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"We try our best": a qualitative study of care staff's perspectives on oral health care for persons with disabilities

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Abstract

Background Persons with disabilities generally have poorer oral health than persons without disabilities, which negatively affects their quality of life. As caregivers play an important role, this study investigated how oral health care is organised and performed by care staff in residential care settings, and examined the barriers and enablers they experience.

Methods A qualitative study was conducted within the social constructionist research paradigm. Eight semi-structured focus group interviews and three individual interviews were carried out between November 2019 and January 2023 with a total of 43 female care staff members from 16 residential care organisations. Data analysis was guided by reflexive thematic analysis.

Results Four major themes were identified. Care staff were aware of clients' oral health needs but faced difficulties in managing them. They faced challenges in both providing daily oral health care and planning professional oral health care. Ineffective coping strategies such as lowering standards, distancing oral health care from general care, and externalising responsibility were reported (Theme 1). Furthermore, oral health was perceived as a source of tension within the organisation, including conflicts with clients or their network, within and between staff teams, and across different organisational levels (Theme 2). Care staff mentioned setting-related challenges, including the diversity of clients and variations in workflows and organisational structures within and between organisations (Theme 3). Despite these challenges, several enablers were identified, including the availability of clear guidelines, tailored training, and collaboration with external partners (Theme 4).

Conclusions Care staff in residential settings for persons with disabilities face persistent challenges in providing oral health care. However, the enablers identified in this study offer valuable guidance for researchers and practitioners seeking to improve oral health in this setting.

Keywords Qualitative research, Persons with Disabilities, Residential Facilities, Oral Health Care, Caregivers

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Background

According to the World Health Organization's *Global report on health equity for persons with disabilities*, an estimated 1.3 billion people worldwide live with significant disabilities, representing approximately 16% of the global population [1]. Compared with the general population, individuals with disabilities are more likely to die prematurely, experience poorer overall health, and face greater limitations in daily functioning [1]. These health inequities are also evident in oral health outcomes [2]. Persons with disabilities generally have poorer oral health and face a higher risk of dental problems than persons without disabilities [3–8]. This risk is even higher for individuals living in institutional settings [7]. Moreover, poor oral health in persons with disabilities negatively affects their quality of life and overall well-being [9, 10].

Caregivers play a fundamental role in the oral health of persons with disabilities by providing assistance with and supporting daily oral hygiene, being an important factor in the prevention of periodontal disease and dental caries [11–13]. However, they often encounter barriers such as uncooperative behaviour and the anxiety of persons with disabilities regarding oral health care [13, 14]. Wilson et al. therefore emphasised the importance of identifying and addressing these barriers when designing and evaluating interventions to improve the oral health of persons with disabilities [14].

In 2018, Flanders introduced a policy reform known as "Person-centred financing" (Dutch: Persoonsvolgende Financiering, PVF). This reform created a system based on vouchers and personal budgets, giving individuals with disabilities greater choice in arranging their care and allowing them to "purchase" support as consumers. At the same time, disability services were required to adopt social entrepreneurship approaches and develop strategies for economic sustainability [15, 16]. Despite a focus on deinstitutionalisation and community-based care, the reform has not led to substantial changes in practice: the majority currently use vouchers to "purchase" essentially the same services as before [16]. For minors, a similar PVF shift was planned for 2019–2024, but implementation was paused in 2021 [17].

When developing health interventions, conducting a needs assessment is an important first step to know the nature and causes of a health problem by understanding health behaviour and its underlying determinants [18, 19]. To explore the needs and barriers in residential care settings for persons with disabilities in Flanders (the Dutch-speaking part of Belgium), a survey study in managers and caregivers of care organisations was conducted in 2018. The main findings were that (1) ongoing oral health promotion projects and collaboration with dental professionals had a positive impact on care staff in addressing oral health care needs, (2) the absence of structured guidelines and routines concerning oral health care acted as a barrier to effective care, and (3) there was a need for education and practical training tailored to specific challenges, such as managing uncooperative behaviour [20].

The results of the survey study were insufficient to fully determine whether and how oral health promoting efforts in residential care for persons with disabilities could improve the oral health care practices of care staff. The organisation, practices, barriers and enablers relating to oral health within this setting were not fully understood, nor was it clear whether and how ongoing oral health promotion projects and collaboration with dental professionals impacted care staff. Furthermore, the impact of policy reforms within the setting on oral health care outcomes were unclear, indicating the need for a more in-depth understanding. Additionally, given the notably low survey response rate, further investigation into whether this reflected low perceived need for oral health care or a lack of motivation to engage with the topic would help to contextualise the survey results. Accordingly, the following research questions were formulated for qualitative research involving care staff members: (1) How is oral health care organised and performed by care staff in residential care for persons with disabilities? (2) What are the current barriers and enablers experienced by care staff members regarding oral health care in residential care for persons with disabilities?

