When research and municipalities collaborate:

Co-creation experiences from the project **Lifelong Oral Health.**

Louise Folker Christensen | Astrid Pernille Jespersen | Esben Boeskov Øzhayat



TABLE OF CONTENTS

INTRODUCTION 3

SUMMARY 4
Part I: Co-Creation - Recommendations 4
Part II: Changes 4

PART I: CO-CREATION AS ORGANISATION & PROCESS 5
Partners 5
Organisation 6
Projektorganisation 6
Phases 7
Pre-Project Phase 7
Mapping Phase 7
Development and Implementation Phase 8
Dissemination of Insights and Initiatives 8
Unforeseen Situations and Relational Work 9

ADVICE FOR COLLABORATION BETWEEN RESEARCH AND MUNICIPALITIES 10

PART II: CHANGES RESULTING FROM CO-CREATION 11
The Research Behind the Changes 11
Measuring Perceived Changes Among Care Staff 13
Changes in the approach to the mouth and oral care 13

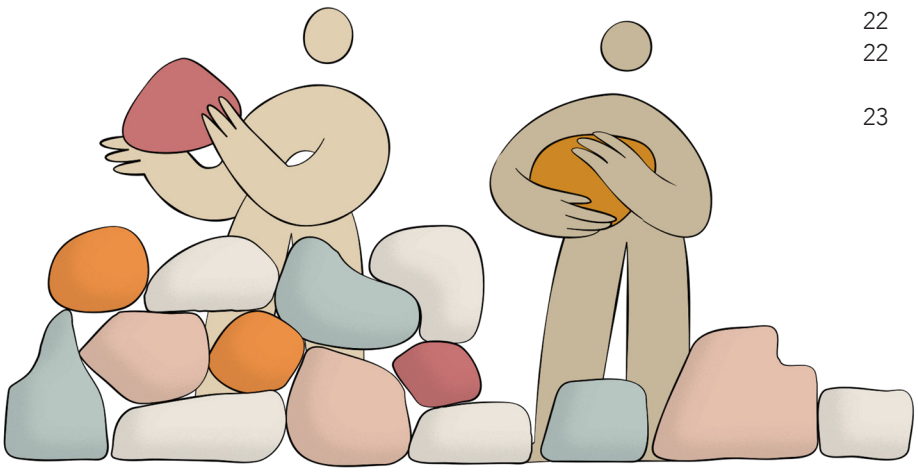
SPECIFIC CHANGES: LANGUAGE USE, COMMUNITY AND EMOTIONAL WORK 14
From Inadequate Language use to Establishing a Shared Dialogue 14
From Silence to a Shared Approach 14
From Individual Shame to a Shared Sense of Pride 15

SPECIFIC CHANGES: KNOWLEDGE, PROFESSIONALISM AND OWNERSHIP 16
From Lack of Knowledge to a Crucial Understanding 16
From Being Taken for Granted to Being Recognised as a Challenging Care Task 17
From Low Prestige to Taking Ownership 17

SPECIFIC CHANGES: PRIORITISATION, DOCUMENTATION, AND COLLABORATION 18
From an Invisible Task to Taking Higher Priority 18
From Lack of Documentation to Emerging Systematic Practice 19
From a Single-Discipline Approach to an Interdisciplinary One 20
Broader Perspectives on Co-Creation 21

EXAMPLES OF LOCAL INITIATIVES 22
Dialogue on Communication 22
Teaching 22
Visibility 22
Practical Measures 22

CONCLUSION 23



Layout and illustration | Sanne Fredin

INTRODUCTION

This report documents experiences, insights and changes resulting from the co-creation project Lifelong Oral Health – Improved Oral Health for Older People in Vulnerable Situations (SMUHL). The project was carried out through a collaboration between the Department of Odontology and the Centre for Humanities Health Research—both at the University of Copenhagen—and the municipalities of Frederiksberg and Greve. The report was prepared by the researchers following the project's conclusion and reflects insights and experiences that we, as researchers, believe can benefit other co-creation projects operating at the intersection of research and municipal practice.

In **Part I** of the report, we present our experiences in organising and conducting a co-creation project, focusing particularly on some of the complex and unforeseen situations that inevitably arise when researchers and municipalities collaborate, as well as examples of how we have handled them in practice. This section is therefore aimed at municipalities, researchers, practitioners, decision-makers and funding bodies working with co-creation, complex welfare challenges, and the practical implementation of new initiatives.

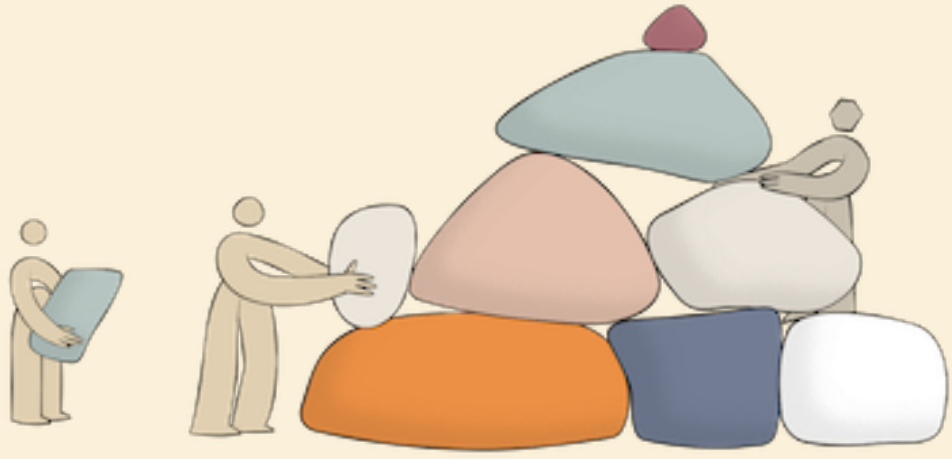
In **Part II** of the report, we review the specific changes that took place under the auspices of the SMUHL project, when research and municipal practice converged on a seemingly simple task: improving the oral health of older people. In this section, we describe what the task proved to entail in practice, including the need for professional upskilling, improved collaboration, and stronger institutional embedding. This section is aimed at practitioners and researchers working specifically with oral health, caregiving and changes within the care sector.

The SMUHL project stems from oral health issues that have emerged in the wake of the growing population of older people in Denmark. In recent years, there has been a significant improvement in the dental health of the Danish population, with more people retaining their teeth throughout their lives. However, this has created the paradox that older people now more frequently suffer from dental and oral diseases. This paradox threatens the health and quality of life of many older people, particularly those in vulnerable situations. The overarching aim of the SMUHL project has therefore been to develop recommendations for managing the oral health of older people in vulnerable situations, thereby contributing to improved health and quality of life within older care. These recommendations are compiled in the report Lifelong Oral Health - Insights and Recommendations. This report has a different focus.

In this report, we focus on the co-creation process itself: What does it take to engage in close collaboration across research and municipal practice? What happens when the task involves specialised technical expertise, relational work, interdisciplinary collaboration, and the management of difficult emotions? What barriers, dilemmas, and opportunities arise when frontline staff, managers, and specialists collaborate on a care task where conflicting considerations and needs clash? And what forms of change can—and cannot—be achieved through co-creation, skills development, and institutional embedding?

