Faculty of Dental Surgery

ROYAL COLLEGE OF SURGEONS OF ENGLANI

Clinical guidelines to support oral health care for older adults

September 2026

Faculty of Dental Surgery

Faculty of Dental Surgery, Royal College of Surgeons of England

The Faculty of Dental Surgery (FDS) is an independent professional body of the Royal College of Surgeons of England (RCS England). It is committed to helping the entire oral health team achieve and maintain excellence in practice and patient care.[i]

Acknowledgements

The FDS would like to thank the guideline expert panel for their hard work in developing these guidelines. Our gratitude also goes to the stakeholder organisations and others who commented during the consultation phase. Finally, thanks to Sally Williams (Director, inQuisit Ltd), who assisted with guideline development, and Tayla Maloney (Policy Manager, RCS England).

Guideline expert panel

The following individuals oversaw development of these guidelines and provided expert clinical input:

- **Dr Giten Dabhi** – Chair of the England Community Dental Services Committee, British Dental Association; Community Dental Services Clinician, Whittington Health NHS Trust
- **Dr Mili Doshi** – Chair of the British Society of Gerodontology; Consultant in Special Care Dentistry, Surrey and Sussex Healthcare NHS Trust and the Royal Hospital for Neuro-disability
- **Dr Charlotte Curl** – FDS Board Member, RCS England; Consultant in Special Care Dentistry, King's College Hospital NHS Foundation Trust
- **Dr Charlotte Eckhardt** – Former FDS Dean, RCS England; Consultant Orthodontist, Swansea Bay University Health Board
- **Dr Rakhee Patel** – Deputy Chief Dental Officer for England; Senior Clinical Lecturer and Honorary Consultant in Dental Public Health, King's College London
- **Dr Sobia Rafique** – Chair of the British Society of Special Care Dentistry; Consultant in Special Care Dentistry, King's College Hospital NHS Foundation Trust

No conflicts were declared by members of the expert panel with respect to the guideline development process.

Stakeholder organisations

The following organisations commented on these guidelines in draft form:

- British Association for the Study of Community Dentistry (bascd.org)
- British Association of Dental Nurses (badn.org.uk)
- British Association of Dental Therapists (badt.org.uk)
- British Dental Association (www.bda.org)
- British Geriatrics Society (www.bgs.org.uk)
- British Society of Special Care Dentistry (bsscd.org)
- College of General Dentistry (cgdent.uk)

Feedback was also sought from individual general dental practitioners, dental nurses, and dental hygiene and dental therapy representatives.

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[i] www.rcseng.ac.uk/dental-faculties/fds/faculty

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Foreword by Dr Charlotte Eckhardt

Delivering high-quality oral healthcare for older adults requires a consistent, evidence-based approach that reflects the complexity of clinical need and the diversity of care settings in which patients are treated.

These guidelines, developed by the Faculty of Dental Surgery at the Royal College of Surgeons of England, in partnership with the Office of the Chief Dental Officer for England and an expert working panel, are designed to support that ambition. They bring together existing guidance, current evidence and expert clinical consensus into a single, practical resource for the oral health team.

The guidance spans the full pathway of care: from prevention and assessment through to treatment planning, delivery, recall, onward referral and end-of-life care. It is intended to support the full multidisciplinary team (including dentists, dental nurses, dental hygienists and therapists, and dental technicians) in day-to-day clinical decision making across general, community and hospital dental services.

The aim is simple: to help oral health teams identify risk earlier, plan care before problems become serious, and adapt treatment to the needs and circumstances of each older person. The impact for older people should be good oral health, which is an important part of general wellbeing, supporting a person's quality of life, independence and dignity.

The Faculty of Dental Surgery encourages clinicians, commissioners and wider healthcare partners to adopt and implement this guidance in order to strengthen and support the delivery of care. I would like to thank the expert working panel for their commitment and expertise in developing these guidelines.

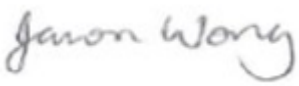
Dr Charlotte Eckhardt
Former Dean of the Faculty of Dental Surgery
Royal College of Surgeons of England

Foreword by Dr Jason Wong

As our population ages, maintaining good oral health throughout later life is an important part of supporting healthy ageing. Although people are retaining their natural teeth as they age, these are often heavily restored and need effective oral care for maintenance. Most older adults will live independently without any need for formal or informal support, including to maintain good oral health. However, some will experience increasing physical or cognitive decline resulting in increased risk of oral health deterioration because of an inability to self-care, a reliance on others or increasing challenges in accepting dental care.

Alongside NHS England's *Framework for Maintaining the Oral Health of Our Ageing Population*, these clinical guidelines are a timely and valuable contribution to our approach for improving the oral health of older adults. Developed by the Faculty of Dental Surgery at the Royal College of Surgeons of England and an expert panel, they bring together the latest evidence and expert clinical insight to support oral health teams in delivering high-quality care. They emphasise the importance of prevention, early intervention and multidisciplinary working, helping clinicians respond to the changing needs of an ageing population.

I welcome this work and its alignment with wider efforts to improve oral health outcomes and with taking a life-course approach to healthy ageing. I encourage oral health teams and dental clinical leaders to support the implementation of these guidelines so that older adults can maintain good oral health, independence and a good quality of life.



Dr Jason Wong
Chief Dental Officer for England

Summary

Most people age well and maintain good oral health throughout their lives. As we age, however, the prevalence of chronic conditions, cognitive impairment, disability and frailty increases, which in turn can affect an individual's ability to manage oral hygiene and elevate the risk of oral diseases.

Older patients often present to dental services with multiple comorbidities[1] and complex needs, including dental caries, periodontal disease, tooth loss, denture issues and other oral conditions. Older people living in deprived areas are more likely to experience frailty and have fewer years free from disability. (See section 2 for further details.)

Most older adults prefer and should be able to continue to access oral healthcare in general dental services (GDS) throughout their lives. This enables continuity of care and dental services being delivered in a familiar environment.

These clinical guidelines are intended to facilitate good oral healthcare for older adults, as part of supporting older people to live independently and in good health for as long as possible. Emphasis is placed on prevention and early intervention, delivered in primary dental care where possible, including managing the increased oral health risk factors associated with ageing. Delivering prevention requires a whole-team approach: dental nurses, dental hygienists, dental therapists, dentists and dental technicians all contribute to supporting and maintaining patients' oral health.

Some older adults, owing to their medical or dental needs, may require advice and guidance, or referral to community-based dental services (CDS) or hospital-based dental services (HDS). These guidelines accentuate the value of local shared care arrangements for advice or treatment by CDS or HDS when indicated. The guidelines also promote the integration of oral health in the overall health management for older adults, prioritising multidisciplinary collaboration between primary and secondary care dental services, patient-centred care and treatment strategies that adapt to changing needs over time.

These clinical guidelines support clinical decision making for individual patients and are designed to sit alongside NHS England's *Framework for Maintaining the Oral Health of Our Ageing Population*.[2] This is the NHS England clinical standard and supports the planning and delivery of oral health systems for older people by dental commissioners and local authorities. Revised domiciliary guidance is also being prepared, and this will sit alongside these clinical guidelines and the NHS England clinical standard.

Recommendations are evidence based where possible, supplemented by the expert clinical opinion of practitioners in special care dentistry, dental public health and CDS.

Key recommendations for oral health teams

Creating appropriate care environments (section 3)

- *Provide care primarily in general dental practices*, focusing on dynamic prevention and treatment planning tailored to age-related changes. Utilise digital platforms (where available) for remote advice and guidance from CDS or HDS, including domiciliary dental care.
- *Identify local pathways for enhanced and specialist care*, including shared care approaches with GDS, CDS, HDS and domiciliary dental care, and remote teledentistry options for patients who cannot access care. Gaps in services should be highlighted to and addressed by commissioners.
- *Implement reasonable adjustments* in line with the Equality Act 2010, including longer appointments, flexibility around appointment times, and access to specialised equipment to support mobility, comfort and transfers.
- *Ensure that dental practices are fully accessible and dementia friendly*, with step-free access, clear signage, appropriate lighting and supportive waiting environments.
- *Strengthen communication and workforce capability* by using appropriate communication aids, training reception and clinical staff to support frail older adults, issuing appointment reminders and maintaining ongoing education in dental care for the older person.
- *Embed robust safeguarding practices*, recognising the increased vulnerability of older adults with additional needs, and ensuring that staff are trained, vigilant and aware of reporting pathways.

Key recommendations for oral health teams

Comprehensive assessment (section 4)

- *Undertake a comprehensive assessment* at each stage of care, including reviewing medical comorbidities, medications, cognitive and functional status, behavioural and dietary changes, social circumstances and dental history to inform treatment planning.
- *Ensure consent-led, person-centred examinations*, reassessing capacity at every visit and involving carers or family where appropriate. Adapt examination methods to communication needs and levels of cooperation.
- *Apply appropriate investigations and pain assessment strategies*, recognising that pain may present as behavioural change, particularly in patients with dementia or limited verbal communication.
- *Maintain high vigilance for urgent oral conditions*, including oral infections, denture issues, fractured teeth and oral malignancy.
- *Manage urgent care with additional safeguards*, following established guidance while accounting for systemic illness, disorientation and challenging behaviours, and minimising distress and sensory overload.

