



**An Exploration of
Nursery
Toothbrushing initiatives**
for
Greater Glasgow NHS Board
Health Promotion Department

submitted by

Scottish Health Feedback

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1. Background

Within Greater Glasgow a number of toothbrushing initiatives are operating within the Pre-5 and Nursery setting. These aim to raise awareness of, and improve and/or develop, toothbrushing skills within the nursery setting and at home. Briefly, the following models in operation at the time of this research project were:

1. 'One-off' instruction/education session with **all** children. Resources used in nursery sessions and then taken home
2. A number of instruction/education sessions with children and staff. Daily toothbrushing programme for **full-time** children (nursery staff led, resources provided). Additional free resources provided for home use (one-off allocation)
3. A number of instruction/education sessions with children and staff. Daily toothbrushing programme for **all** children (nursery staff led, resources provided). Additional free resources provided for home use (one off allocation)
4. A number of instruction/education sessions with children and staff. Daily toothbrushing programme for **all** children (nursery staff led, **resources paid for by sale of brushes and paste**). Additional resources **sold at cost price** to parents/carers for home use (3 monthly)

As part of a review of children's dental services within Glasgow, it was recommended that locally-based Oral Health Action Teams (OHATs) be set up to promote dental health in the pre-five age group. It was proposed as part of this development that the existing pre-5 initiatives should be examined in order that a standardised model of good practice could then be identified and (potentially) taken forward by the OHATs. In addition, in 2000 the Scottish Executive stated that toothbrushes and paste would be provided free of charge to all children between 0-48 months. It was recognised that the proposed 'good practice' model would have to take account of this proposal.

Greater Glasgow Health Board Health Promotion Department (GGHBHPD) commissioned Scottish Health Feedback to explore the perceptions of key decision makers (oral health professionals), nursery staff and parents and carers of children attending the nursery setting.

2. Research aims and objectives

The major research aim was:

- To identify elements of 'good practice' from existing toothbrushing initiatives within Glasgow in order to propose a model for replication by local Oral Health Action Teams.

In order to achieve this aim, the objectives were:

- To consult with key decision makers to identify criteria for good practice
- To explore the experiences, perceptions and attitudes of nursery staff working in the different nursery models
- To explore the experiences, perceptions and attitudes of parents and carers of children attending the different nursery models.

3. Research design and methods

In order to identify the different elements of good practice, it was proposed that three different groups of people were to be consulted:

- Key decision makers (oral health professionals, health promotion officers, etc)
- Nursery staff (working in the four different models)
- Parents/carers (whose children attend examples of the four different models).

As there was a limited timescale and budget for the work, it was proposed that only a few significant research questions be asked of each group.

(a) **Key decision makers** — These individuals were identified after discussions with GGHBHPD staff. Six such professionals were selected for interview, but as one individual was relatively new in post only five interviews were actually conducted. Interviewees included a dental public health consultant and practitioner, as well as members of the community dental service. These key decision makers were interviewed on a one-to-one basis by telephone. These five short interviews covered the following issues:

- What elements of the toothbrushing initiatives represent good practice?
- What factors might facilitate or inhibit the 'rolling out' of a good practice model(s)?
- How might this model be developed in the short and long term?

These interviews were conducted before the interviews with nursery staff and parents to inform schedule development. After initial analysis of the responses, the interview schedules for the parents and nursery staff members were then drawn up.

(b) **Nursery staff** — Nurseries and pre-5 establishments were chosen by GGHBHPD staff (see Table 1). Eight establishments were selected (two nurseries per model).

Table 1 — Nursery and pre-5 establishments involved in project

NURSERY	TYPE OF MODEL*	INTERVIEWEE
A	1	Head teacher
B	1	Head teacher
C	2	Head teacher
D	2	Head teacher
E	3	Head teacher
F	3	Head teacher
G	4	Staff member
H	4	Staff member

- * 1 *'One-off' instruction/education session with all children. Resources used in nursery sessions and then taken home*
- 2 *A number of instruction/education sessions with children and staff. Daily toothbrushing programme for full-time children (nursery staff led, resources provided). Additional one-off free resources provided for home use*
- 3 *A number of instruction/education sessions with children and staff. Daily toothbrushing programme for all children (nursery staff led, resources provided). Additional one-off free resources provided for home use*
- 4 *A number of instruction/education sessions with children and staff. Daily toothbrushing programme for all children (nursery staff led, resources paid for by sale of brushes and paste). Additional resources sold at cost price (3 monthly) to parents/carers for home use.*

Although the nurseries selected on the whole reflected the four distinct types of model quite accurately, not all of the sample corresponded exactly to every aspect of the relevant model. For example, the Head Teacher at Nursery B reported that instruction sessions were held over the course of 1 month, and the interviewee at Nursery H said that only the full-time children took part in a toothbrushing programme at the time of interview. All of the nurseries were located in areas of socio-economic deprivation.