Methods

Design

To address these research questions, an open and exploratory qualitative study within the social constructionist research paradigm was conducted [21]. In social constructionism, reality is understood as being socially constructed through individuals [22]. Multiple realities exist, shaped by the interactions and experiences of social actors [23]. As Berger and Luckmann noted in *The Social Construction of Reality*: "The reality of everyday life further presents itself to me as an intersubjective world, a world that I share with others", knowledge is understood as intersubjective [24]. The authors brought prior knowledge to the study through engagement with the scientific literature, discussions with colleagues in the field, and their own personal practical experience: as a special care dentist (principal researcher) and as researchers involved in projects aimed at improving health (all involved researchers). Accordingly, the study comprised iterative movements between inductive insights derived from participants' perspectives and deductive reasoning informed by the researchers' prior knowledge [25]. The Reflexive Thematic Analysis Reporting Guidelines (RTARG) were used to guide the reporting of the study [26, 27].

Setting

This study formed part of a needs assessment prior to the development of an oral health promotion programme, designed to improve oral health care in residential care organisations for persons with disabilities in Flanders.

Participants

Participants were recruited in three waves, guided by insights obtained during the research process. The first wave consisted of a convenience sample. An open call to residential care organisations resulted in three focus groups interviews, organised at a central location. Participants were predominantly part of the paramedical staff (e.g. nurses and speech therapists) or middle management, meaning that the perspectives of staff directly engaged in daily oral health care were underrepresented. To reach these caregivers, purposive sampling was used. In the second wave, three additional focus group interviews were conducted within residential care organisations. Finally, in a third wave, two focus group interviews and three individual interviews were conducted focusing on home care nurses. This wave was added because residential care staff indicated that daily oral health care was often a shared responsibility with home care nurses. All participating home care nurses were employed in the same home care organisation specialised in residential care for persons with disabilities but provided care in various residential care organisations. Due to COVID-19 measures, some of the interviews were conducted online via Microsoft Teams® (see also Table 1).

Dataset generation

Eight semi-structured focus group interviews and three individual interviews were conducted between November 2019 and January 2023. The researchers opted for focus group interviews as the interaction between participants from different residential care facilities was expected to provide deeper insights into the research questions [28]. However, data generation was hindered by participant cancellations for various reasons. In wave one these included: being too busy on the worksite, lack of management approval due to workload, a high number of new clients, and sickness. In wave two reasons included: difficulty in releasing around five care staff members simultaneously, insufficient staffing hours, and the impact of COVID-19 workload and restrictions. To enable the collection of sufficient data in wave three, it was decided to

Table 1 Overview of interviews and characteristics of the participants

Interview	Participants[a]	Organisations	Wave[b]	Location	Duration
1	Coordinator = 1 Nurse = 5 Speech therapist = 3	Adults IDD[c] = 1 Children IDD = 1 Adults and children IDD = 3	1	Centralised place	01h34min
2	Care worker = 2 Coordinator = 1 Nurse = 1	Adults IDD = 4	1	Centralised place	01h24min
3	Nurse = 4	Adults ABI[d] = 1 Children and adults IDD = 2	1	Centralised place	01h18min
4	Care worker = 6 Coordinator = 1 Nurse = 1 Speech therapist = 1	Children and adults IDD = 1[e]	2	Care organisation	01h03min
5	Care worker = 4 Nurse = 1	Children and adults IDD = 1	2	Care organisation	01h10min
6	Care worker = 3 Nurse = 1	Adults with IDD = 1	2	Online	47 min
7	Home care nurse = 2	Home care organisation = 1[f]	3	Online	51 min
8	Care worker = 1 Coordinator = 1 Home care nurse = 1	Adults with IDD = 1 Children and adults IDD = 1 Home care organisation = 1[f]	3	Online	49 min
9	Home care nurse = 1	Home care organisation = 1[f]	3	Online	45 min
10	Home care nurse = 1	Home care organisation = 1[f]	3	Online	36 min
11	Home care nurse = 1	Home care organisation = 1[f]	3	Online	32 min

[a] All participants were female

[b] Wave 1: centralised place; Wave 2: focus care staff members; Wave 3: focus home care nurses

[c] Intellectual and Developmental Disabilities

[d] Acquired Brain Injury

[e] Organisation also part of interview 3

[f] Same home care organisation specialised in residential care for persons with disabilities

supplement focus group interviews with individual interviews. In total, 43 female care staff members from 16 different residential care organisations and one home care organisation participated in the study. Data generation was stopped when the principal researcher, in reflexive discussion with co-authors, determined that the dataset contained adequate information power to generate meaningful insights in relation to the research aims of the study [29]. An overview of the interviews and participants is presented in Table 1.