The SMUHL project is funded by a donation from Sygeforsikring "danmark" and a grant from the Velux Foundation. The report can be read in conjunction with the project's other publications and dissemination materials, which are available on the project's website: **www.odont.ku.dk/Forskning/sund-mund-hele-livet**.

We would particularly like to highlight our film Co-creation in Practice, produced in collaboration with the municipalities of Frederiksberg and Greve, which presents advice for researchers and municipalities engaging in co-creation processes. Together, the film and this report constitute our reporting on the co-creation process.



SUMMARY

This report summarises insights from the four-year co-creation project *Lifelong Oral Health* (SMUHL), conducted by researchers and municipal older care with the aim of improving oral health among older people in vulnerable situations. The findings demonstrate that, in practice, the task extends far beyond the scope of dental expertise, encompassing organisational, professional, and emotional dimensions.

Part I: Co-Creation – Recommendations

The project indicates that effective co-creation requires early and broad involvement of researchers, management, and frontline staff to establish legitimacy and a sense of ownership. Clear governance structures with well-defined mandates—and specifically the involvement of municipal project managers across different levels—are crucial for ensuring coherence and momentum.

At the same time, relational work and ongoing communication are vital, given the inherent differences in professional expertise, terminology, and organisational conditions. Projects should therefore support locally developed solutions rather than top-down implementation to ensure lasting integration. Finally, experience shows that unpredictability is inevitable and that the ability to adapt and act on new opportunities is key to success.

Part II: Changes

The co-creation process has led to changes that can be grouped into four key themes:

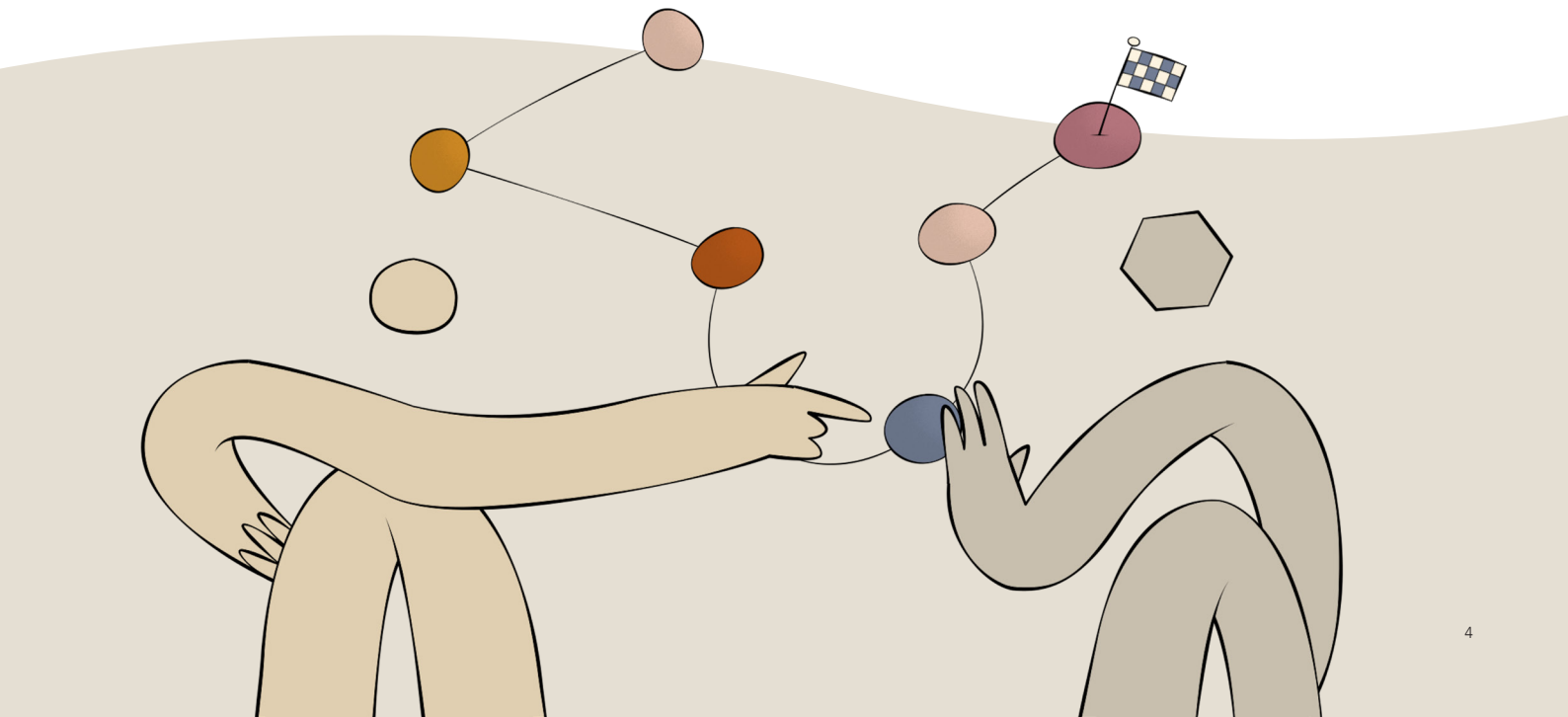
Dialogue and Communication:
From silence to a more open and systematic dialogue about oral care across disciplines and organisational levels, supported by initiatives such as workshops and regular meeting forums.

Education and Training:
From a lack of knowledge to enhanced professional competence through targeted teaching, practice-based training, and peer learning, thereby strengthening professionalism.

Visibility:
From an invisible task to increased everyday awareness through the use of materials, visual cues and integration into workflows.

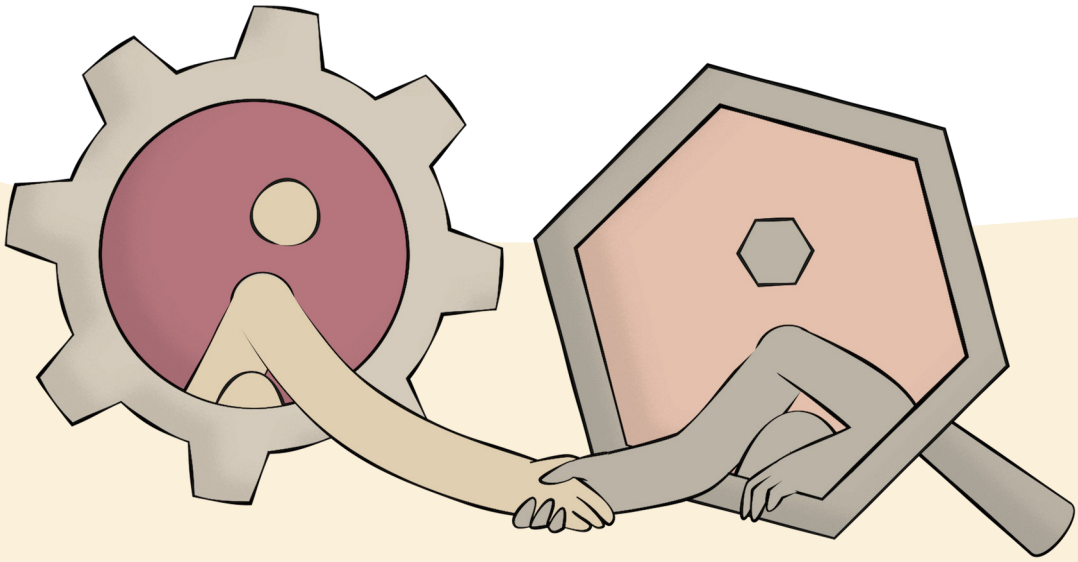
Practical measures:
From ad hoc practices to a more systematic approach through revised workflows, clearer placement within digital systems, and the use of concrete tools in care delivery.