Prevention (section 5)

- *Prioritise early, anticipatory oral care*, focusing on prevention early on in progressive conditions (e.g. dementia), identifying oral health risk factors promptly and intervening before frailty or complex illness limits treatment options. Treat caries and periodontal disease proactively rather than reactively.
- *Provide all older adults with personalised, patient-centred prevention plans*, tailored to health status, changes in level of dependency, preferences and daily routines, prioritising small, achievable changes and supporting independence where possible. Factor in patient preference for dental treatment, including past preferences.
- *Apply targeted preventive strategies for high-risk groups*, using enhanced measures (e.g. high-fluoride products, remineralisation strategies, dry mouth care, denture hygiene instructions and dietary advice), particularly for those who are frail, cognitively impaired, medically compromised or at increased risk of developing dental disease.
- *Integrate oral health into wider care and prescribing decisions* by aligning oral health prevention with broader health and care plans, reducing sugar frequency where appropriate, and addressing lifestyle factors such as the wider impacts of diet, smoking and alcohol use.
- *Involve and train carers and care staff in effective daily mouth care*. Identify individuals who require support with mouth care, and deliver it in a safe and compassionate way.
- *Review prevention plans* regularly to reflect changes in oral health risk factors and care needs.

Treatment planning (section 6)

- *Tailor treatment plans* for older adults to frailty, comorbidities, social support, patient preferences and ability to tolerate care, prioritising minimally invasive approaches. Non-operative and comfort-focused strategies may enhance quality of life for some individuals.
- *Use pragmatic treatment planning*, focusing on prevention, avoidance of crises and planning for a future where individuals may find it challenging to tolerate dental intervention.
- *Favour pragmatic, comfort-focused or stabilisation strategies* when active intervention offers limited benefit or increased risk.
- *Apply structured frameworks* (e.g. Seattle Care Pathway)[3] to align treatment intensity to levels of dependency.
- *Embed shared decision making*, respecting capacity, legal frameworks, the patient's current (and past) preferences and involvement of carers or multidisciplinary teams. Patients should be empowered to evaluate treatment benefits against quality-of-life impact.

Delivery of treatment (section 7)

- *Undertake careful planning for treatment delivery in older adults* owing to higher risks of comorbidities, polypharmacy and disability. Multidisciplinary input is often essential.
- *Use behavioural and anxiety management techniques*, including conscious sedation where appropriate, to alleviate patient anxiety and help patients cope with treatment. Older adults are more sensitive to sedatives such as benzodiazepines, and require dose adjustments and close monitoring during and after sedation.
- *Consider referring patients with complex medical conditions to CDS or HDS*, where necessary, including patients requiring dental treatment under general anaesthesia.
- *Provide verbal and written instructions regarding aftercare* to patients and carers following dental care, including whom to contact out of hours.
- *Promote the importance of safe denture and implant care*, including adding the patient's name to the denture and creating spares (either via a denture copy technique or scanning a denture so it can be 3D printed) to minimise problems from loss or damage. Regular clinical and radiographic review is needed to detect inflammation, discomfort or peri-implant disease, and implant passports are useful to facilitate future care.

Key recommendations for oral health teams
Recall intervals (section 8) • *Recall intervals should be individualised*, considering risk factors, health and patient preferences. • *Shorter recall intervals* are often appropriate for older adults owing to an increased age-related disease risk. • *Use digital platforms for remote advice and patient consultation*, where appropriate, to prioritise high-need patients and maintain contact between in-person appointments. • *Provide clear safety netting for patients*, including signposting, follow-up arrangements and, in some cases, supervision or out-of-hours support after dental procedures.
Onward referral (section 9) • *Plan to deliver care for older adults in primary dental services*, supported by coordinated pathways across GDS, CDS and HDS, developing services with advice by telephone or using digital platforms where needed. • *Make collaborative, patient-centred shared care the default*, with clear communication, coordinated planning and shared decision making. • *Involve specialist or CDS for complex or urgent needs* and, where possible, adopt a shared care approach with the referring general dental practitioner. • *Use local pathways for seeking specialist advice before making a referral to CDS or HDS*, including digital platforms to facilitate advice and guidance where available (e.g. Consultant Connect).[4] Use recognised assessment tools to guide appropriate escalation. Consider patient-initiated follow up pathways for shared care patients where appropriate.
End-of-life care (section 10) • *Follow best-interest principles*, considering the patient's capacity, prognosis and previously expressed wishes. • *Key goals* should include maintaining a clean and comfortable mouth, and maintaining function and dignity. • *Support oral health at the end of life*, including managing common problems such as dental pain, xerostomia, oral thrush, denture problems and mucositis. • *Final-days mouth care* should prioritise hydration, gentle cleaning, managing infection and maintaining oral comfort.

Definitions

Older people	Following the World Health Organization framework, healthy ageing is defined by the development and maintenance of functional ability.[5] For the purposes of these guidelines, older adults are considered within three broad functional groups: 1. *Functionally independent* – able to live independently despite chronic diseases 2. *Living with frailty* – requires some assistance and may reside independently or in a care setting 3. *Functionally dependent* – needs ongoing assistance, typically in care settings or at home with 24-hour support
Frailty	Frailty, as described in the Chief Medical Officer's 2023 annual report, is a state of health where individuals lose in-built reserves, increasing vulnerability to health changes triggered by factors such as infection or medication adjustments.[6] Clinically, frailty identifies older adults at highest risk for adverse outcomes, including disability, falls, hospitalisation and long-term care. Early detection can slow progression and help maintain independence. Frailty is distinct from multimorbidity although overlap exists. Prevalence is higher and onset earlier in deprived areas. The focus has shifted from chronological age to vigilance for frailty at any age.[3]

Glossary

Community dental services (CDS)	CDS provides care for children and adults with specialist needs but who do not usually need dental treatment in hospital.
Conscious sedation	Conscious sedation is a technique in which the use of a drug or drugs produces a state of relaxation of the central nervous system, enabling treatment to be carried out while verbal contact with the patient is maintained throughout the procedure.
Dental caries	Dental caries (also known as tooth decay or dental cavities) is the process where bacteria in dental plaque produce acids that destroy tooth tissues over time.
Domiciliary dental care	Domiciliary dental care services provide dental treatment for patients who are housebound and cannot access a dental surgery owing to physical or mental disability.
Functional dentition	Functional dentition refers to having sufficient natural teeth to perform essential oral functions, such as chewing and speaking effectively.
General dental services (GDS)	GDS refers to the primary way dental care is provided by general dental practitioners, usually in a high street practice, providing dental care to the public, with some services covered by the NHS and some available privately.
Gerodontology	Gerodontology is focused on the oral healthcare of older adults. www.gerodontology.com
Hospital dental services (HDS)	HDS refers to advice and treatment for patients admitted to hospital because of trauma or disease, as well as for other hospital inpatients. Specialist dental services may be accessed in a specialist dental hospital or a district general hospital. Specialist hospital care usually includes special care dentistry, oral medicine, restorative dentistry, oral and maxillofacial surgery, orthodontics and paediatric dentistry.
Integrated care boards	Integrated care boards replaced clinical commissioning groups in the NHS in England from 1 July 2022. To find out about integrated care in your area, see: www.england.nhs.uk/integratedcare/integrated-care-in-your-area
Level 1, 2, 3 care	Level 1 – general dental care Level 2 – dentist with enhanced skills or experience Level 3 – specialist/consultant[7]
Mucositis	Mucositis is when the mouth or gut is sore and inflamed. It is a common side effect of chemotherapy and radiotherapy.[8]
National Institute for Health and Care Excellence (NICE)	NICE is an executive non-departmental public body of the UK's Department of Health and Social Care. www.nice.org.uk
Oral health team	The oral health team includes dental hygienists, dental nurses, dental technicians, clinical dental technicians, dental therapists and dentists (dental surgeons).
Periodontal disease	Periodontal disease, or gum disease, refers to several conditions affecting the tooth-supporting tissues. Examples include gingivitis (inflammation of the gum surface) and periodontitis (deeper inflammation of the gums and socket bone that supports the tooth root, leading to progressive loss of the gum and socket bone).[9]
Special care dentistry	Special care dentistry provides oral healthcare services for adults who are unable to accept or receive routine dental care because of physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, or a combination of these factors.[10]
Teledentistry	Teledentistry has been defined as the use of technology for remote oral healthcare delivery between patients and oral healthcare providers or between healthcare providers.[11] It includes use of digital platforms for remote advice and guidance between oral health teams, as well as for patient consultations.
Xerostomia	Xerostomia is a medical condition that affects the flow of saliva and causes the mouth to feel dry. It is commonly known as dry mouth.

1. Introduction

Primary care GDS is usually the first point of contact for oral healthcare, and plays an essential role in preventing, detecting and managing oral diseases. Oral health teams in primary care can provide continuity of care, with the oral health team regularly seeing the same patients over many years. Most older adults can be managed effectively in primary care, with specialist advice and referral where needed for the most complex presentations. These guidelines are designed to empower oral health teams in addressing the oral health requirements of older patients.

NHS England's *Framework for Maintaining the Oral Health of Our Ageing Population* underscores the necessity of proactive planning for the evolving oral health needs of older adults.[2] This is the NHS England clinical standard and supports the planning and delivery of oral health systems for older people by dental commissioners and local authorities. It advocates for a needs-based approach to service delivery, emphasising early and ongoing prevention that adapts to individual patient requirements. As patient care becomes more complex, a pragmatic treatment planning strategy should be adopted, prioritising dental fitness in the early stages of cognitive disorders or frailty.

While oral health teams may draw on the standard, it does not provide support with clinical decision making. This document aims to meet the need for clinical treatment guidelines addressing complex care needs and pragmatic treatment planning for older adults.

Guideline scope

These guidelines support clinical decision making by oral health teams providing care for older adults.