An interview guide (See Supplementary Material 1) was used to ensure all topics were covered: oral health in clients, staff education and training, current oral health care organisation and practices regarding daily oral health care and planning professional oral health care (dental visits), and oral health promotion in residential care. The guide was developed by IP, EP, and DD based on the findings from the previous questionnaire survey in the setting [20], the objective of improving oral health in residential facilities through an oral health promotion programme, and experiences with an ongoing carer-led oral health intervention in nursing homes for older adults [30]. The interview guide was adapted before the start of the interviews with the home care nurses (wave 3), with less focus on planning professional oral health care and more focus on organisation and current practices around daily oral health care. All focus group interviews were moderated by two female researchers (IP, MSc in Dentistry, and EP, MSc in Psychology), both trained in qualitative research methods. Following each focus group, the researchers held a debriefing session. The three individual interviews were conducted by the principal researcher (IP, MSc in Dentistry). The professional backgrounds of the researchers and the goal of the study were disclosed to the participants. Interviews were conducted in informal spoken Dutch. Although the interview guide was used, a conversational and flexible approach was adopted. Participants were encouraged to speak freely, while moderators probed and adapted questions in response to participants' answers. Field notes were taken during and immediately after the interviews. All interviews were audio-recorded and transcribed verbatim in Microsoft® Word by an undergraduate dental student.

Data analysis

Data analysis was guided by reflexive thematic analysis (RTA), drawing on the foundational work of Braun and Clarke (2006) and more recent contributions to ensuring accurate interpretations of RTA [26, 29, 31, 32]. The analysis was conducted by the principal researcher (IP). MAXQDA Analytics Pro (24.10.0) was used to support the process [33]. The analysis began by re-listening to the recordings and checking the transcripts against the original audio recording, paying attention to the interview context and interactions between participants. Patterns and links within the data were written down in memos. Next, an initial, semantic (close to the data) coding in Dutch was conducted, resulting in 636 initial codes. Memos were again written and discussed with two co-researchers (BJ and LP). Subsequently, in line with the research aims of the needs assessment prior to the development of an oral health promotion programme, codes were refined: redundant codes were deleted, and others were reorganised into codes and subcodes, combining semantic and latent (implicit and broader) meanings. This process resulted in 130 codes, which were translated into or created in English. The codes were clustered into candidate themes, which were discussed with two co-researchers (JG and LJ). Creative coding maps in MAXQDA were used to refine the themes, link codes with subcodes and merge codes where necessary, balancing analytical overview with depth. Before finalising the process, the text extracts for each theme were re-read to ensure they formed coherent patterns. This analysis resulted in a coding tree of 97 codes and subcodes within four themes. The framework of the coding tree with the first order codes is presented in Fig. 1 and an overview, including all levels and sublevels of the coding tree, is provided as Supplementary Material 2. Illustrative quotes were selected across the data set and translated into English using the AI tool ChatGPT (Large Language Models GPT-4 and GPT-5, OpenAI). The accuracy and meaning of the translations were verified against the original text by all authors of the manuscript. The original quotes with their translations are available in Supplementary Material 3. The report was reviewed by all co-researchers involved (EP, DD, BJ, LP, JG, and LJ).

Ethical considerations

The study was approved by the Ghent University Hospital ethics committee under national registration number B670201941973. All participants received oral and written information about the study, voluntary participation, and confidentiality before providing written informed consent.

Quality practices

During dataset generation and data analysis, different strategies were applied to ensure the quality of the findings. In-depth information about the decisions within the study is reported, and a rich description of the context enables the reader to judge the applicability of the findings to their own context. Reflexivity was integrated throughout the research process. The principal researcher discussed her analysis path with other researchers from diverse domains and backgrounds, all

