose of this study was to explore GDPs attitudes and perceived barriers towards providing DDC to dependent older adults in Northern Ireland. Many of the barriers identified in this study have been reported elsewhere but to our knowledge this is the first to describe the risk of professional litigation as a significant barrier to DDC.6,9,13 This could reflect the dramatic growth in litigious claims against GDPs in the UK over the past ten years.14,15 Most of the relevant literature on DDC predates this so it may not have been at the forefront of dentists’ minds, as it is now. The participants concerns are fully supported by the quantity and significance of recent literature on dental litigation.14,16

More experienced participants were not as concerned about litigation as their younger colleagues perhaps due to having built good relationships with their patients over many years or as one Dutch study found, a lack of concern as they are nearing the end of their career.15 Although poor remuneration for DDC was another major barrier there was the prevailing impression amongst approximately half of the participants that no amount of financial reward would encourage them to jeopardise their professional registration. Maybe it is not that dentists do not want to do DDC but that they are afraid to.

Even though the payment offered for DDC within the NHS is comparable to other treatment fees, and covers transport costs at a similar rate to other public service sectors, it is not comparable to the treatment time required for each visit. It can take 6-8 times longer to treat one domiciliary patient in their own home as it does to treat a similar patient in the surgery. As Brocklehurst et al. explained, time and money are intrinsically linked in NHS general dentistry.17 Costs are so high for GDPs that a high volume of patients must be seen and treated to ensure financial viability. However, it costs more to undertake DDC than a GDP gets paid for it, so they are effectively donating their time and money to treat elderly patients. It is understandable why participants felt the salaried Community Dental Service could provide DDC as activity levels are not financially driven, but this service is also under immense pressure.

Therefore, when dentists say DDC is not financially viable, it is not because the fee is low per se but because it is low in relation to the amount of time DDC takes and the money that could be earned instead by treating patients within the dental surgery. This explains why any GDPs who undertake DDC do so during lunchtime or after work, often without a nurse, to minimise out of surgery time.

The difficulty in treating domiciliary patients was described by all participants, but they did elaborate that it is not so much complex treatment but a complex environment in which to provide treatment. Prior studies have not differentiated this clearly.13,18,19 Nor have they accounted for the high volumes of lost dentures which all participants cited as a major, but easily preventable problem. It is recommended that all new dentures are labelled with patient details as described by the National Institute for Clinical Excellence (NG48) and awareness raised on the risk of wrapping dentures in tissue when not being worn.20

In agreement with other studies, GDPs suggested a more united front on prevention, especially from LTCF staff, could help to improve the oral health of dependent older adults and may reduce DDC demand for acute dental issues.21,22 Patients’ oral health journey should not start and end with the GDP and LTCFs must be made more accountable for oral care of their residents.23 DDC could be made much easier for the dentist and patient if nursing homes worked with them by possibly providing a dedicated treatment area, up-to-date medical histories and a reliable point of contact for dental specific issues, such as alerting a new resident’s dentist to their change of address. Further research into the resources required by LTCFs to promote oral health would be welcomed.

The only participants who worked in practices where DDC was not provided at all were dentists working in large corporate practices (practices owned by multi-national conglomerates). This suggests a possible conflict of interest between a dentist’s ethical duty of care and a practice that is owned and managed by a corporate body. Clarifying the role of GDPs in DDC provision and setting clear guidelines on responsibilities for DDC could prevent future decreases in DDC availability as larger numbers of practices become part of corporate bodies. This is worrying for the future as corporate companies continue to grow along with an ageing population whose required treatment approach does not seem to fit into their business model.

This study grew from the assumption that demand of DDC far outstrips supply. There is evidence in the literature that the oral health of dependent older adults is extremely poor, hence a high need for DDC, but need alone does not ascertain demand.7,24 Three of the participants interviewed said they had never been asked to do a domiciliary visit while the others claimed they rarely declined a request.
This study raises serious questions about the current adequacy of oral health care for older adults, and these need to be addressed at organisational, clinical and structural levels. At an organisational level, confusion has been created by indemnity providers and the Regulation and Quality Improvement Authority, a governing body independent of the NHS. Their recommendations and guidelines around DDC are often disparate, thereby creating one of the major barriers to DDC for GDPs who tend to avoid it for fear of not being properly indemnified. Furthermore, are GDPs alone to bear the blame of minimal DDC when the BDA claims the NI general dental service shows no leadership or guidance for them? Vagueness and lack of training around DDC had led to some dentists being unaware of their role in DDC. At a clinical level who is indeed responsible for the dental neglect of older adults unable to access the high street dental practice? The health trust, nursing homes or individual dentists – many of whom have reported the complexity of treatment in a poor setting as a major barrier? Should GDPs be held accountable for the oral state of patients who are too frail to open their mouths wide enough or whose condition is too precarious for effective treatment? Should the dental care system be restructured to remunerate dentists differently, utilise Community Dentists in the provision of DDC and oblige LTCFs to take responsibility for their residents’ oral hygiene? The government has a statutory obligation to provide the highest level of available dental care equally to all citizens, via the dental care system as a whole, and not just GDPs. As the findings of this study suggest a majority of dependent older adults in NI do not have access to oral health care, it raises concern around deep inequalities between those adults in LTCFs and their community living peers, and supports previous research highlighting their plight. Reframing the problem away from GDPs and setting it within the context of the government’s health agenda could provide upstream solutions, reducing need through active prevention strategy and de-mystifying the service through clear direction.

The researcher, a practising dentist with experience in DDC in Northern Ireland was the main data collector and interpreter. Her personal experience will have introduced bias, but it is also an important strength. With a deep understanding of practical dentistry reduced time was spent finding common ground between interviewee and interview so more in-depth responses could be garnered. Response bias was minimised by reinforcing anonymity, reminding the participant there were no right or wrong answers, and passing no judgement. Member-checking with three participants increased the dependability of the data.

Although telephone interviews do not allow for visual cues, participants can feel more relaxed because they feel safer in their own space and often feel able to disclose more sensitive information. Evidence is weak that face-to-face interviews produce better quality data and due to the SARS-CoV-2 pandemic and national restrictions on movement, telephone interviews became the most suitable option.

The majority of participants providing DDC did so in LTCFs so the data collected inadvertently focused on LTCF residents and captured fewer issues specific to dependent older adults in their own homes. This seems to be a shortcoming in all research on DDC and this specific niche would benefit from further investigation.

5 | CONCLUSION

This qualitative study provides in-depth understanding of GDPs views towards DDC. Avoidance was the predominant attitude, built on the perception of multiple barriers which centre round finance, high risk of litigation, complexity of treatment, and the system within which DDC lies. Anxiety associated with litigation and professional indemnity for DDC provision has emerged as a new theme in this area. The implications of these findings suggest that for dependent older adults, access to oral health care is often limited.

CONFLICT OF INTEREST

The authors declare they have no conflict of interest.

AUTHOR CONTRIBUTION

GMK and MS: conceived the original research. SW, JMM and GMK: attained ethical approval. EK and GMK: undertook recruitment of participants. EK: collected the data. EK, SW and JMM: analysed and interpreted the data. EK: involved in manuscript writing. SW, GMK and JMM were responsible for revising, editing and approving the final version.

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SUPPORTING INFORMATION
Additional supporting information may be found online in the Supporting Information section.

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