Most people should be able to access oral healthcare in primary care GDS throughout their lives. These guidelines are intended to support primary and community oral health teams in delivering high-quality care for older adults living independently, in sheltered accommodation or in community care settings. They outline key considerations when providing care for this population, with emphasis on prevention, early intervention and care delivered in the community, in line with *Fit for the Future: 10 Year Health Plan for England*.[12]

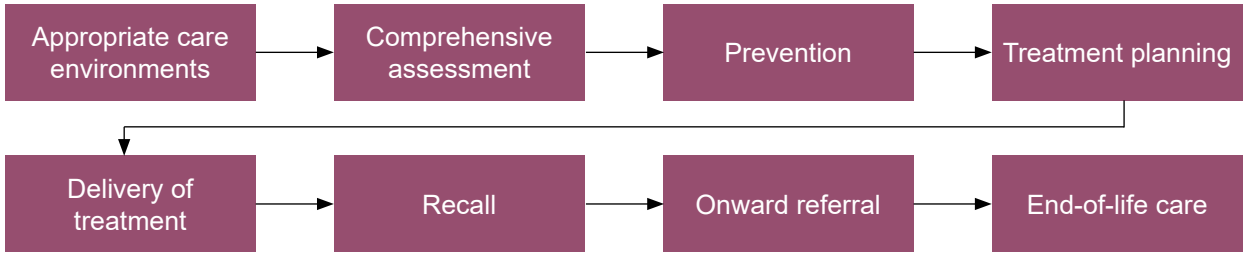
The NHS England clinical standard expects local systems to work together to understand the oral health needs, public health approaches and dental access for older people residing in their area.[2] Moreover, planning should be considered in partnership with local dental committees, local dental networks and oral health promotion services under the clinical leadership of managed clinical networks.

Oral healthcare should be integrated into broader healthcare provision. Incorporating oral health into services such as geriatric care, oncology and perioperative pathways can improve health and social outcomes as well as contributing to system-wide efficiencies.[13] The guidelines therefore promote the inclusion of oral health considerations in overall health management for older adults, particularly at the point of medical diagnosis and during care planning for individuals at risk of rapid health decline, including those with mental illness, frailty or cognitive impairment. An example of good practice could be for dental teams to become involved at neighbourhood and place-based levels as part of assessments of the Dementia 100 pathway.[14]

The guidelines address key aspects of the oral healthcare pathway, as shown in Figure 1. The recommendations are evidence based where possible, supplemented by expert clinical opinion from practitioners in special care dentistry, dental public health and CDS. This combined approach aims to strengthen the workforce with skills in managing older people (gerodontology) and to support the delivery of safe, appropriate care for older adults.

Clinical judgement, professional expertise, and consultation with patients and carers remain essential when applying these guidelines. The guidelines are not intended to replace structured training programmes tailored to different roles in oral health teams.

Figure 1 *Key aspects of the oral healthcare pathway*



2. Oral health in older adults

The global population is experiencing increased longevity, with most people now expected to live into their sixties and beyond.[16] In response, the United Nations has designated 2021–2030 the Decade of Healthy Ageing, tasking the World Health Organization with leading initiatives to reduce health disparities and to enhance the quality of life for older adults, their families and communities.[5]

Most older adults in the UK maintain good health and independence throughout later life. The Chief Medical Officer's 2023 annual report highlights that most do not have dementia or major debilitating conditions prior to death, and that disease and disability can often be delayed through preventive measures and sustained physical, mental and social activity.[6]

≥85 years	Over the next 50 years, the number of people aged ≥85 years in the UK is expected to **treble**, from 1.8 million in 2024 (2.5% of the population) to 5.0 million in 2074 (7.1% of the population).[15]
≥75 years	Over the next 50 years, the number of people aged ≥75 years in the UK is expected to **double**, from 6.5 million in 2024 (9.4% of the population) to 12.7 million in 2074 (17.7% of the population).[15]
≥65 years	Over the next 50 years, the number of people aged ≥65 years in the UK is expected to **double**, from 13.2 million in 2024 (19.0% of the population) to 21.4 million in 2074 (29.9% of the population).[15]

There are significant socioeconomic inequalities, however. Living in the most disadvantaged areas in England has been associated with people having disability affecting activities of daily living 11.0 years earlier for men and 12.0 years earlier for women than those living in the least deprived areas.[17]

Good oral health is integral to overall health and wellbeing.[18] Maintaining the ability to eat and drink supports independence and recovery from illness.[19] Nevertheless, older adults generally report poorer oral health-related quality of life.[20]

Oral health risk factors

Although many older adults remain healthy, the prevalence of chronic conditions, mental health conditions, cognitive impairment, disability and frailty increases with age, elevating the risk of oral diseases such as periodontal disease and dental caries. For example:

- There is a bidirectional relationship with periodontal disease and diabetes, with diabetes increasing the risk of periodontitis two- to threefold.[21]
- There is emerging evidence of a bidirectional relationship between periodontal disease and cognitive decline: poor periodontal health has been linked to cognitive decline and cognitive decline has been linked to poor oral hygiene.[22]
- There is a correlation between frailty and poor oral health-related quality of life.[23]
- Oral cancer ("head and neck cancer") incidence increases with age.[24,25]

Polypharmacy, particularly medications causing xerostomia, is a significant contributing factor for caries (especially root caries) in this population.[9] Older people are at increased risk of medication-related osteonecrosis of the jaw from exposure to anti-resorptive medication alone (e.g. bisphosphonates to reduce osteoporosis-related fractures), or in combination with anti-angiogenic drugs or immunomodulators for osteoporosis and cancer.[26]

Other oral health risk factors include a diet high in sugars, inadequate oral hygiene, low or no topical fluoride and poorly fitting dentures.[9]

Older adults can experience a range of mental disorders that have a significant impact on their oral health, including dementia, severe mental illness (e.g. schizophrenia), depression, anxiety, substance use disorders, personality disorders and delirium. These conditions may be longstanding or develop later in life, and often coexist with frailty, multimorbidity and cognitive impairment. Mental illness can affect motivation, insight, executive function, pain reporting, cooperation with care, oral hygiene practices and attendance patterns.

There are projected to be 1.4 million people living with dementia in the UK by 2040.[27] Individuals with dementia frequently experience poor oral hygiene due to inconsistent standards of oral care, and are more likely to develop periodontal disease, experience tooth loss and have reduced chewing efficiency, all of which are associated with cognitive decline.[28] Dementia can lead to forgetting to perform regular oral care, non-compliance with oral care when

provided by a third party due to anxiety or lack of interest and irregular dental attendance. A person with dementia can also have challenges with accepting dental treatment and difficulty communicating pain, discomfort or distress.[29]

There are around 100,000 cerebrovascular accidents (strokes) every year in the UK and approximately 1.3 million people are living after a stroke.[30] After having a stroke, individuals often experience impaired manual dexterity, communication difficulties, food pouching and swallowing problems, which can impede their ability to maintain independent oral hygiene. Dietary modifications (such as softer, more cariogenic foods) and a dry mouth further increase the risk of dental disease.[19]

Older adults are more vulnerable to delirium triggered by infection (including urinary tract infections and chest infections), prescription medicine, dehydration, constipation, injuries (e.g. hip fractures), low blood sugar levels or surgery.[31] One study found that every lost tooth enhances the delirium risk by 4.6%.[32] Dental and oral infections can contribute to delirium in older adults, and this should be considered in assessment and management.

Advancements in oral health have resulted in more older adults retaining their natural teeth although these are often extensively restored with direct fillings and fixed prosthodontics, such as crowns, bridges and dental implant restorations, as can be seen in Table 1.[33] Individuals with multiple risk factors for poor oral health can experience rapid oral health deterioration and this can be difficult to manage in advanced age.

As people age, they tend to have greater exposure of root surfaces due to gingival recession caused by periodontal disease; this means that they are more susceptible to caries.[20] The 2023 Adult Oral Health Survey found that over a quarter (28%) of dentate adults aged ≥75 years had extensive obvious tooth decay and almost half (43%) had obvious decay.[33] Having extensive obvious tooth decay increased with age: 9% of younger adults aged 16–24 years had extensive obvious decay but this increased to 28% among those aged ≥75 years. Around 1 in 10 participants (11%) aged ≥75 years reported having no natural teeth (edentulous) while half (50%) of adults in this age group had 21 or more teeth.

Table 1 *2023 Adult Oral Health Survey*[33]

Clinical oral health	65–74 years	≥75 years
% of dentate adults with 21 or more natural teeth	72.0%	49.6%
% of dentate adults with 18 or more teeth that are both unrestored and clinically unaffected by decay or trauma (coronal and root surfaces)	12.7%	3.1%

Impact of poor oral health

Poor oral health can lead to pain and infection, difficulty chewing, diminished self-esteem and social isolation,[34] and it can also affect cognition, behaviour change, quality of life and life expectancy.[35] It is associated with malnutrition in older people, especially in institutional settings,[36] and also has a direct impact on general health, with established links to diabetes, cardiovascular and cerebrovascular diseases, frailty, falls and mental disorders (including cognitive impairment).

Cardiovascular and cerebrovascular disease: Chronic periodontitis is associated with cardiovascular disease.[34] Number of teeth, periodontal disease, oral health, xerostomia, and bite force may predict risks for cardio- and cerebrovascular diseases, such as coronary heart disease and stroke.[37]

Diabetes: Poor oral health can adversely affect diabetic control.[34] A two-way relationship has been identified; severe periodontitis can be associated with increased risk of developing diabetes and treatment of periodontal disease in people already living with diabetes can improve short-term glycaemic control.[21]

Aspiration pneumonia: Aspiration of pathogenic oral bacteria increases the risk of aspiration pneumonia in susceptible individuals, such as those with dysphagia.[32] Dysphagia is more common in older people, including those with central nervous system diseases such as Parkinson's disease, dementia or stroke and those with xerostomia.[38] There is increasing evidence that regular, effective oral hygiene reduces the risk of aspiration pneumonia in frail populations.[34] Aspiration pneumonia in older adults is associated with high morbidity and mortality rates, and can lead to prolonged hospitalisation and increased frailty.