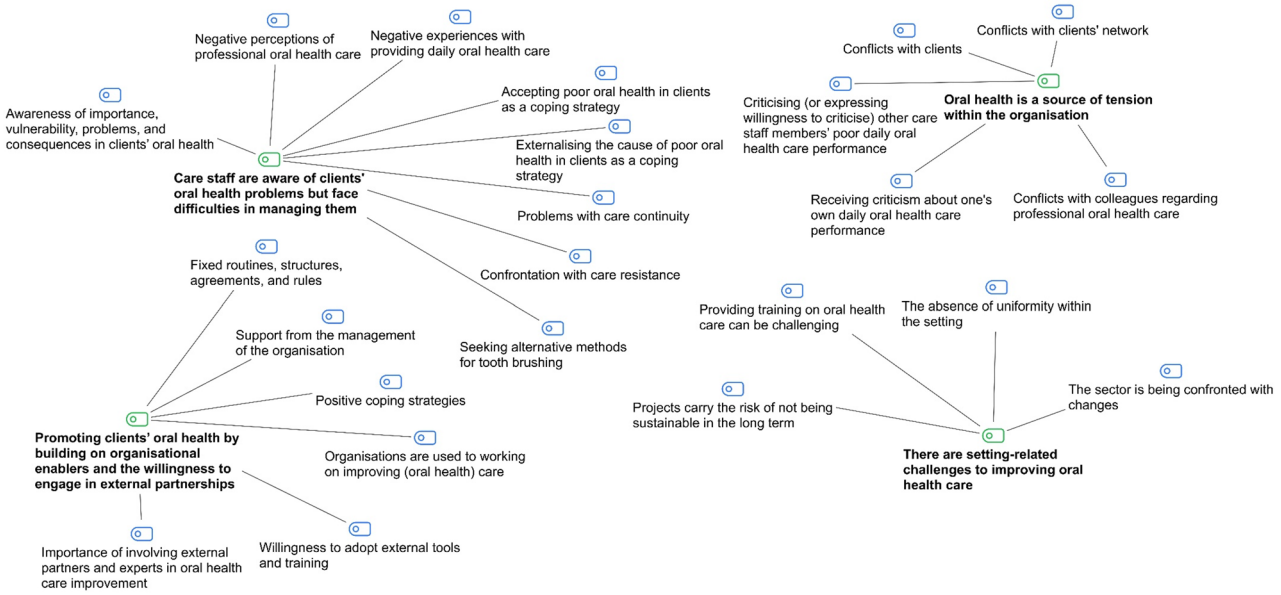

Fig. 1 Framework of the coding tree

trained in qualitative research. All authors were mindful of their personal and professional background, and co-researchers acted as "critical friends" for the principal researcher to encourage reflexivity [34, 35].

Reflexivity of the principal researcher (IP)

I am a white woman in my early thirties, living in Flanders. I have a background in oral health promotion for persons with disabilities and I am a dentist with experience working with this population. I also have several years of experience as a volunteer caregiver for persons with disabilities. During the interviews, some cases discussed individuals I had previously supported as a volunteer or who were patients in my dental practice. Although I did not disclose these prior connections to the participants, it enhanced my understanding and ability to empathise with their perspectives.

Declaration of generative artificial intelligence (AI) in the writing process

The authors declare the use of generative AI during the preparation of this manuscript. The AI tool ChatGPT (Large Language Models GPT-4 and GPT-5, OpenAI) was used to support the translation of codes and participants' quotes, as well as to provide assistance in improving the phrasing, grammar, and readability of the paper.

Results

Theme 1: "We try our best": care staff are aware of clients' oral health problems but face difficulties in managing them

Participants recognised the importance of oral health and the vulnerability of clients with disabilities to oral health problems. At the same time, they expressed difficulties and negative emotions about both professional and daily oral health care (Quote 1).

> *Quote 1: "How come it works in other residential facilities, like when I hear [participant 5] talking, and yet we always seem to run into a wall somewhere, even though everyone knows it's important..." (Interview 1 – Wave 1).*

Negative perceptions about professional oral health care were mainly reported in wave 1 (predominantly paramedical staff or middle management). Dental visits were described as resource-intensive, challenging, and sometimes of limited benefit, with doubts expressed about their effectiveness (Quote 2).

> *Quote 2: "Not everyone can even lie down in that chair, that's where it already goes wrong. The [dentist] just can't work the way he should. You can't get the mouth open. It's all just one big farce, those dentist visits." (Interview 4 – Wave 2).*

Participants described identifying an appropriate dentist as challenging and based on their own experiences. The physical accessibility of dental practices remains limited, although some newer practices were accessible, and a wish for domiciliary dental care for this target group was expressed in two focus group interviews. Some participants also expressed a cautious approach to dental treatment under general anaesthesia, while others were confronted with refusals for such treatment from hospitals (Quote 3) or from the clients' network.

Quote 3: "She [the dentist] has now referred us to a hospital to have it done under general anaesthesia once, but they refused […] there were supposed to be two teeth pulled, and they didn't consider that enough to do under anaesthesia, so yeah." (Interview 2 – Wave 1).