Overall, SMUHL demonstrates that co-creation can generate significant, practice-oriented changes in complex welfare tasks when organisation, relationships, and local practices are considered holistically. While changes may evolve haphazardly and depend on local conditions, they can simultaneously lead to broader cultural and organisational improvements. Lasting change requires sustained management support, strong collaborative relationships, and active management of the emotional dimensions of care.



PART I:
CO-CREATION AS ORGANISATION & PROCESS

In this first part of the report, we present how the SMUHL project is organised and how it has unfolded in practice. Our aim is to highlight that a co-creation project with ambitions to drive change requires a complex organisational structure spanning institutions, professional disciplines, and organisational levels, as well as research and practice. At the same time, we wish to demonstrate that even the most carefully thought-out project design cannot prevent the unforeseen, messy, and challenging situations that inevitably arise during co-creation projects. Consequently, this section serves as inspiration for designing future co-creation projects involving municipal practice and research, offering insights into both the organisation and management of projects where research findings, collaborative arrangements, and the co-creation process itself evolve in *unexpected ways*.



Partners

The SMUHL project is designed as a cross-sectoral initiative, as previous projects and interventions with the same objective have rarely yielded lasting or scalable improvements. These previous projects typically only involved dental professionals, thereby lacking local integration or professional ownership among non-dental care staff.

The SMUHL project distinguishes itself by being embedded within the older care services of the participating municipalities and by involving a much wider range of professional disciplines across various areas of responsibility and organisational levels. As researchers, we have worked closely with staff and residents from two nursing homes, two home care units, and one rehabilitation unit across the municipalities of Greve and Frederiksberg. Participants include social and health care helpers and assistants, nurses, occupational therapists, and dental professionals, as well as managers at all organisational levels—ranging from department and project managers and local unit managers to administrative leaders closely involved in the political processes at the municipal offices. Furthermore, the five care units cover diverse areas of care, such as dementia care, substance abuse services, palliative care, and rehabilitation. The municipal dental care services in both municipalities also participated in the project, providing insight into how organisational frameworks influence implementation and collaboration regarding oral health. Finally, residents and their relatives associated with the five care units participated in the project through interviews and public meetings.

Similarly, the research group is interdisciplinary in composition, comprising dentists specialising in community dentistry from the Department of Odontology and humanities researchers with a background in ethnology and expertise in the health humanities, everyday life, and ethnography—from CoRe (Centre for Health Humanities Research), both at the University of Copenhagen. In addition, VIVE – The Danish Centre for Social Science Research has contributed a register-based study on Dental Care Utilisation Among Older Adults in Denmark (VIVE 2022a).

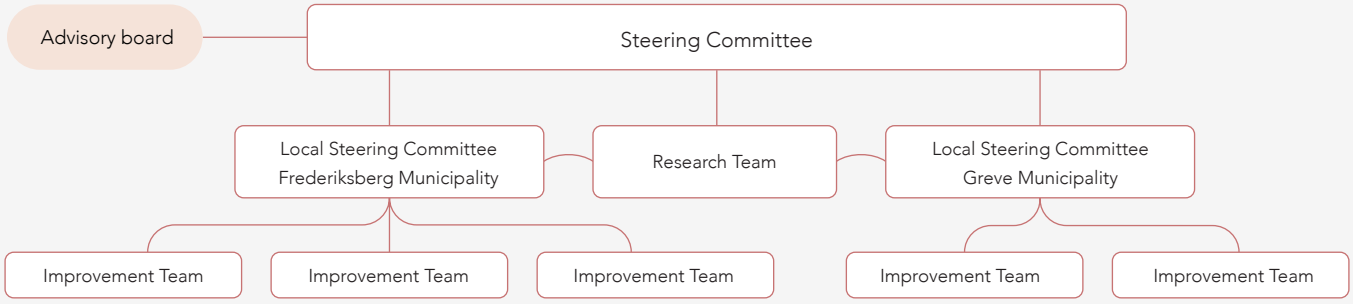
In addition to the partners, the project has involved an external advisory steering group. The group is comprised of citizens from each municipality's Senior Citizens' Council and representatives from the Danish Health Authority, the Danish Senior Citizens' Council, the Danish Society for Patient Safety, the Danish Dental Association, the Gerodontology Section at the Department of Dental Medicine at Karolinska Institutet in Stockholm, the Citizen Science research group at the University of Copenhagen, and the National Institute of Public Health (SIF) at the University of Southern Denmark. The group has monitored the project's progress and provided input and feedback during semi-annual meetings. This has been particularly valuable regarding communication channels and stakeholder activities and has helped embed oral health initiatives within the Danish healthcare system—including educational institutions, regional authorities, and inter-municipal collaborations.

The combination of dental, structural and everyday knowledge—alongside the involvement of a diverse group of partners and stakeholders spanning both research and practice—has made it possible to develop solutions that account for the needs of citizens, the practices of care and dental staff, and local municipal frameworks.

Organisation

The organisation of the SMUHL project is designed to foster active interaction among the various professional disciplines, organisational levels, and institutions involved. Consequently, the project has been structured across multiple levels, with work proceeding locally at the five participating care units, concurrently in the two municipalities, and across a range of teams, steering groups, and activities (see figure: Project Organisation). The organisational approach has thus focused on promoting collaboration and knowledge sharing across shift teams, professional disciplines, management levels, departments, and local institutions, as well as across the two municipalities.

Projektorganisation



It has been crucial to the project that an overarching steering group—comprising two local project managers, administrative managers from both municipalities, and the research team—was established from the outset to ensure coherence, knowledge sharing, and collaboration across all project partners. Furthermore, it has been pivotal that the municipal project managers and administrative managers held a clear mandate, enabling us to actively make decisions within the steering committee.

In addition, two local steering groups were established, one in each municipality, comprising local project managers, local managers of the participating care facilities, and representatives from the special dental care, with the aim of fostering collaboration and coordination across units and professional disciplines.

Work at the care unit level was carried out through five local improvement teams that were already established in each participating care unit, comprising social and health care helpers and assistants, nurses, occupational therapists, local managers, and project managers, to ensure local grounding and ownership among frontline staff. The two municipal project managers were thus actively involved in all project committees and teams, ranging from the overarching steering committee to the local steering committees and improvement teams, which has ensured collaboration across the project's various levels and between the municipalities and the research group.