Cognitive disorders: Cognitive decline can hinder an older person's ability to independently maintain oral hygiene.[39] Indicators such as fewer remaining teeth, periodontal disease and difficulties chewing or swallowing are linked with cognitive disorders and depression, including dementia.[40] Older adults with more natural teeth have a lower risk of cognitive frailty.[41] Poor oral health can trigger pain or infection, worsening dementia-related crises.[25] Oral pain is associated with increased risk of depression.[40] Periodontal disease has also been associated with cognitive conditions.[42]

Frailty: Few remaining teeth, reduced masticatory function and chewing, swallowing or saliva disorders are strongly associated with frailty.[43] Tooth loss and xerostomia specifically increase the likelihood of progressing to frailty.[44] Oral frailty is significantly associated with a higher risk of falls in adults aged ≥65 years.[45]

Given the relationship between oral and general health, patient-centred and preventive approaches are essential.[15] Oral healthcare for older people should be integrated in broader health and social care frameworks, promoting holistic patient-centred services.[20] In practice, this requires oral health teams to collaborate with multidisciplinary teams, including geriatricians, old age psychiatrists, community mental health teams, memory teams, nurses, dieticians, general practitioners, palliative care teams, speech and language therapists, social care workers, carers and safeguarding teams.

Poor oral health shares risk factors with chronic conditions such as cancer, diabetes and heart disease. Tackling common risk factors (e.g. poor diet, smoking, alcohol use, inadequate oral hygiene, stress and trauma) can improve both oral and general health.[46] Evidence in support of other oral health interventions tends to be new and emerging. For example:

- Early-stage research indicates that improving oral health through interventions such as dental rehabilitation and denture use can slow frailty progression.[47]
- Maintaining or improving oral function may enhance diet and physical function in older adults, helping lower the risk of frailty and other adverse health outcomes while improving quality of life.[48]

Access and barriers

Adults aged 65–74 years are the age group most likely to attend regular dental appointments, followed by adults aged ≥75 years,[49] and yet they often perceive difficulties in finding a dentist or accessing information about treatment cost and are less aware of dental care pathways. This is particularly challenging for those residing in care homes.

Barriers include previous negative experiences, transportation challenges and the need for escorts.[24] Frailty is associated with reduced dental attendance, necessitating targeted interventions to prevent disengagement from oral healthcare.[50] Irregular dental attendance reduces opportunities for early detection and treatment of oral cancer and other mucosal diseases.[36]

Reliance on third parties such as healthcare professionals, care staff or informal carers (e.g. family members) for oral care can result in rapid oral health decline when not effectively undertaken. Carers of people living with dementia can experience difficulties in maintaining oral health, accessing the mouth, managing dentures and dealing with competing demands, and they experience barriers in navigating and securing oral health services.[51]

Dental service provision for care home residents remains inconsistent and there is limited information on service access for those receiving care at home.[20] While the Care Quality Commission's *Smiling Matters* progress report highlights improvements in staff training, oral health assessment, and awareness of guidance from the National Institute for Health and Care Excellence,[52] access to primary care general dental practitioners and other members of the dental team continues to be a significant challenge.

3. Creating appropriate care environments

Most older adults should be able to access oral healthcare in general dental practice throughout their lives. Older adults usually prefer dental examinations to be conducted by a dentist in a clinical setting rather than at home.[53]

Domiciliary dental care is an option for individuals unable to attend a dental surgery. While treatment options are limited in this setting, practitioners can typically undertake a range of care. An increasing number of patients require domiciliary dental visits but failure to increase capacity or properly commission NHS services can leave some older adults vulnerable to poor access to routine and urgent care.[54] Current domiciliary services vary widely and can face significant operational constraints, including workforce, travel and parking restrictions, equipment, environmental limitations and the need for clear triage criteria. The NHS England clinical standard observes that an increasing number of people will need domiciliary dental care to maintain oral health, and this should be factored into commissioning models in both CDS and GDS, as well as staff training.[2]

Mobile dental units may be available in some areas and can help bring oral healthcare to patients, as well as expanding access to wheelchair lifts, hoists and radiography equipment.

Patient-facing teledentistry (for example, consultations with patients or carers by telephone or using digital platforms) can facilitate access to care for older adults with mobility issues or complex medical conditions and for those living in residential care, or in rural or remote communities. Teledentistry, where available, can be useful for triage, as well as for diagnosing and treatment planning for existing patients, and for post-procedural management.[55] However, technology for remote healthcare delivery will not suit all older adults, and limited digital skills among some patients and caregivers or living in rural areas with limited internet access may increase the risk of digital isolation; such cases should be escalated in the care team.

The NHS England clinical standard articulates a need to avoid unnecessary referrals to specialised services and advocates a shared care approach, including virtual consultations.[2] Oral health teams in GDS should identify local pathways for enhanced and specialist care, including shared care approaches with CDS, HDS and domiciliary dental care, and remote telephone or digital options for patients who cannot access care. Where such pathways are lacking, this should be highlighted to commissioners.

General dental practices

General dental practices may need to make reasonable adjustments in accordance with the Equality Act 2010 to meet the needs of some older adults.[56] These may include extended assessment times and specialised equipment or facilities.[57] The timing of appointments may need to consider the availability of carers, medication regimes, and the time it takes the patient to get dressed and ready in the morning.

Practices should accommodate wheelchairs and be easily accessible, with ground-floor entry, ramps, automatic doors and sufficient space. There should be grab rails in toilets with access for wheelchairs.

Dental chairs with a knee-break design, side handles, adjustable headrests and wipeable cushions offer advantages for managing some older patients. Additional pillows may be used to provide extra support and improve patient comfort, particularly for patients with mobility or postural needs.

Waiting areas should be well lit and clearly signposted, with comfortable seating and high-contrast décor and signage for those with visual impairments.

A range of communication aids should be available to support patients with visual or hearing impairments, and practices should have access to translation and interpretation services.

Reception staff should be trained to assist frail patients and those with orientation, communication or other needs, as well as in safeguarding and the value of attendance checks.

Appointment reminders via telephone, text message, email or letter should be issued to support patients with memory impairments. Checklists are available to assist in creating dementia-friendly environments, including having a quiet space, clear signage, and appropriate lighting, flooring, seating and navigation.[58]

All members of the oral health team should be trained to support older adults with frailty, chronic ill health or disabilities. Continuing professional development in geriatric care should be integrated into personal development plans.

- Guidance on making reasonable adjustments for disabled people when accessing general medical practice surgeries has relevance for general dental surgeries.[59]
- Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out expectations of healthcare providers in regard to patient-centred care.[60]
- Greater Manchester Primary Care Provider Board offers a dementia-friendly dental toolkit to reduce anxiety around visits and support continued attendance.[61]
- NHS England has produced a training video helping dental teams understand the perspective of an older person with dementia.[62]
- The Care Quality Commission provides guidance for dental practices on caring for people with dementia.[63]
- The College of General Dentistry has published good practice guidelines for dementia-friendly dentistry.[64]

Safeguarding older adults at risk

Older adults with additional care needs, such as cognitive and medical conditions, are at increased risk of abuse and neglect.[65]

Oral health teams may be the first healthcare providers to notice changes in behaviours or that something is not quite right, especially in patients seen regularly at the dental practice. Steps should be taken to follow up older patients who fail to attend or are not brought to appointments, such as following up non-attendance or contacting the patient's general medical practitioner if concerned.

Dental teams have a statutory duty to ensure that safeguarding measures are in place, including appropriate training and awareness of reporting pathways. The NHS Safeguarding website provides guidance and contact information for reporting concerns.[66] The Alzheimer's Society also provides useful information about safeguarding people with dementia.[67]

4. Comprehensive assessment

A comprehensive assessment is essential when managing the oral health of older adults as multiple medical, social and dental factors influence care planning. The clinical team should consider making reasonable adjustments and organising appointments of sufficient duration to carry out comprehensive assessments, especially as a patient's needs may change significantly in the interval between recall appointments. Team members may help by covering some aspects of the assessment remotely, before the patient attends in person.

Medical history: Include relevant comorbidities, hospital admissions, allergies, medication use, cognitive status, mental health, physical disabilities, falls risk, frailty, swallowing difficulties, behavioural, weight and dietary changes, and appetite.

Medications: Many older people will be prescribed more medications that may affect dental care, such as by increasing the risk of bleeding, infection or medication-related osteonecrosis of the jaw. Polypharmacy can also increase the risk of xerostomia, which contributes to increases in oral disease. Guidance should be sought from clinical pharmacists in the patient's general practice surgery, or through the NHS Specialist Pharmacy Service (SPS) Medicines Advice service (0300 770 8564, asksps.nhs@sps.direct)[68] or directly from the SPS Dental Medicines Advice service (0151 794 8206, nwmedinfo@nhs.net).[69] The SPS can advise on drug interactions when prescribing for older adults.

Social history: Document living arrangements, levels of independence, ability to perform self-care, involvement of caregivers, and (depending on the patient) explore whether there is a lasting power of attorney for health and welfare or appointed deputies.[70]

Dental history: Record the date of the last dental review, past treatments, current oral concerns, oral hygiene practices, existing dental conditions and risk factors for deterioration.

As it may not always be possible to carry out a comprehensive assessment, it will sometimes be appropriate to focus on some key areas, such as daily oral hygiene habits and eating and drinking.