Mostly in the interviews from wave 2 and 3 (predominantly care staff directly engaged in daily oral health care), providing daily oral health care was described as difficult, time-consuming, and characterised by a general perception of "we try our best" (Quote 4). The notion of "engaging in a battle" was frequently mentioned (Quote 5).

Quote 4: "The dentist was really not happy, and yeah, we can only do our best, right." (Interview 7 – Wave 3).
Quote 5: "And brushing their teeth… that's… almost impossible… It's really just a battle, and it's very hard to put them in a discomfort." (Interview 10 – Wave 3).

Some participants reported that providing daily oral health care caused discomfort for clients, which conflicted with their own understanding of what good care should entail (Quotes 5 and 6). Furthermore, the standard of "good tooth brushing" in clients was in some cases perceived as unattainable and some participants mentioned using alternative approaches, such as swaps or mouthwashes, as substitutes for tooth brushing.

Quote 6: "And then it's like, either you choose to keep going to get their mouth clean, even if it causes trouble for hours afterwards. I really think that's something you have to weigh carefully. How far do you go to really get someone's mouth clean, because it has to be done? Or do you say no, I've already spent some time on it, now I'll give up a bit, because their well-being is also… well, that's important too." (Interview 5 – Wave 2).

Overall, participants reported encountering care resistance from clients, including physical resistance and refusal of oral care by adult clients on the grounds of self-determination. Problems with care continuity were observed in both daily and professional oral health care. These included a lack of structure and routine, insufficient embedding of oral health in organisational practices, and ambiguity in roles and responsibilities (Quote 7).

Quote 7: "Because apparently that arrangement wasn't clear either, and last week we got a complaint […] that the teeth were still full of plaque. But we all said, 'we assume the teeth are brushed, that the residential staff supervise tooth brushing,' and that's what the problem was […] so I don't really have a clear view of it." (Interview 7 – Wave 3).

In coping with difficulties, some participants normalised poor oral health in clients or disconnected it from their general care (Quote 8), accepted a lower standard of care, or expressed doubts about the possibility of improvement.

Quote 8: Participant 1: "That's true, because I noticed once when I'd taken photos for [organisation name]'s Facebook, and then I thought, if people or parents see that, it really doesn't look very well cared for."
Participant 5: "Although that doesn't always mean he isn't properly cared for, you know." (Interview 5 – Wave 2).

Responsibility for clients' poor oral health was externalised by participants in all waves. They attributed poor oral health in clients to factors such as time and workload pressure, staff turnover, and clients' pre-existing oral health conditions. Failures by other stakeholders (organisational care staff, clients' network, home care staff, and management) were reported across all waves, but most frequently in waves 1 and 3 (Quote 9).

Quote 9: "Uh yeah, I do notice, I think we care more about it than the residential staff actually. You notice it in small things sometimes. Like when someone spends the weekend somewhere else, and then on Monday morning, like this morning, you arrive and think, 'well, well, the toothbrush isn't here,' which means it hasn't been there since before the weekend. So I assume the teeth weren't brushed… But I find it very important myself." (Interview 7 – Wave 3).

Theme 2: "Then they'll see me as a nag": oral health is a source of tension within the organisation

Our analysis revealed that oral health care frequently acted as a point of friction within the organisation, with recurring patterns of disagreement and critique that indicated underlying tensions. Conflicts were described at different levels. Oral health was associated with conflicts with clients (Quote 6) or disagreements with clients' networks. Tensions were also identified within staff teams, between teams, or across different levels of the organisation (Quote 10).

Quote 10: "But it's the same with the 10 o'clock snack, so they [the colleagues] want to know in advance what time the dentist is coming because they're in that structure, those guys with their 10 o'clock snack. But then the teeth haven't been

brushed by the time the dentist arrives, and there you are. For many, that 10 o'clock snack is more important than the dentist coming once every six months." (Interview 1 – Wave 1).

Some participants criticised their colleagues for their shortcomings, or reported feeling tempted to criticise but lacking the tools to do so constructively (Quote 11). Others shared experiences of receiving such criticism (Quote 12).

Quote 11: "And maybe from our side too, from me in the medical department, we should repeat it more often in the group. To tell the care staff: 'Brush those teeth.' I once saw food stuck in there, and you don't want that… yeah… But that's also a bit of a balancing act, because if I do too much, then they'll see me as a nag…" (Interview 3 – Wave 1).
Quote 12: "Sometimes we get comments when they go to the dentist, like 'yeah, the teeth should be brushed better.' But well, that's all easily said, it's not always that simple." (Interview 11 – Wave 3).