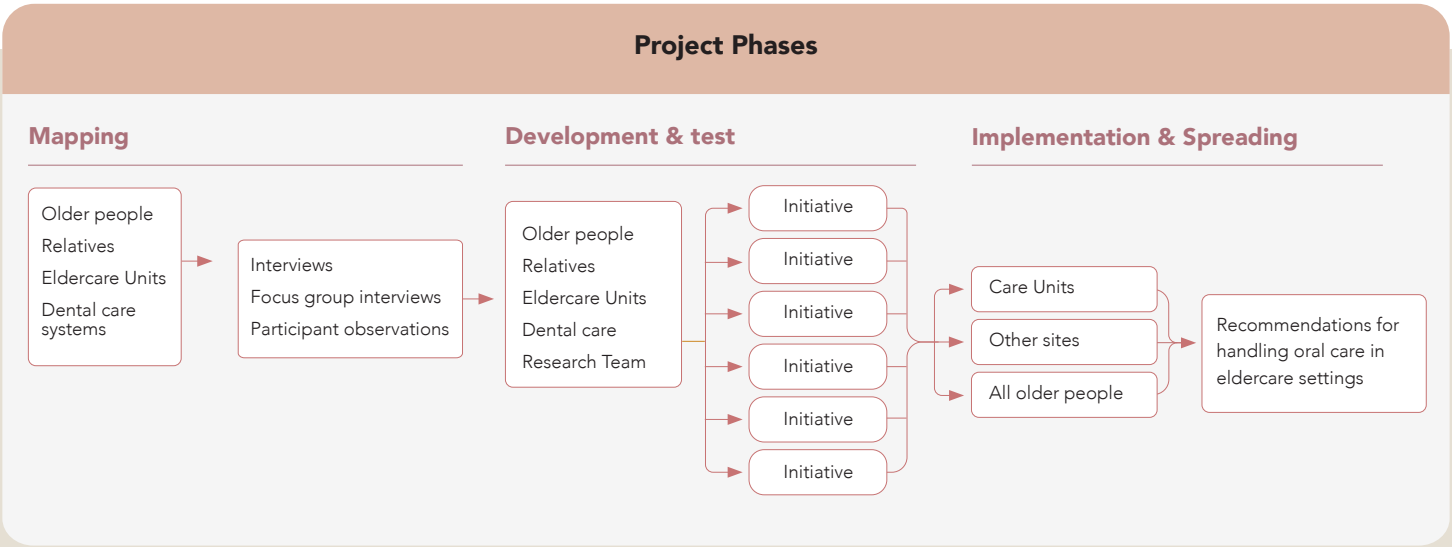
Although we, as researchers, have primarily been part of the overall steering committee, it is evident that our visibility across all project groups has been significant for the project's development and momentum, as well as for the legitimacy of the collaboration. In this regard, establishing close collaborative relationships widely across the municipalities from the outset has proven particularly important. These relationships have made it possible to address challenges with curiosity and a mutual understanding of one another's different positions. In particular, our collaboration with the municipal project managers has proven crucial in handling unforeseen situations.

At first glance, the organisation of the project appears highly complex, but our experience shows that this multifaceted project structure has created clear communication channels and fostered a sense of ownership over the project.

Phases

SMUHL's project design comprised three main phases: mapping, development, and implementation. In addition, preliminary work was carried out regarding project development and grant applications. Following the implementation phase, concluding work was undertaken to disseminate the project's initiatives, experiences, and recommendations.

Throughout the process, all project partners have participated in local project meetings and workshops as well as joint activities, including a kick-off workshop, five learning seminars, and a concluding symposium. The driving force behind the project has thus been the co-creative process, in which practitioners and researchers shared knowledge and insights and developed practice-oriented initiatives—both locally and through close collaboration with one another.



Pre-Project Phase

The project was initiated by the Department of Dentistry, which reached out to the Centre for Humanities Health Research to launch a collaboration on oral health in the care sector. Co-creation with the municipalities subsequently began with preliminary meetings regarding the project concept. It was crucial that all co-creation partners were involved early in the project design and the process of applying for project funding—including aligning the budget and resources prior to the project's commencement. It was particularly important that the municipal partners had the budget to cover both local and joint project activities, ensuring they could allocate sufficient time to the project.

Mapping Phase

The project's mapping phase laid the foundation for the development of the co-creation process. During this phase, we—as researchers—conducted extensive ethnographic fieldwork in the two participating municipalities. We interviewed older citizens, relatives, care staff, and dental professionals across various organisational levels and visited care facilities to closely observe everyday practices, including specific situations involving oral care. The aim was to gain a deep understanding of workflows, priorities, and the conditions shaping oral care in practice. In parallel, we carried out clinical assessments of the citizens' oral health status at the five participating care facilities, providing systematic insight into the local state of oral health. This interdisciplinary foundational data has thus made it possible to identify significant challenges while also highlighting existing strengths and opportunities for practical development.

The purpose of the mapping phase was not only to document; it was also crucial to the co-creation process. During this phase, the researchers maintained a highly visible presence in the field, fostering familiarity and close relationships within the project. By swiftly bringing data into play, we, as researchers, established a shared foundation for dialogue and prioritisation, ensuring that research findings were firmly embedded in the project. This grounding fostered learning, legitimacy, and a sense of ownership, while also ensuring that subsequent development initiatives were based on concrete insights rather than assumptions. When our research team presented our findings at the first joint learning seminar with the municipalities, the participants experienced a mix of recognition and surprise, and these presentations served as a vital springboard for shared engagement and established our legitimacy for the remainder of the co-creation process. Thus, the mapping phase served as the project's shared knowledge base and as a driving force for the subsequent development and implementation.

Development and Implementation Phase

The development and implementation phase built on the insights gained during the mapping process. Based on research data and findings, the project has led to a wide range of practical initiatives across the two participating municipalities. These initiatives range from concrete, hands-on solutions to more systemic changes and were developed locally, taking the specific conditions, resources, and workflows of individual care units into account. In addition to the research findings, the municipalities drew ongoing inspiration from one another through joint project activities and meetings, fostering knowledge sharing and mutual learning. As researchers, we prioritised facilitating collaboration and the exchange of ideas between the municipalities while deliberately refraining from proposing specific initiatives ourselves. We adopted this approach to ensure that the initiatives were firmly rooted in actual care practices within the municipalities and to guarantee that further development and adaptation could continue independently of us, even after the project concluded.

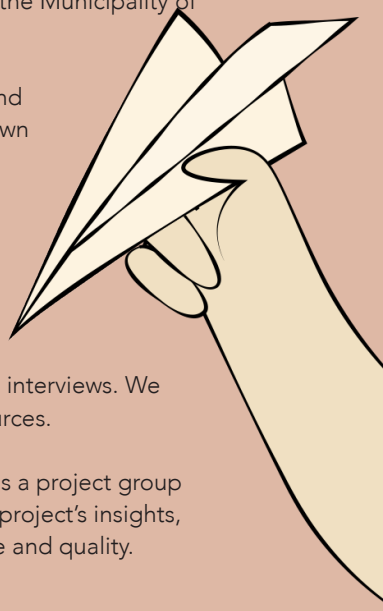
The initiatives include, among other things, new collaboration models, adaptations to digital recording systems, formalised training programs and meeting structures—including peer-to-peer initiatives—as well as clearer guidelines on how care staff can request and receive assistance with oral care tasks. In addition, more tangible tools were introduced such as baskets for oral care supplies, pocket-sized reference cards for quick consultation, and the procurement of new types of toothbrushes to support daily practice. These initiatives have been developed and continuously adjusted in close alignment with local needs and everyday operational contexts. At the same time, local steering committees in each municipality have ensured coherence across the various units—particularly regarding initiatives requiring regular coordination between different entities, such as home care services and nursing homes. This has, among others, been the case for initiatives concerning recording and documentation.