Clinical examination

Seek consent at the start of each consultation and reassess capacity at every visit as circumstances can change rapidly in some older patients. For patients with impaired or fluctuating capacity, follow General Dental Council guidelines in order to involve carers or family members with gathering a patient history and informing the examination approach. (See information on shared decision making in section 6.)

A systematic extra- and intraoral examination should be carried out at each in-person appointment, considering the patient's communication needs, and their ability to cope and consent. Common extraoral findings include temporomandibular joint pain and lymphadenopathy.[71] Common intraoral findings in older adults include missing teeth, gingivitis, periodontal disease and dental caries.

Radiographic examination should follow established selection criteria, based on dentition and caries risk,[72] recognising that older adults have a significantly higher prevalence of periodontal disease and caries.[73]

General dental practitioners may assess older adults with varying communication needs, such as those with cognitive impairments, or those receiving palliative or end-of-life care. Practitioners should recognise that pain may be expressed through behavioural changes like agitation or an aversion to oral care. Multiple pain assessment scales are available for adults with dementia and/or who have limited ability to communicate, such as the Abbey pain scale.[73] Carers can also play an important role in identifying when an individual with dementia is experiencing oral pain and discomfort.[51] Advice and guidance can be sought from CDS where needed (depending on local capacity and commissioning arrangements).

Urgent dental care

Oral health teams should manage urgent care as for other patient groups but with additional safeguards, reflecting the potential for systemic illness, disorientation, challenging behaviours, and the need to minimise distress and sensory overload. People's ability to access urgent dental care will be influenced by whether they live independently, in assisted living or in a care home. Residents of care homes can be particularly at risk owing to a lack of governance around standards of mouth care and staff training for identifying urgent oral health problems and accessing emergency dental care.[20]

Urgent care assessment should follow accepted principles. (See box in this section for details of guidance from the British Society of Gerodontology and the Scottish Dental Clinical Effectiveness Programme.) Additional considerations in older adults include the need to be alert to systemic symptoms and prepared for challenging behaviours in those who become disorientated with the need for urgent care. Such behaviours might include a refusal to eat or drink, self-injurious behaviour or refusing oral hygiene care, where previously the patient was cooperative.

The oral health team should make reasonable adjustments (such as timing of appointments, length of appointments and adopting good behavioural management techniques) in the first instance for patients with cognitive issues who are distressed. If unable to accept dental care, it may be necessary to prescribe analgesics and antibiotics if there is an infection, with follow-up review by telephone or face to face. Consideration may be given to the need to provide or refer for sedation or, in some cases, general anaesthesia.

Maintain high vigilance for urgent oral conditions, including oral infections, denture issues, fractured teeth and oral malignancy.

Dental practices offering urgent or emergency care to individuals without a regular dentist should inform patients about the benefits of routine dental visits and provide guidance on finding a local dentist, promoting ongoing oral health maintenance.[18]

- British Society of Gerodontology guidelines recommend that oral health assessment for people living with dementia should focus on the four Cs (communication, competence, consent and compliance) as well as on the oral side effects of medications and dietary adjustments required to maintain nutrition.[35]
- Face-to-face dental assessments are advocated for people living with severe mental illness, with simple risk assessment advised to determine whether clinic attendance is safe for the patient and the clinical team.[74]
- The Scottish Dental Clinical Effectiveness Programme provides structured assessment checklists and recording tools for oral health assessment, including assessment of dentures and periodontal examination.[75]
- Guidance from the Scottish Dental Clinical Effectiveness Programme for prioritising dental emergencies in primary care practice.[76]

5. Prevention

Preventive care for older adults (including those with frailty or cognitive impairment, or those receiving end-of-life care) can be managed within GDS, supported by multidisciplinary teams. Oral health teams should ideally be involved from the diagnosis of progressive conditions, such as dementia, to enable proactive oral care planning.[35] This should happen through ongoing collaboration with other health and social care teams so that oral health teams are alerted to patients with frailty, dementia and other chronic conditions. The oral health team may be the first to notice changes such as deterioration in oral hygiene, missed appointments and slower gait in patients seen regularly at the dental practice, which should be documented and discussed with the patient or their carer, and may involve contacting their medical practitioner.

Dental problems are frequently addressed only at crisis points, complicating management and outcomes. Most common oral diseases, such as dental caries and periodontal disease, are largely preventable, and early intervention can slow progression and reduce pain, infection and the need for dental intervention.[77]

The NHS England clinical standard stipulates that all preventive advice should be evidence based and align with *Delivering Better Oral Health*.[2,8] Oral health teams should promote to all adults the importance of a healthy diet, good oral hygiene, use of fluoride toothpaste, spitting rather than rinsing after brushing, and cessation of tobacco and alcohol use. Where appropriate, advice should also include denture hygiene and dry mouth care. Individuals at higher risk of dental caries, periodontal disease, oral cancer and tooth wear may require targeted measures such as fluoride varnish, high-fluoride toothpaste or rinse, dietary support, fissure sealants and advice (possibly guided instruction) on daily interdental cleaning.

Key approaches

Anticipatory care is emphasised in the NHS England clinical standard and elsewhere.[2,78] In practice, this means early risk identification, regular review, and timely preventive and definitive care before frailty, chronic or complex conditions limit treatment tolerance. For example, do not wait for new dental caries to appear; employ remineralisation strategies, such as making customised mouthguards to hold fluoride toothpaste over vulnerable teeth for prolonged periods.[79]

Advance care planning discussions should take place with older adults with a diagnosis likely to impair their decision making (such as dementia) while they still have the capacity for these conversations. Oral health teams should refer to universal principles for advance care planning[80] and related frameworks.[81]

Dynamic prevention focuses on early identification and management of oral health problems, and treats conditions like caries and periodontal disease as ongoing biological processes. Definitive care should be provided before patients become frail, with preventive strategies tailored to the individual's age, health status and dependency level, and adjusted for changes in medical health, diet, cognition and manual dexterity.[77] Older adults can experience a rapid health decline, for example during and following hospitalisation, which reinforces the need to actively treat oral issues such as root caries when they first appear. It is important to adapt oral hygiene routines for individuals as their situation changes; after a stroke, for instance, toothbrushes may need to be adapted to help the person grip and gadgets can help dispense toothpaste. Dynamic prevention strategies include use of high-fluoride varnishes and silver diamine fluoride. Consider adding the use of an electric toothbrush for improved efficiency of plaque management for patients who can tolerate this.

Targeted prevention techniques include the use of fluoride toothpaste in trays for nighttime or rest time wear.

Personalised prevention plans

All older people should receive personalised prevention plans. People who are physically frail, have cognitive impairment, are undergoing treatments that increase oral health risk (such as cancer therapy) or have intellectual and developmental disabilities will have a particular need for personalised care plans.[9,82]

Preventive advice should be patient centred, respect individual preferences and align with existing routines. Small, incremental changes are often more effective than introducing an entirely new regime.

Supporting independence is key; this requires assessment of what individuals can manage themselves and where assistance is needed. Prompts and reminders can help those with cognitive decline to maintain independence and self-worth.[77]

Daily mouth care should focus on removal of dental plaque, food debris and thickened saliva secretions, and keeping oral tissues moist. Practical adaptations include:

- *Toothbrushes* – small-headed, electric, enlarged-handle, three-headed or suction toothbrushes, selected according to need and patient tolerance.[77]
- *Toothpaste* – twice daily fluoridated toothpaste, high-fluoride products for those at high caries risk and non-foaming sodium lauryl sulphate (SLS)-free toothpaste where aspiration risk exists.[77] SLS-free toothpastes may also be favourable for patients at risk of gingival and periodontal irritation (e.g. patients on polypharmacy and those with multiple comorbidities may be more likely to experience mucosal irritation).
- *Denture care* – guidance on cleaning, labelled storage containers and organised storage of mouth care products.[77] For patients with cognitive or visual impairment, ensure that denture tablets and fixatives are out of direct reach as they present a safety hazard because they can be mistaken for edible tablets or gels.

Older people with increased caries risk should receive enhanced measures, including fluoride mouth rinse where safe (i.e. no risk of inhalation or ingestion), regular fluoride varnish, prescription fluoride toothpaste, dietary advice, and support to reduce the frequency of smoking, alcohol and substance use as much as possible.[74] Silver diamine fluoride can be a helpful adjunct, particularly for older adults who cannot tolerate invasive dental treatment.

Increasing age is associated with an increased risk of malnutrition, which often goes unrecognised in the community. The impacts of malnutrition are wide ranging and can delay recovery. Dietary advice therefore needs to be realistic and tailored to the individual. For example, in care homes, sugar should not be excluded but its frequency should be reduced (such as using artificial sweeteners in tea or coffee so that fluid intake is maintained). Caloric intake also needs to be balanced and rinsing the mouth or increasing the frequency of mouth care is advised. In some cases, oral nutritional supplements may be prescribed for older people and prevention should be advocated to minimise the risk if these contain sugar. Oral health teams should only suggest use of a straw if the person will still consume the same amount as otherwise there may be a risk that they will not ingest sufficient calories.

Prevention plans should be pragmatic, integrated with wider health and care plans (e.g. mental health and frailty care plans), and developed collaboratively with other healthcare professionals. CDS and integrated care boards should work with local authorities to support effective prevention and oral health promotion.[83]

Preventive care plans should be reviewed regularly to reflect changes in health, dependency and care needs.

Third-party support

People who lose functional independence may need support from care staff or family. There is evidence that oral cleaning habits of frail older people can be improved with external support.[84] Oral health teams should obtain the patient's consent to involve third parties and share relevant information.