Theme 3: "Within our organisation, living group, or with our clients, things are…": there are setting-related challenges to improving oral health care

Participants indicated that challenges inherent to the residential care setting also influenced the provision of oral health care. Some participants highlighted that the sector is facing changes in its structure and the organisation of financial resources (PVF reforms). In addition, the absence of uniformity within and between organisations created further difficulties. The diversity of clients was mentioned in all interviews, requiring tailored care and specific expertise (Quote 13).

Quote 13: "Everyone has their own manual, actually, every care recipient does, and that's what makes it so difficult." (Interview 3 – Wave 2).

Alongside this, variations in workflows and organisational structures were observed within and between organisations, affecting both daily and professional oral health care practices. Distinct characteristics inherent to the home care setting were also described. Home care nurses emphasised that their organisation faces competition in the market and occupies a subordinate role in relation to residential organisations (Quote 14), which makes it more difficult to provide feedback to staff within the residential organisation. Moreover, they noted that oral health care is not remunerated separately as a distinct care activity in their setting.

Quote 14: "They are part of the institution, and we come in as an external group, which always makes things a bit more delicate, what comments do you give, or… we always have to be careful so that we can keep working there. We work there as independent nurses, so you really have to weigh your words. Especially don't say that they haven't brushed those teeth, because that doesn't come across well." (Interview 7 – Wave 3).

Some participants further reported that providing training on oral health care in the residential care setting could be challenging due to workload issues, limited staff engagement with the topic (Quote 15), and the diversity and complexity of the target group.

Quote 15: Participant 1: "It's, of course, a very… I find it an unappealing topic to get training in. I can imagine, to be honest, that few people would choose it; they'd probably pick another kind of training instead.".
Participant 2: "I also think that, especially as residential support worker, it's not really our priority either." (Interview 8 – Wave 3).

In addition, the possibility of involving clients in health promotion projects was rarely mentioned and often perceived as impossible (Quote 16).

Quote 16: "I don't think it's feasible to go directly to the clients themselves, in our organisation, to provide training on that." (Interview 3 – Wave 1).

It was also described that projects aimed at improving oral health care carry a risk of not being sustainable in the long term, due to time and workload issues, as well as the lack of implementation of sustainability measures (Quote 17).

Quote 17: "And then it turns into… because about two years ago we started a small group around healthy eating, and in the end it was just thrown aside, because we didn't get time for it, we didn't get any hours for it, and then you really can't do anything properly, yeah." (Interview 2 – Wave 1).

Theme 4: "We have made agreements about that": promoting clients' oral health by building on organisational enablers and the willingness to engage in external partnerships

In addition to difficulties and challenges, our analysis also identified several factors that facilitated the provision of oral health care in clients. Fixed routines, clear structures, agreements, and organisational rules were

consistently mentioned as enablers for improving clients' oral health (Quote 18).

> *Quote 18: "We've now set it up in one of the living groups that they really have to brush their teeth in the group, and we're really seeing an improvement in oral hygiene there." (Interview 2 – Wave 1).*

Embedding oral health care within organisational procedures was seen to clarify responsibilities for both daily and professional oral health care (Quote 19).

> *Quote 19: "We've made some agreements about that here at our residence. Uh, and the nurses have started brushing the teeth because they weren't doing it before. Since we made those agreements, they've been doing it." (Interview 6 – Wave 2).*

Some participants referred to the use of screening forms or oral health care plans within their organisations. Structural collaboration with dental professionals, including the provision of domiciliary dental care, was also described as a facilitator of professional oral health care.

Several participants mentioned that oral health care was already integrated into staff onboarding, or expressed a wish for it to be included within their organisation. The importance of having a responsible person or designated point of contact for oral health within the organisation was also described. In addition, some participants emphasised that support from management was crucial for translating intentions into concrete action (Quote 20).

> *Quote 20: "I felt that if I had to do that alone from the medical department, it wouldn't be supported. Now, the caregivers also know, 'Ah, there's a group we can direct questions to,' and you really need to have management and policy on board before you can truly get the space to invest in training." (Interview 2 – Wave 1).*

Some participants described feeling in control of providing oral health care for their clients or reported using coping strategies that helped them manage challenges. Challenges were perceived by some participants as motivators for improvements, while others reported coping strategies including assisting with or taking over tooth brushing, managing physical and verbal resistance, or perceiving daily oral health care as a meaningful moment of attention for clients (Quote 21).