Overall, the changes have not been introduced as uniform solutions or imposed top-down, but have rather been implemented gradually and selectively, drawing on local experiences. This approach has fostered a sense of ownership and made it possible to continuously adapt the initiatives to support care work in each of the municipalities.

> "The project has evolved in such diverse ways. It's impossible to describe it briefly. At the start, we had no idea it would become so extensive; we simply thought it was about brushing a few more teeth. But we've learned a great deal. It has required a very multifaceted effort, yet I truly believe the changes have been well worth it."
>
> Manager

Dissemination of Insights and Initiatives

A key aspect of the project's design reflects the ambition to create lasting local improvements and initiatives that can be scaled to other municipal care services. Consequently, both municipalities were tasked with rolling out the project's initiatives from the five participating care units to other departments and teams, although they approached this dissemination process quite differently. In the Municipality of Frederiksberg, all care units were asked to integrate the project's insights and implement local changes simultaneously—in other words, they initiated a broad rollout of the initiatives all at once. By contrast, in the Municipality of Greve, the project was introduced more gradually, one care unit at a time.



At the same time, there has been significant, albeit unexpected, dissemination of the project's insights and initiatives. Other municipalities, educational institutions, and professional care advisory services have drawn inspiration from the project and initiated similar work themselves, often after reading the national report we published during the project (Folker et al. 2024). Several educational institutions—including those specialising in social and health care, nursing, and dental care—have incorporated the project's findings into exam papers, competitions, and textbooks (Andersen, 2024). Likewise, nursing and anthropology students have shared their work with us, including bachelor's projects on tooth shame and related topics. Furthermore, international researchers from Sweden, England, the United States, and Iran have reached out to invite us to give presentations and lectures and to engage in discussions based on our research articles—just as a multitude of national and international journalists have sought comments and interviews. We have participated in many of these opportunities, though we have also had to prioritise our project resources.

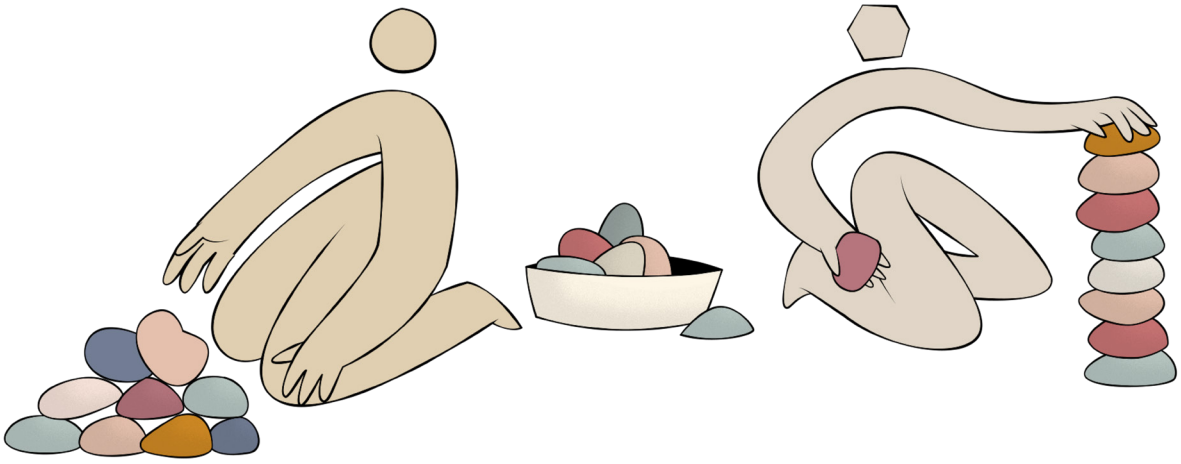
All in all, this means that the SMUHL project continues to grow, evolve, and spread far beyond what we as a project group initiated. Consequently, no one now has a complete overview of the initiatives launched, inspired by the project's insights, or where they are taking place. We consider this a success and a demonstration of the project's relevance and quality.

Unforeseen Situations and Relational Work

So far, we have described the organisation and process of the SMUHL project based on its formal framework and planned phases. However, a key insight from our work is that unplanned activities—including ad hoc tasks, unforeseen situations, and extensive relational and emotional work—have played at least as significant a role in practice. We have found that even a thoroughly planned project design could not anticipate or accommodate all the circumstances that arose along the way.

A clear example is the project figures (see pages X and X), which illustrate the project phases and the development of the initiatives. These figures depict a relatively linear and straightforward project trajectory, whereas the actual process has been far more complex. The project and its initiatives have evolved at varying paces and in different directions depending on local care contexts in ways that could never be captured in a simple graphic representation.

Furthermore, it has become clear to us that we and the municipalities entered the project with fundamentally different professional starting points, expectations, priorities, and terminologies. We also operate under different organisational conditions regarding knowledge, workflows, and resources—both across the divide between research and municipal practice and within the individual organisations themselves. These differences have not merely appeared as exceptions but as fundamental conditions of the co-creation process. Consequently, the collaboration has required a sustained acknowledgment of, and curiosity about, each other's perspectives. In practice, this has entailed ongoing adjustments and close communication.



A key lesson learned is that many challenges can be addressed by continuously investing time in shared reflection and in clarifying purpose, direction, and expectations—not only at the start of the project but throughout the entire process. Central to this effort have been the close collaborative relationships between us and key figures within the municipalities and the project's overall steering committee. We have thus found that strong relationships—and their ongoing maintenance—are a fundamental prerequisite for co-creation.

The project has also had to address the fact that researchers, management, and staff do not necessarily view or prioritise a problem or project idea in the same way. At times, this has resulted in varying levels of engagement and ownership among the project's different care units. Simultaneously, the project's parameters have constantly shifted due to organisational factors such as staff turnover, internal tensions, or changes in resources. This has occasionally led to uncertainty regarding roles and responsibilities, creating frustration and misunderstandings. In this context, relying on close collaborative relationships has been crucial—and at times, it has required immediate action to prevent problems from escalating.

Despite the strong relationships, the unforeseen has thus been a fundamental operational condition. The co-creation process itself has generated changes that have given rise to new needs and situations. For instance, we have found that our research results led to insights and a need for change that no one had anticipated at the project's outset, necessitating new decisions and directions along the way. The changes resulting from co-creation have required continuous dialogue and transparency, both of which have been central to the project's development.

Conversely, we have also found that strong local ownership has often led practitioners to launch meaningful initiatives without direct researcher involvement. We view this as a sign that the co-creation process has fostered agency and sustainability, enabling the project's ideas to be carried forward and put into practice.

Overall, the SMUHL project has demonstrated that co-creation can unfold in vastly different ways—even within a shared framework—depending on local cultures, strategies, and priorities. This variation underscores that the strength of co-creation lies in flexibility and the ability to operate across diverse and unequal conditions. Thus, co-creation has not emerged as a linear implementation process but rather as a dynamic collaboration in which complexity and unpredictability are integral to the work and, at the same time, a significant source of learning and development.