Brief individual interviews were conducted with a member of nursery staff per establishment. The interviewees tended to be nursery Head Teachers, although other members of staff were interviewed if they were more knowledgeable of the current toothbrushing initiatives employed at their nursery (Nurseries G and H). Seven interviews were conducted by telephone, and one was conducted on a face-to-face basis. These interviews addressed:

- Perceptions of current initiatives
- Facilitating and inhibiting factors towards developing good practice
- Willingness of staff to adapt to work with 'good practice' elements

(c) **Parents and carers** — Scottish Health Feedback prepared a combined information and consent sheet for parents and carers, and asked nursery staff at the eight participating establishments to distribute them to 10 parents/carers. Given the time constraints of the project, no attempt was made at randomising the sample. Instead, nursery staff were advised to distribute the sheets to parents and carers who either seemed to be the most knowledgeable of the toothbrushing initiatives or who had been associated with the nursery for some time (parents of children who had only been attending the nursery for a few weeks (parents of new attenders) were thought the least likely to have the relevant knowledge). Parents and carers who completed the consent slip returned it directly in a FREEPOST envelope to Scottish Health Feedback. It was suggested that interviews be conducted by telephone, although face-to-face interviews were also offered to parents and carers who expressed this preference. The response rates of those willing to be interviewed and number of interviewees per nursery are shown in Table 2.

Table 2 — Parental response rates and interviewees per Nursery

NURSERY	RESPONSE RATE	NUMBER OF INTERVIEWEES
A	-	-
B	9	6
C	-	-
D	2	2
E	3	2
F	3	3
G	3	1
H	3	2

In total, 16 interviews were conducted with parents and carers associated with 6 nurseries. The interviews covered:

- Perceptions of current initiatives
- Positive and negative features of current ways of working
- Willingness of parents to participate in a 'best practice' model

In total, 29 interviews were conducted with the three different respondent groups. The full notes taken during the individual interviews (telephone and face-to-face) were written up, typed up and analysed. Near verbatim quotes are used in the Results section.

4. Results

(a) Responses of key decision makers

Awareness of models operating in Greater Glasgow

On the whole the respondents could give several examples of the toothbrushing initiatives operating in pre-5 establishments in Glasgow, although some interviewees pointed out that they did not have much knowledge of the operational side of nursery initiatives. Most examples given corresponded to one of the four types of model described on page 1 of this report. In addition, it was perceived that models 3 and 4 (see page 1) were either SMILE nursery initiatives, or extensions of the original SMILE model. Finally, one respondent reported that *“many private nurseries are doing their own thing”*, with variation on aspects of brushing and storage.

Good and bad practice in current models

The interviewees gave many examples of perceived good and bad practice in nursery toothbrushing initiatives. Consensus was reached that good practice should involve good quality instruction for all of those involved in the initiative (ideally, including parents and carers) and proper supervision of the children. A majority of the respondents also favoured selling brushes and paste at cost price to parents as part of a good practice model. However, this argument was countered by another individual who felt that parents and carers in more deprived socio-economic neighbourhoods would not be able to afford resources at cost price. The majority of respondents also thought that the diet of the children had to be considered, and not just in the nursery setting, again emphasising the importance of targeting parents. In addition, it was stated that parental consent was imperative if a toothbrushing programme were to be implemented. Other aspects of good practice which were mentioned included supportive policies, for example, in relation to storage systems and cross-infection, all of the children having their teeth brushed (full and part-time attenders) and a nominated member of nursery staff overseeing the initiative and answering any queries or concerns.

Examples of bad practice were also given, often being the converse of the good practice elements already mentioned. For example, interviewees stated that they had seen initiatives running in which toothbrushes were not identifiable as belonging to a particular child, as well as utilising badly splayed brushes. It was again pointed out that resources being provided free of charge for parents and carers might not actually be beneficial in changing their children’s oral health behaviour. Finally, one interviewee said that one-off instruction sessions were not to be encouraged.

Proper instruction in the nurseries, showing proper toothbrushing technique, backed up with healthy food. It’s not helpful to give parents things free all the time. It’s good they are encouraged to buy a toothbrush and paste. Giving them it free doesn’t change behaviour
(Respondent No. 1)

The fact that toothbrushes and paste are for sale — parents make a monetary investment and will utilise that investment (Respondent No. 3)

Instruction for all involved in the initiative along with parental instruction... in my children’s nursery parents could afford to buy the toothbrushes and paste but in deprived areas it is completely naive to think that the parents’ budget could run to toothbrushes and paste
(Respondent No. 4)