> *Quote 21: "Having you just for them for a moment, because most of the time they have to share you constantly." (Interview 5 – Wave 2).*

Our analysis suggested that organisational experience with quality improvement initiatives was also an important enabler. Organisations were familiar with project-based work, working groups, and train-the-trainer approaches. The organisation of oral health training was reported in all interviews of wave 1. Speech therapists, given the link with swallowing and aspiration, and staff members with a personal interest were regarded as important drivers of oral health initiatives. However, access to information and training on oral health for persons with disabilities was fragmented and limited. A willingness to adopt external tools and training was observed. Participants expressed interest in receiving education, but particularly the need for practical, tailored, and engaging training and supporting tools and materials was stressed in all interviews. In addition, the need for clear guidelines and opportunities for sharing experiences was mentioned.

The importance of involving external partners in improving oral health was noted in different interviews. Some participants mentioned the need for external expertise to cope with tensions around oral health or with feelings of uncertainty when providing oral health information to colleagues (Quote 22).

> *Quote 22: "Then you run into the difficulty when questions come up. That I probably won't be able to answer them. I find that a bit less ideal. It's possible, of course, but I think the preference would be for an external training for everyone." (Interview 5 – Wave 2).*

Dentists were considered an important source of oral health information, and the promising role of dental hygienists in promoting and supporting oral health within organisations was described. Empathy and affinity with the target group were seen as important qualities for oral health professionals.

Discussion

This study aimed to gain an in-depth understanding of the organisation, practices, barriers and enablers related to oral health care behaviour of care staff within residential care organisations for persons with disabilities. Care staff recognised the importance of oral health but reported challenges in both providing daily oral health care and in planning professional oral health care. They showed ineffective coping strategies such as lowering standards, distancing oral health care from general care, and externalising responsibility. Despite these challenges, several enablers were identified, including the availability of clear guidelines, structured routines, tailored training, and collaboration with external partners.

Many of the barriers identified in this study are consistent with existing literature, such as time constraints and uncertainty in managing physical resistance [14, 36]. The absence of a "one size-fits-all" approach to oral care for persons with disabilities has also been previously documented [14, 36]. Our findings emphasised the need for support to implement a tailored approach and extended this understanding by revealing additional challenges related to variations in workflows and organisational structures. Although PVF reforms did not result in major structural changes [16], participants noted that the sector was undergoing significant change due to these reforms. We interpreted this as possible disruptions and increased stress within the sector, which consume time and energy and may have reinforced participants' tendency to attribute poor oral health outcomes in clients to external factors such as time and workload pressures.

It is likely that the externalisation of responsibility for poor oral health also involved attributing it to the failures of other stakeholders, which aligns with our second theme: oral health is a source of tension within the organisation. We propose that ambiguity surrounding roles and responsibilities may have contributed to these tensions. The diffusion of responsibility and a "blame culture" in oral health care has been documented previously [37–39]. Similar ambiguities and the involvement of multiple stakeholders have also been reported in other health promotion activities in residential care for persons with disabilities [40].

It is possible that externalising poor oral health functions as a coping strategy for care staff, making the demanding task of caring for persons with disabilities more bearable. High levels of burn-out and occupational stress are well documented in this sector [41, 42]. Some participants appeared to avoid oral care conflicts to prevent immediate distress or negative emotions among clients, as providing discomfort conflicted with their own understanding of what constitutes "good care". Benoot et al. found that persons with intellectual disabilities in residential care value relationships and social structure as central to their wellbeing [15]. From the perspective of care staff, we interpreted that "good care" may place more emphasis on relational aspects such as social interaction and friendship with their clients.

Some participants further reported that providing training on oral health care in residential settings could be challenging or doubted that improvement in oral health care of clients was possible. This contrasts with the observed willingness to adopt external tools and training. Participants emphasised that training should be practical, tailored, and context-specific. Another notable finding was the uncertainty about how to share oral health knowledge with colleagues, despite organisations being familiar with project-based work, working groups, and train-the-trainer approaches in other health domains. This may reflect a fragmentation between general and oral health, a division also described in other contexts [43]. Our interpretation is further supported by the tendency of some participants to disconnect oral health from general health, as illustrated in Quote 8 in Theme 1.

Furthermore, external support was perceived as a potential solution to cope with tensions about oral health, suggesting that staff aimed to avoid being seen as "nagging". It could also offer hope in what some described as a desperate situation. Stenfert, Kroese and Smith observed similar dynamics in their study on the role of psychologists in residential care: staff teams sought to be "rescued" from desperate situations, while psychologists felt pressure to act as experts who "knew the answers". Paradoxically, staff did not always respond positively to such an expert-led approach, leading the authors to recommend adopting a collaborative expert role that takes account of the organisational readiness and culture [44]. Given that a lower standard of care was sometimes adopted as a coping strategy in our study, it is important that standards and procedures remain realistic and attainable, as unachievable expectations can be demotivating.