Advice for Collaboration
Between Research and Municipalities

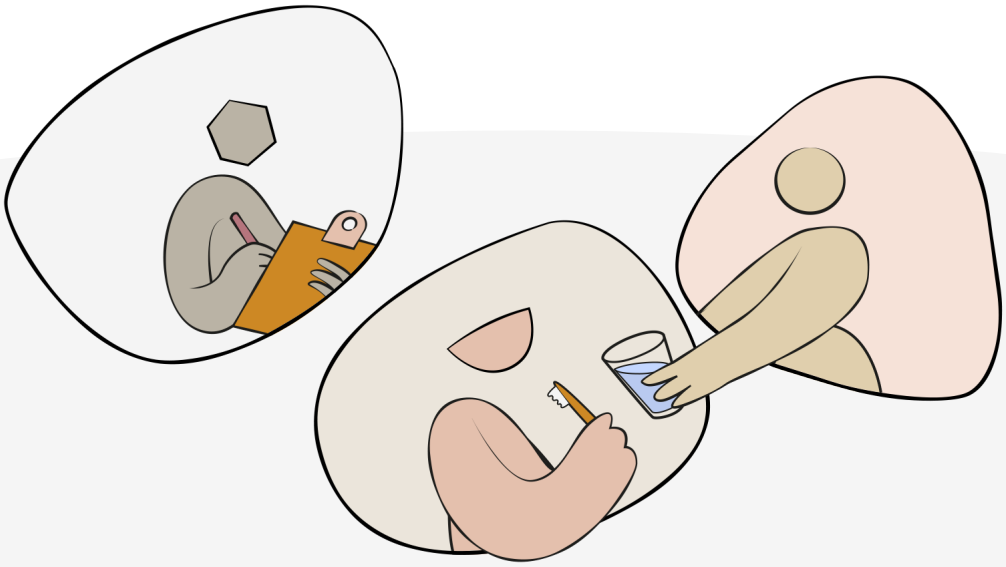
- Build mutual familiarity and maintain it throughout the project.
- Establish a steering committee with a clear mandate.
- Acknowledge differences and remain curious, especially in the event of disagreements.
- Address problems quickly and in a spirit of trust.
- Maintain open channels of communication.
- Ensure municipal project managers participate in all project teams and committees to guarantee knowledge sharing and project coherence.
- Researchers should acknowledge the dynamic nature of daily municipal operations.
- Municipalities should acknowledge the researchers' need for structure and time.
- Support the development of local initiatives and avoid top-down implementation that relies on the researchers' presence, to ensure that the initiatives have lasting, institutional embedding.
- Seize and leverage unforeseen opportunities for change and collaboration as they arise.
- Celebrate the process along the way—co-creation often requires a long-term effort.



PART II:
CHANGES RESULTING FROM CO-CREATION

In this second part of the report, we move from the organisation and process of the SMUHL project to the more concrete changes it has brought about. Here, we reflect on how a seemingly simple ambition—improving the oral health of older adults—has in practice proven to encompass far more than just tooth brushing. Through the four-year co-creation process, we have learned that the task has touched upon emotional dynamics, professional hierarchies, organisational structures, and types of interdisciplinary collaboration.

Consequently, we present the research insights that have driven these changes and describe how the changes have taken shape—manifesting as new conversations, competencies, priorities, and collaborative practices in everyday municipal operations—sometimes dramatically, and other times more gradually and experimentally.



The Research Behind the Changes

The key insight gained from the project is that oral health and oral care involve far more than just the mouth itself. Early in the ethnographic fieldwork, it became apparent that some of the major barriers to oral health in older care stemmed from the fact that the older people, their relatives, and care staff alike paid little attention to the issue and lacked knowledge regarding the potential consequences of oral health problems. Consequently, oral care was frequently overlooked or deprioritised in favour of the many other health issues and care needs present in older care. Furthermore, the field lacks dedicated, intuitive systems and (digital) infrastructures to ensure a daily focus and collaboration across different professional disciplines. In addition, oral care is not a mandatory subject in social and health care training programs. Overall, it became clear that the area was under-examined, under-prioritised, and characterised by an ad hoc approach in practice.

Our clinical assessments of oral health and the accompanying questionnaire survey among residents of the five participating care facilities revealed significant problems. Only about 25% had satisfactory oral hygiene, approximately 55% had oral disease, and around 45% reported that dental problems affected their quality of life. Consequently, about 25% required tooth extractions. We also identified several risk factors for increased disease among the older citizens, including high consumption of medications that can cause dry mouth (xerostomia).
At the same time, our registry study showed that many older adults—particularly those living at home with high care needs—rarely visited the dentist. Dental care utilisation among the older was influenced by both health-related and social factors, revealing significant inequality in access to dental care.

> "It dawned on us that this had been a completely overlooked professional task. When the researchers showed us that 37 out of 37 residents in one unit had gingivitis - well, do you think a Nursing Home manager feels proud of that? Fortunately, we have come a long way since then."
>
> Manager, Nursing Home

At an early stage, ethnographic fieldwork revealed that oral care situations can be highly intrusive, intimate, and emotionally charged for both the care recipients and the care staff involved in the process. Often, this was to such an extent that older individuals refused the care entirely, and caregivers refrained from performing it. Consequently, as part of the project, we investigated these emotional dynamics and developed the concepts of tooth shame and dental disgust. This sparked extensive ethical discussions within the project, highlighting the tension between caregivers' regard for the recipients' feelings and autonomy, and the concern of dentists and dental hygienists for the recipients' oral health. This tension led to debate and, in some instances, challenges regarding collaboration.

> "No, I don't want the caregivers standing there watching me brush my teeth. […] I'd rather do it myself. I don't like that kind of surveillance. No thanks. It's too intrusive. That's just not me."
>
> Resident

During the project's mapping phase, it therefore became clear that this was a co-creation task extending far beyond the practical work of tooth brushing. The task was largely a matter of emotions, personal boundaries, ethical dilemmas, and various—at times conflicting—care considerations. Consequently, it was necessary to also address emotional dynamics, workflows, and interdisciplinary collaboration to enable access to the mouths requiring enhanced care.

Initially, the insights gained were overwhelming, as the barriers to oral health in older care appeared intangible and difficult to address—particularly when viewed alongside the serious clinical findings regarding the status of the older people's oral health. However, it turned out that this collaboration centred on emotions, relationships, professional expertise, and knowledge became core components of the project. Participants from the municipalities noted that the project contributed to "a cultural shift," "a shared understanding," and "an ongoing and much-needed dialogue." Conversely, a minority of care workers in the participating facilities highlighted that very little had actually changed. These conflicting perspectives underscore both the challenges and the potential associated with addressing oral care on such a broad scale.

> "It compromises my professional nursing standards, but I have to admit that I almost never brush the residents' teeth. It's too intrusive - both for them and for me."
>
> *Care Staff*

At the same time, the process revealed that this was not a case of a linearly planned implementation, but rather of changes unfolding "in the wild." The participating care units differed significantly in terms of organisation, professional practice, and culture, making strict central management neither feasible nor appropriate. Instead, the changes evolved in a situated and context-sensitive manner—often without central direction, but rather actively prioritised and shaped at the local level. Consequently, the initiatives became specific and tailored to the individual units' needs, resources, and existing workflows. This type of local grounding required considerable courage—not least from local unit managers, project managers, and administrative heads—who had to make room for experiments, adjustments, and professional priorities that rarely lent themselves to standardisation.

We begin with an overview of the project's impact on care staff's approach to oral care. We then delve into the four-year co-creation process, focusing on the nature of the work and the specific initiatives involved, as well as how the changes unfolded, or, at times, failed to unfold, in the everyday practice of the care units.