Commissioning guidance emphasises supporting older people at risk, and their carers, to maintain a daily oral hygiene routine, training care staff and carers in oral health, and implementing oral care protocols in care settings.[19] Oral health is included in the Skills for Health dementia core training framework so that staff undertaking dementia awareness training will understand the importance of good oral health for people living with dementia.[85]

Care staff in residential settings should be trained to undertake oral health assessment and support individuals with oral care[25] as many care homes lack clear policies, comprehensive oral healthcare plans and adequate staff training.[86] Dental providers should support prevention in these settings by working closely with care home staff and residents, using the full dental team, clarifying treatment charges and exemptions, and avoiding removal of residents from patient lists due to attendance gaps.[52]

General dental practitioners should advise carers on mouth care for older people, including:

- *Prompts and reminders* – Timers can help those in early cognitive decline remember twice-daily brushing and dental appointments.[77]
- *Positioning* – Mouth care can be provided by carers from behind, in front or to the side, using eye contact for a supportive, non-threatening approach.[77]
- *Dry mouth care* – Encourage regular water intake where possible, and consider saliva-stimulating lozenges, or moisturising gels or sprays.[77]
- *Flexibility over timing* – Different times of the day may help for some people who resist mouth care.

Oral health teams can signpost carers to existing resources:

- The Alzheimer's Society offers advice on dental and mouth care, with tips for families and carers supporting someone with dementia.[29]
- The British Society of Gerodontology supplies resources for oral care in older adults, including a video for carers and a patient/carer leaflet.[87]
- The Mouth Care Matters programme offers training and education for health staff to support hospital patients needing help with mouth care.[88] The video training sessions offer up-to-date guidance on a range of topics, including brushing teeth, denture care and dry mouth.
- The Adult Oral Health in Care Homes toolkit is designed to help with the implementation of guidelines from the National Institute for Health and Care Excellence for improving the oral health of adults in care homes.[89]

6. Treatment planning

Treatment planning for older people, particularly those living with frailty or functional dependence, requires a more tailored approach than for younger or healthier patients. Standard procedures may not always be appropriate and surgical interventions should be avoided when the risks outweigh the likely benefits.[90] General dental practitioners should evaluate treatment invasiveness in relation to prognosis, life expectancy and comfort requirements.

Advancements in dentistry have meant that more patients are having complex treatments, including implant-retained prostheses. Ageing adults can become reliant on a third party to maintain these appliances. Some community and domiciliary dentists may not feel confident or have the specialist equipment to manage these cases when treatment fails. Discussions with the patient at the time of planning should include how to maintain oral health appliances in the future.

Treatment plans should be guided by a comprehensive clinical assessment and tailored to the individual's lifestyle, frailty level, medical conditions, social support, preferences, and the balance of risks and benefits. Plans must also consider the patient's ability to travel to appointments and the potential for deterioration in general, cognitive or mental health.

Pragmatic treatment planning

Pragmatic treatment planning considers oral health needs in context. Minimally invasive interventions should be prioritised wherever feasible. For some patients, stabilisation and comfort-focused care may deliver better outcomes than active intervention. For example, asymptomatic retained roots in a patient with multiple comorbidities who struggles to leave home may be best managed through monitoring rather than hospital referral for extraction.

Effective treatment planning should also account for the long-term implications of proposed options. In frail or cognitively impaired patients, minimally invasive strategies (such as partial caries removal followed by glass ionomer sealing) may be appropriate.[55] However, restorative treatment, including more complex procedures, can still be suitable for many older adults when carefully selected.[91]

A key consideration is whether the proposed plan is realistic and sustainable. For example, extensive restorative work such as implants or crown and bridge treatment may not be appropriate for patients with moderate to advanced cognitive impairment. In such cases, non-operative options (including pharmacological symptom management) may provide better quality of life. Other strategies include creating a shortened dental arch,[92] or placing healing abutments or burying implants when indicated in progressive diseases like dementia.

In older adults with neurodegenerative conditions, general dental practitioners should collaborate with multidisciplinary teams, relatives and carers to assess levels of cognitive impairment.[35] Careful planning for people in the earlier stages of dementia can reduce complex dental problems developing later when dental treatment is likely to be more challenging.[61] People with advanced cognitive impairment may require shared care between GDS and HDS or CDS. (See information on shared care arrangements in section 9.)

For adults with a cancer diagnosis, NHS England advises aligning oral healthcare with the patient's medical status and treatment cycles, and prioritising stabilisation.[93] Guidance published by the Faculty of Dental Surgery at the Royal College of Surgeons of England emphasises that treatment plans should be responsive to therapy-related complications such as osteoradionecrosis and medication-related osteonecrosis of the jaw, infections, mucositis, xerostomia or trismus, in addition to the implications for restorative dentistry, extractions and periodontal care.[94]

In people with severe mental illness, the British Society of Special Care Dentistry advises a holistic approach, together with rapidly addressing pain and infection, and giving careful consideration to advanced restorative treatments and multi-appointment treatment plans.[74]

The Seattle Care Pathway offers a structured, evidence-based framework for planning care in older adults.[3] It aligns treatment approaches with levels of patient dependency:

- *No dependency* – Routine treatment should be offered.
- *Pre-dependency* – Consider the long-term viability of restorations and prostheses, and plan treatment outcomes for easy maintenance.

- *Low dependency* – Identify, repair or replace strategically important teeth guided by the principle of the shortened dental arch, with or without implants, to maintain oral function. Plan for ongoing maintenance, including restorative and surgical treatments, to maintain function and prevent or control infection and pain.
- *Medium dependency* – Repair and maintain strategically important teeth with conservative treatments (e.g. atraumatic restorative technique) with fluoridated glass ionomer materials, and design oral prostheses to simplify oral hygiene and prevent infection. Use prosthodontic attachments between overdentures and abutment teeth or implants to simplify hygiene and maintenance.
- *High dependency* – Offer palliative treatment on demand from the patient to control pain and infection, and enable them to maintain social contacts and activities.

- Relevant guidance from the Scottish Dental Clinical Effectiveness Programme – e.g. *Oral Health Management of Patients at Risk of Medication-related Osteonecrosis of the Jaw*,[95] and *Prevention and Treatment of Periodontal Diseases in Primary Care*[96]
- The Scottish Dental Clinical Effectiveness Programme's dedicated website for drug prescribing covers a wide range of dental prescribing, including use of antibiotics for bacterial infections and management of xerostomia.[97]
- Tools are available to support decisions over whether to extract root remnants and unrestorable broken teeth in frail older adults.[98]
- Treatment strategies have been suggested for five common oral conditions seen in older adults: xerostomia and caries risk, periodontal disease, taste disorders, mastication and swallowing, and burning mouth syndrome.[99]
- The Faculty of Dental Surgery at the Royal College of Surgeons of England has published guidelines on the oral and dental management of patients before, during and after cancer therapy.[94]

Shared decision making

Shared decision making is fundamental to patient-centered care. Patients should be empowered to balance the benefits of treatment with potential impacts on quality of life and independence.[6] Oral health teams should respect patients' views with regard to any dental care.

Most older adults can actively participate in decisions regarding their oral health. Mental disorder should not be assumed to limit a person's capacity to consent or provide reliable information. Even where capacity is reduced, it remains essential to involve the individual in the decision making process. Oral health teams should establish each patient's preferences, regardless of mental capacity, and ensure that these are reflected in treatment decisions.[100]

Oral health teams should demonstrate understanding of relevant legislation (for England and Wales, the Mental Capacity Act 2005; for Scotland, the Adults with Incapacity (Scotland) Act 2000)[101,102] as well as the principles of capacity assessment[61,103,104] and best-interests decision making.[105,106] They should also be able to recognise fluctuating capacity,[107] executive dysfunction[108] and impaired insight.[109]

When a patient cannot provide an accurate history, information should be gathered from family members, and the presence of a lasting power of attorney for health and welfare or an appointed deputy should be determined,[70] as well as any advance care planning. If no lasting power of attorney exists, the clinician becomes the decision maker.[20]

When treating patients with cognitive impairments, procedures should be explained in simple terms and the patient's involvement in decisions should be encouraged.[35] This may include using yes/no questions and observing non-verbal cues to assess understanding.[63]

- General Dental Council standards and guidance on communicating effectively with patients and obtaining consent[110]

7. Delivery of treatment

Effective treatment requires multidisciplinary planning, especially for patients with cardiac, respiratory, renal, hepatic or immunocompromising conditions, mental illness, cognitive impairment or behavioural challenges.

Once a tailored treatment plan is established, dental care can proceed. Procedure-related complications are more likely to occur in older adults owing to anatomical changes,[90] multiple comorbidities and polypharmacy.

Pain and anxiety

Good pain and anxiety control is important to help patients cope with treatment.

Local anaesthesia is the first-line approach for older adults, including those with multiple health conditions.[111]

Some older adults may need treatment under conscious sedation, which can be provided in primary care for ASA (American Society of Anesthesiologists) grade 1 or 2 patients.[112] For patients with complex medical conditions, referral to CDS or HDS may be appropriate, including for patients requiring dental treatment under general anaesthesia. (See section 9 for further details.)

Conscious sedation should involve thorough assessment and dental teams must adhere to established standards.[6,77,79]

Inhalation sedation with nitrous oxide/oxygen is widely accepted as a safe and effective technique[113] alongside good behavioural management. Inhalation sedation may not be suitable for patients with moderate or advanced cognitive impairment as it requires cooperation to work effectively.

Older adults are at increased risk for sedation-related complications, such as respiratory depression, necessitating dose adjustments and enhanced monitoring.[114] Guidelines recommend reduced dosages and incremental titration for older patients, particularly those living with frailty.[113] Advanced sedation techniques should be managed by a dedicated sedationist in a hospital setting and considered for medically complex or challenging cases.[113] All practitioners should recognise the limits of their own competence and refer to specialist teams when needed.