The enablers identified in our study can inform researchers and practitioners seeking to improve oral health in this setting. These include establishing fixed routines, integrating oral health care into staff onboarding, clarifying responsibilities, providing time, and embedding oral health guidelines and protocols within organisational policies. Kalf-Sholte et al. similarly emphasised the importance of structure and routines, encapsulated in the phrase "it has to be in your system" [36]. Our finding that managerial support was essential for translating intentions into concrete action supports existing literature highlighting the need for organisational leadership, culture change, and a system-level approach [13, 36, 45]. It is also noteworthy that some participants referred to screening forms or oral health care plans within their organisations, tools that have already been described in interventions improving oral health in residential care [46].

This study has several strengths. Conducting data generation in three waves provided rich insights from different perspectives within the care setting. Moreover, data generation and analysis were carried out alongside a series of reflexive discussions with multiple researchers throughout the research process. During this process, the principal researcher maintained continuous reflexive awareness of her dual role as both a special care dentist and an oral health promotion researcher. Her ability to draw on her own personal and professional experiences was considered to add further depth to the study findings.

However, the study has also limitations. Timing, COVID-19, and logistical challenges resulted in considerable time gaps between the first and final interviews and

the writing of the report, which could potentially have led to a loss of information. Nevertheless, debriefings were held after each interview, memos were maintained, and the final analysis began with re-listening to recordings and verifying transcripts. At the same time, rather than relying on a single cross-sectional time point, our study spanned a four-year period that included the COVID-19 pandemic. This broader temporal scope may have contributed to greater stability in our findings over time. As some focus group discussions included participants from the same organisation or individuals who were acquainted with one another, it is possible that this may have led to some more socially desirable responses. Furthermore, as our sample consisted exclusively of female caregivers, it is possible that relational aspects of "good care" were more prominently emphasised. At the same time, to the best of our knowledge, there is currently no evidence on gender differences in the perception of care within disability care settings and obtaining a mixed-gender sample in this context is particularly challenging due to the high predominance of female care staff in the sector. Finally, although the open call for participants for wave three was widely distributed, all participating home care nurses were employed by the same home care organisation specialised in residential care for persons with disabilities, which may have limited the richness of our results on the organisational aspects impacting home care nurses perspectives and care. However, as these nurses participated in individual interviews, worked across multiple residential care sites, and provided rich data, the insights generated were considered meaningful.

As individuals living in institutional settings are at higher risk of poor oral health, and caregivers play a fundamental role in oral health of persons with disabilities [7, 11–13], this study focused on the perspectives of care staff within residential settings. However, our findings also raised new questions. Even when explicitly prompted in our interviews, care staff rarely reported involving clients in oral health improvement initiatives and often perceived such involvement as impossible. This aligns with previous research describing a still oppressive and controlling institutional culture within Flemish residential care [47]. Future research could therefore focus on capturing the perspectives of persons with disabilities themselves, as well as those of their personal networks (e.g., family members), regarding their needs in improving oral health care.

Conclusion

Care staff in residential care for persons with disabilities recognised the importance of oral health for their clients with disabilities but faced challenges in both providing daily oral health care and planning professional oral health care, including care resistance, time and staff constraints, unclear responsibilities, and organisational barriers. Ineffective coping strategies such as lowering standards, distancing oral health care from general care, and externalising responsibility were reported. However, enablers such as availability of clear guidelines, structured routines, tailored training, and collaboration with external partners showed potential to improve oral health care in this setting.

Abbreviations

ABI	Acquired Brain Injury
IDD	Intellectual and Developmental Disabilities
PVF	Person-centred financing (Dutch: Persoonsvolgende Financiering)
RTA	Reflexive Thematic Analysis
RTARG	Reflexive Thematic Analysis Reporting Guidelines

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

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Authors' contributions

IP, EP, and DD conceived the study ideas; IP and EP collected the data; IP, LP, BJ, JG, and LJ analysed the data; IP led the manuscript writing; EP, DD, LJ, JG, LP and BJ critically reviewed the data interpretation and manuscript. All authors read and approved the final manuscript.

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Data availability

The full datasets from this study cannot be shared publicly because of the sensitivity of the interview material and the possibility of identifying participants. Anonymised excerpts are available in the published paper.

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. The study was approved by the Ghent University Hospital ethics committee under national registration number B670201941973. All participants received oral and written information about the study, voluntary participation, and confidentiality before providing written informed consent.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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