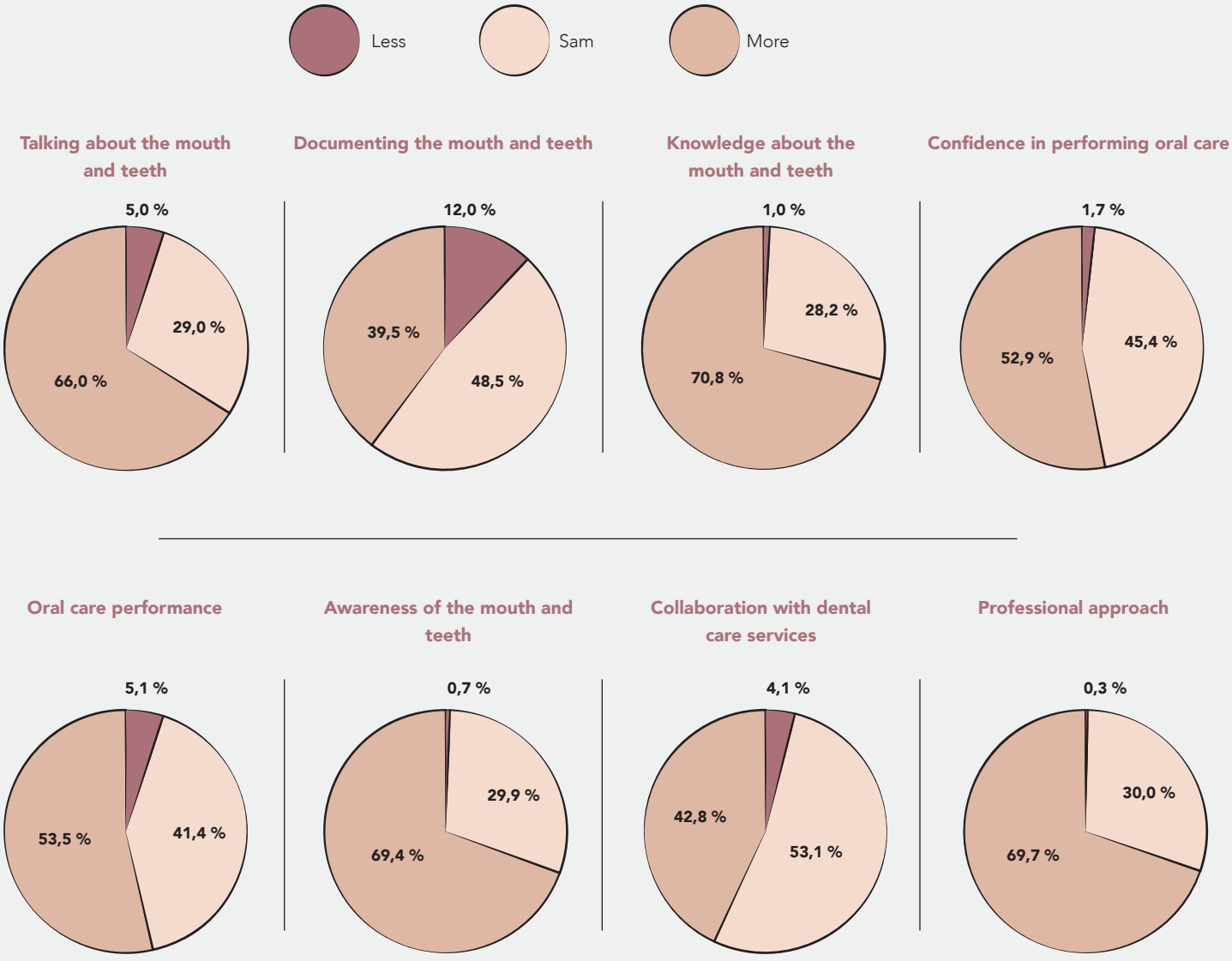
> "This is precisely what we struggle with every single day. I've never thought about it in these terms before, but it's really helpful to have the nature of the task we're actually facing put into words."
>
> *Care Staff*

Measuring Perceived Changes Among Care Staff

In the final phase of the SMUHL project, a systematic questionnaire-based evaluation was conducted to assess how the co-created interventions influenced care staff's approach to oral and dental care (data collected in September 2024). To participate in the evaluation, staff members were required to have been involved in the interventions for three months or longer.

The results show that the majority of staff experienced a more professional approach to oral health and oral care, including increased knowledge, greater awareness, and more frequent discussions about oral and dental care in daily practice (Table below). Documentation practices were perceived by many as unchanged, and likewise collaboration with dental care services showed minor changes. Participation in oral care training, permanent employment status, and employment in home care were factors associated with the perceived improvement.

Changes in the approach to the mouth and oral care



These figures indicate that initiatives co-created through municipal practice and research—followed by flexible implementation across municipalities—can lead to increased professionalism in a complex area where staff have struggled significantly to handle the task.

Specific changes:
Language Use, Community and Emotional Work

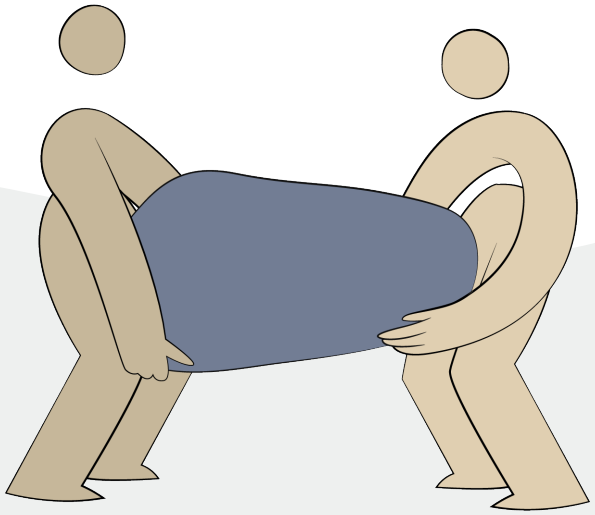
From Inadequate Language use to Establishing a Shared Dialogue
During the initial fieldwork, it became clear to us that neither the older citizens, their relatives, nor the care staff were accustomed to—or particularly comfortable with—discussing the mouth and oral health issues. The citizens often avoided the topic, and relatives were surprised that we asked about oral health and care, as it had never really been a focal point. Similarly, the care staff appeared unaccustomed to discussing oral health and care. Dental terms such as crowns, dental bridges, periodontal disease, and the like were often used at random—and the care staff found it particularly difficult to talk about the emotional discomfort that characterised oral care situations.

> "My teeth are fine. They don't hurt or anything. Couldn't we talk about something else instead?"
>
> *Resident*

As we arrived at our findings, we presented them to the project participants from the municipalities at joint learning seminars. Here, many participants noted that our findings offered them "a whole new language" to describe their practical experiences—experiences that had previously been shrouded in silence. Consequently, one of the key insights was the importance of opening up a shared dialogue about challenging issues that served as the foundation for the ability of the co-creation process to translate into concrete, locally relevant initiatives. Several project participants have highlighted this shared dialogue as an essential and necessary basis for developing the project's initiatives.