Clear, tailored instructions should be provided (verbally and in writing) to patients, caregivers and escorts regarding sedation effects, aftercare, postoperative risks, resuming normal activities and emergency contacts.[113]

- *Standards for Conscious Sedation in the Provision of Dental Care* published by the Intercollegiate Advisory Committee for Sedation in Dentistry[115]
- Guidance from the Scottish Dental Clinical Effectiveness Programme on conscious sedation[113]

Dentures and implants

Denture and implant care should include promoting the importance of safe denture care. Many older adults wear partial, complete or implant-retained dentures for function, aesthetics and communication, often wearing the same set for several years.

Frailty and cognitive impairment can reduce compliance with safe denture care, storage and maintenance. Older adults who have loose or unretentive dentures and have swallowing difficulties may be at increased risk of denture ingestion or inhalation. Denture cleaning tablets, fixatives and solutions should be kept safely, away from individuals with visual or cognitive impairment, as there is a risk of accidental ingestion.

There should be a key focus on reducing the impact of loss or damage. Dentures are frequently lost or damaged, especially in care settings.[116,117] The longer an older person is without dentures, the greater the likelihood that they will not tolerate a new set. Oral health teams should consider labelling dentures and creating spare sets via a denture copy technique or scanning a denture so that 3D replacements can be printed. Implant passports are recommended for recording implant details.[118] Denture relining should be considered to improve denture fit, stability and comfort.

Comorbidities and polypharmacy can complicate the delivery and management of implants. Daily self-care is essential to reduce the risk of peri-implantitis and may be harder to achieve in older patients living with frailty, cognitive impairment or functional dependence. Oral health teams should periodically assess implants at appropriate intervals, through radiographic imaging and clinical examination, in order to identify problems such as peri-implant disease. It may be appropriate to transition patients receiving end-of-life care to sleeper implants in order to minimise abrasions to tissues when implant-supported dentures are not being actively used.

Domiciliary treatment

Older adults with complex health and care needs may require oral healthcare treatments to take place in their own homes or residential settings. Guidelines for the delivery of a domiciliary oral healthcare service are currently under review.[119]

The key principles of domiciliary dental care are prevention, disease stabilisation and pain/infection control, with care delivered only where it is safe and in the best interests of the patient (revised domiciliary guidance, publication pending).

Treatment scope can be limited by patient and environmental factors:

- *Treatments that can be safely carried out in a domiciliary setting* include examinations, preventive care, provision of dentures and related treatments, simple restorations and simple extractions.
- *Treatments that are usually not suitable for domiciliary care* include minor oral surgery, restorations of dental implants, complex restorative dental care and conscious sedation (revised domiciliary guidance, publication pending).

8. Recall intervals

Recall intervals for older adults should be based on a comprehensive assessment, considering clinical, medical and social factors, as well as patient preferences and input from family and carers.

National guidelines recommend recall intervals of 3–24 months, tailored to individual risk levels for dental disease.[120] Although there are no specific guidelines for older adults, evidence indicates that increased age elevates disease risk, warranting shorter recall periods.[78] Shortened dental recall intervals are recommended for people with severe mental illness.[74] Patients with dentures may require annual review to allow for repairs and replacement as necessary.

Challenges include securing agreement from high-risk patients for frequent recall appointments, and managing time and workload constraints within GDS.[121] Teledentistry has potential to help prioritise care for those most in need (e.g. managing failing dentition and palliative dental care) and to maintain patient contact between in-person appointments.

For patients in crisis, clear signposting and safety netting are essential. Some patients may require supervision or out-of-hours support after dental procedures. Patients should be provided with verbal and written instructions for whom to contact out of hours to access urgent dental care.

9. Onward referral

Dental care for older adults should be delivered in primary care by GDS whenever possible. However, specialist input may be required for more complex or urgent cases, with care pathways enabling timely access to specialised services. Digital solutions (including teledentistry) can support rapid advice and guidance arrangements, and aid decision making.

Getting It Right First Time recommends stronger coordination between HDS, GDS and CDS for people with special care needs, in line with the NHS Long Term Plan and the 10 Year Health Plan for England.[12,83]

Shared care arrangements

Local systems should enable shared care, ranging from specialist advice to direct involvement in complex treatments. Shared care should be based on:

- collaboration
- patient-centred, holistic care
- coordinated treatment planning
- effective information sharing
- shared decision making

Special care dentistry services or CDS may be required temporarily for complex cases (e.g. surgical extractions in patients with significant comorbidities), with patients returning to GDS once treatment is complete for routine care and monitoring.

General dental practitioners should use local pathways for seeking specialist advice before making a referral to CDS or HDS, including telephone and digital platforms to facilitate advice and guidance where available (e.g. Consultant Connect).[4] Seeking specialist advice can help determine whether a referral is necessary; for example, where an older patient has fractured teeth or lost a crown but is not in pain, and is able to eat and drink, non-intervention may be appropriate.

Referral decisions may be supported by established tools, including:

- *British Dental Association Case Mix tool* – to assess patient complexity, and to support commissioning and referral triage[6]
- *Geriatric assessment models* (e.g. Seattle Care Pathway)[2] – to support holistic assessment, including medical status, functional and cognitive ability, social factors and life expectancy,[122–124] medication side effects, cumulative dental disease and prior dental care,[56] and swallowing difficulties, nutritional status and fall risk[125]
- *ASA physical status classification* – to assess functional capacity,[126] although its application among dental practitioners is inconsistent[127]

When referral may be appropriate

The special care dentistry clinical standard uses the British Dental Assoiation Case Mix tool to indicate the challenges in delivering care that would warrant additional support.[7,57] For example, in terms of communication:

- *Referral to level 2 care (dentist with enhanced skills)* may be appropriate for patients with significant communication difficulties due to multisensory or cognitive impairment.[57]
- *Referral to level 3 care (specialist or consultant services)* may be appropriate for patients with no verbal communication ability due to severe cognitive impairment.[57]

In terms of cooperation:

- *Referral to level 2 care (dentist with enhanced skills)* may be appropriate for patients presenting with a disability or a psychological or mental health state that means that only a limited examination is possible, or there is significant treatment interruption due to inability to cooperate, which may require advanced anxiety and behaviour modification techniques or conscious sedation.[57]
- *Referral to level 3 care (specialist or consultant services)* may be appropriate for patients with severe disabilities or mental health conditions that prevent cooperation with dental examination or treatment, and that may require specialist experience of managing combative, agitated or inappropriate behaviour, basic or advanced sedation techniques, or assessment of the patient under general anaesthesia.[57]

In terms of medical history:

- *Referral to level 2 care (dentist with enhanced skills)* may be appropriate for ASA grade 3 patients with a moderately controlled medical condition or patients with a progressive degenerative medical/disabling conditions (intermediate stage where specialised service or risk assessment is required) who may require indirect specialist supervision.[57]
- *Referral to level 3 care (specialist or consultant services)* may be appropriate for ASA grade 3 patients with an unstable condition, ASA grade 4 patients with a medical condition or patients with a progressive degenerative medical/disabling condition (advanced stage) who may require: multifactorial/multispecialty medical risk assessment; treatment in a medically supported hospital setting; use of conscious sedation for ASA grade 3/4 conditions; shared medical care (e.g. haematology, radiology, oncology, cardiology, respiratory medicine).[57]

Clinical guidelines on the use of general anaesthesia in special care dentistry state that referrals for treatment under general anaesthesia must include comprehensive medical, dental and social histories, details of symptoms and impact, prior treatment and patient or carer expectations.[128] The reason for referral should be explained to patients and carers. Less restrictive options should be considered first, particularly for patients lacking capacity, and discussion with specialists is advised prior to referral. General anaesthesia carries an increased risk of delirium in older adults.

Patient-initiated follow-up in community or hospital settings allows ongoing access to specialist advice while patients remain under the care of their general dental practitioner.

- The clinical standard for special care dentistry outlines the situations that warrant referral to level 3 care.[57]
- Standards for shared care for community services are set by NHS England and Getting It Right First Time.[83]

10. End-of-life care

End-of-life care supports individuals in their final months or years through a multidisciplinary approach involving healthcare, social care, hospice, therapists and spiritual support teams. It forms part of palliative care, which focuses on comfort, symptom relief, and psychological, social and spiritual wellbeing for patients and their families. Care may be delivered by general practitioners or community nurses, specialist palliative care consultants and nurses, or specialist therapists.[129]

Patients approaching the end of life may need medical, psychiatric, mobility and mental capacity assessments before dental care can take place. Decisions should be guided by best-interest principles, previously expressed wishes, and close collaboration with palliative and mental health teams. Decision support tools are available to assist oral health teams.[130]

Oral health is vital to quality of life at the end of life. Common problems include xerostomia, oral thrush, denture-related issues and mucositis. Dental care should focus on symptom relief and disease stabilisation, with decisions made between palliative dental care, comprehensive treatment or no intervention.[131]

Priorities and goals in end-of-life dentistry

Oral healthcare at the end of life should reflect the following priorities:

- *Anticipatory care* – Plan for declining cooperation, treatment failure and reduced ability to maintain oral health.[130] Transition patients to sleeper implants to minimise abrasions to tissues when implant-supported dentures are not being actively used.
- *Physical comfort* – Manage pain and discomfort, infections, xerostomia and the risk of aspiration pneumonia, and maintain oral hygiene.
- *Quality of life* – Support wellbeing by maintaining communication, nutrition, hydration and social interaction.
- *Dignity and respect* – Use prostheses where appropriate to maintain dignity.
- *Holistic support* – Involve patients and their families in shared decision making, considering physical, emotional and spiritual needs. Enable patients to retain a sense of control about their oral healthcare plan.
- *Integrated care* – Work closely with the wider multidisciplinary team and the patient's lead clinician to align care with prognosis and goals.[130]

Mouth care in the final days of life

Mouth care in the final days of life should focus on the following:

- *Mouth/lip hydration* – Use mouth-moisturising gels or gently hydrate with a soft toothbrush dipped in water or spray. Offer 'taste for pleasure' using the patient's preferred drink.[77]
- *Oral care* – Dying patients often have increased oral secretions and respiratory secretions that can coat the palate and tongue, and regular cleaning should be undertaken to avoid the build-up of debris.[77]
- *Teeth* – Brush teeth twice daily with a very soft toothbrush if the mouth is sore.[77]
- *Thrush* – Regularly assess for oral thrush, and maintain oral and lip moisture.[77]
- *Pain relief* – Apply topical analgesia as required (e.g. 0.15% benzydamine hydrochloride spray or mouthwash).[77]
- *Lip care* – Gently remove dried secretions using gentle suction or a toothbrush/MC3 mouth cleanser (formerly MouthEze®) and maintain lip moisture.[77]

- Guidance on palliative dentistry offers flowcharts to support general dental practitioners in assessing patients with terminal illness and to support patient-centred care in patients with life-limiting diagnoses.[130]
- The Mouth Care Matters programme offers video training sessions on mouth care at the end of life.[88]

Appendix 1: Guideline development process

In order to develop recommendations for this guidance, the Faculty of Dental Surgery at the Royal College of Surgeons of England convened an expert panel of dental practitioners in special care dentistry, dental public health and community dental services. Members of the guideline expert panel are detailed at the beginning of this document.

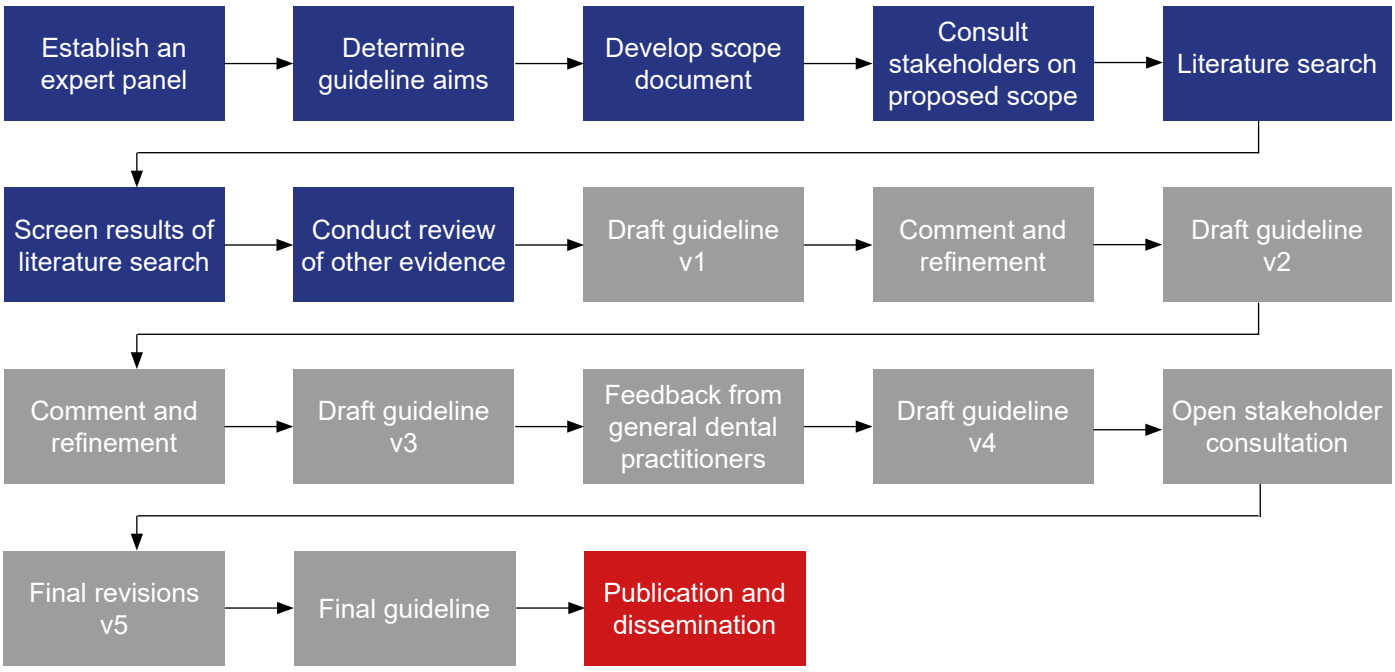
The recommendations contained in this guidance are based on:

- existing clinical guidelines and clinical standards
- the available evidence (there is limited evidence in support of specific oral health interventions or approaches for older adults in primary care)
- consensus opinion of the guideline expert panel, drawing on their combined clinical experience
- government and regulatory reports relevant to dentistry and oral healthcare
- feedback from stakeholders, including general dental practitioners, other oral health practitioners, and representatives of patients and carers

The guideline development process is shown in Figure 2.

Grading the strength of recommendations was not feasible owing to weaknesses in the evidence base.

Figure 2 *Guideline development process*



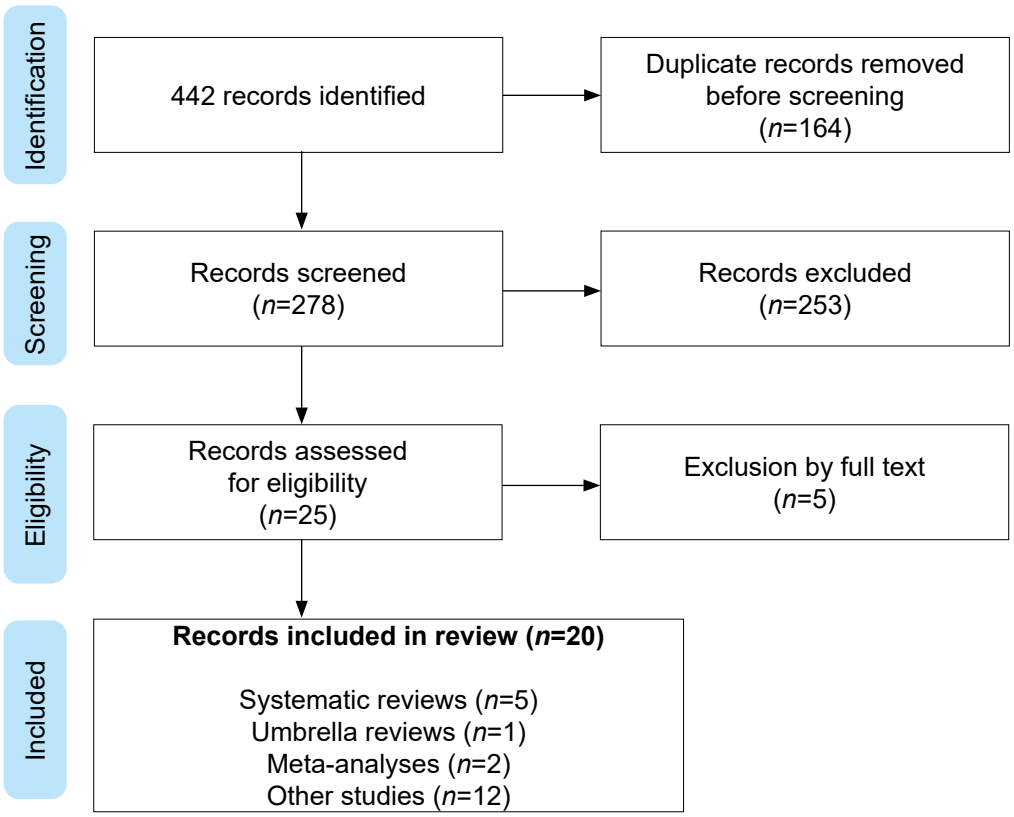
Evidence searches

The guideline development process began on 1 October 2025. Shortly before this, one member of the expert panel arranged a literature search titled “Dental and oral health care for adults living with frailty, chronic illness and disability” (conducted by Whittington Health Library and Knowledge Service), which was completed in September 2025. This was screened using the inclusion and exclusion criteria listed in Table 2. The PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) flow diagram relating to the literature search is shown in Figure 3.[132] Additional evidence was identified through focused internet searches (e.g. searches relevant to access or prevention approaches). Further internet-based searches were also undertaken to identify existing clinical guidelines as well as relevant government and regulatory reports as referenced.

Table 2 *Inclusion and exclusion criteria for literature search*

Screening	Inclusion criteria	Exclusion criteria
Population	Older people (no age specification)	Younger adults with frailty, ill health or disability
Setting	Primary care dental services, community dental services, general dental services	Hospital dental services, special care dentistry, non-dental settings
Study type	Systematic reviews, meta-analyses, randomised controlled trials, observational studies, surveys, interviews, focus groups, guidelines, consensus statements	Case reports, conference abstracts, editorials, non-original research, scoping reviews, qualitative evidence syntheses, studies using artificial intelligence or involving animals
Publication period	2020–2026	Pre-2020
Language restrictions	English language	Non-English language
Country	Studies related to care in UK, Europe, US, Canada, Australia, New Zealand	Studies not generally applicable to UK setting (e.g. populations in low- or middle-income countries, populations in rural areas)

Figure 3 *PRISMA flow diagram for literature search*



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