> "It's not that it isn't still difficult, but now we help each other with it. I'm damn proud when we succeed."
>
> *Care Staff*

From Silence to a Shared Approach
In one of the municipalities, the collaborative dialogue has resulted in a series of initiatives that have made it possible to sustain and further develop the conversation—systematically and across the organisation—even after the project ended. Here, local workshops were established where a project manager visits individual care units to discuss with care staff how they experience oral care situations and to identify the support they need from colleagues and management. These workshops are conducted without the presence of local managers, as a key project finding was that care staff are often reluctant to speak openly when their managers are present. Consequently, "dialogue meetings" were introduced alongside the workshops, where the project manager anonymously conveys insights from the workshops to the management level. At these meetings, representatives from local management, departmental management, and the special dental care management discuss how to improve the framework for care staff facing specific care situations. Collectively, these initiatives were established to ensure that the dialogue initiated during the project period is not lost and that new challenges can be identified and addressed even after the project concludes. The workshops and dialogue meetings serve as concrete examples of how the more intangible and emotional aspects of oral care can be managed and transformed from being solely the individual caregiver's responsibility to becoming a shared, institutionally embedded dialogue and work practice.

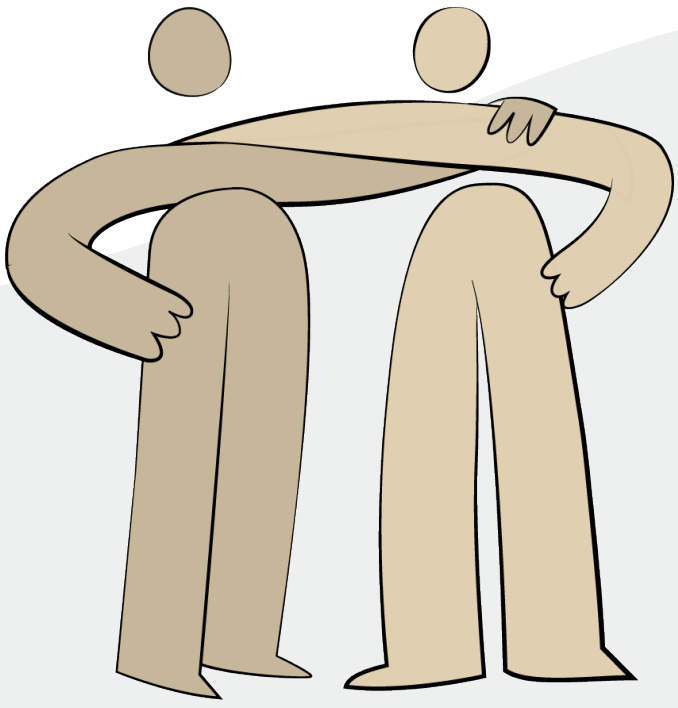


From Individual Shame to a Shared Sense of Pride

A notable change observed during the project's co-creation process is that the discomfort and uncertainty many caregivers initially felt regarding oral care have been collaboratively addressed across organisational levels. It has been crucial that managers at various levels took our findings regarding the caregivers' experiences and feelings very seriously. Rather than dismissing these experiences or criticising individual caregivers, managers in both municipalities have accepted a share of the responsibility. Consequently, several local managers at the care facilities have worked to frame the conversation around oral care—including the discomfort and uncertainty it can evoke—both during scheduled staff meetings and as a more informal part of everyday conversation among staff.

> "The whole conversation around 'dental shame' has become an important part of our daily routine. The work that has stemmed from this means we now have a completely different approach to oral care than we ever had before. We now understand what the task actually entails."
>
> Ward Nurse

Alongside the project's other initiatives, establishing a shared language and formats for dialogue has helped alleviate some of the uncertainty many caregivers experienced. Finally, we observed that the caregivers began to express markedly different feelings about oral care than they had at the outset. While they initially voiced feelings of inadequacy—and at times shame—over their professional uncertainty, they later began to express pride when discussing oral care.



Specific Changes:
Knowledge, Professionalism and Ownership

From Lack of Knowledge to a Crucial Understanding

"Why do we need to spend four years learning how to brush teeth?" several caregivers asked when the project began. Oral care seemed like such a basic task that many found it difficult to see why such an extensive project was necessary. At the same time, the care staff expressed considerable uncertainty regarding how oral care should actually be performed in practice. It quickly became clear that they lacked training, did not feel equipped for the task, and often doubted whether they were performing the oral care correctly. "Does it hurt? Am I doing it too hard? […] Am I brushing all the teeth? I honestly have no idea." None of the caregivers participating in the project had received formal training in oral care, as the subject is not a mandatory part of any curriculum at the social and health care training schools (SOSU schools). This reflected a recurring trend in the ethnographic material: when care staff are not provided with professional training, they draw on personal knowledge and experiences from their own home routines. Consequently, oral care practices varied widely and were inconsistent. It also became evident that a large proportion of the care staff—and the project participants in general—were unaware that oral health problems can have serious consequences for general health and that oral infections can easily spread to vital organs.

> "I never heard a single thing about the mouth during my training. I just do it the way I've learned is best—the way I brush my own teeth and my children's."
>
> Care Staff

> "This woman used to flatly refuse to have her teeth brushed, so I talked to her about it, explained the importance of oral health, and mentioned that many others feel the same way she does. Now, she actually lets me brush her teeth."
>
> Care Staff

Based on this, the municipalities launched a series of training and skills development initiatives. Training sessions were held in which dental professionals from the special dental care instructed care staff, across all shifts, on oral care practices, the symptoms of oral diseases, how to recognise and manage them, and when to contact the dental care service. At some nursing homes, peer-to-peer training was established, with experienced caregivers supporting colleagues and trainees. Additionally, both municipalities introduced an annual theme week during which dental hygiene students visited the nursing homes to assess residents' oral health and instruct staff on the specific care needs of individual residents.

In particular, raising awareness about the broader health implications of oral disease has influenced how care staff perceive the importance of improving this specific care task. For many, performing daily tooth brushing feels far more important today than it did at the start of the project—and this, in and of itself, has led to more successful oral care encounters in practice.

> "We now feel a sense of obligation to do it, because we know how severely it can affect the elderly if we don't. […] Even if, in the moment, it might not feel like you're doing it for their sake."
>
> Care Staff

From Being Taken for Granted to Being Recognised as a Challenging Care Task

As the care staff's knowledge and experience regarding oral care grew, project participants in the municipalities gradually began to view oral care as a specialised, professional care task—one requiring both technical expertise and relational and emotional skills. By the end of the project, virtually all participants agreed that it had in fact taken four years to learn how to brush teeth properly.

In Denmark, there is no national standard for how oral care should be integrated into daily older care. Oral care is typically included as part of other personal care routines—such as bathing, dressing, or brushing hair—without specific workflows, prioritisation, or systematic knowledge sharing. However, the project's initiatives brought about a significant shift in how oral care was understood and organised within the participating municipalities. For care staff, it was a relief to realise that the challenges did not stem from individual incompetence, but rather from the fact that oral care had not previously been recognised as a professional care task across the older care system. It also became clear to managers that the task had lacked the necessary framework to be properly carried out by the care staff.

Thus, oral care is now regarded as a complex and demanding professional practice requiring time, a calm environment, and specialised skills—and one for which resources and time are now increasingly being allocated to enable care staff to enhance their expertise.

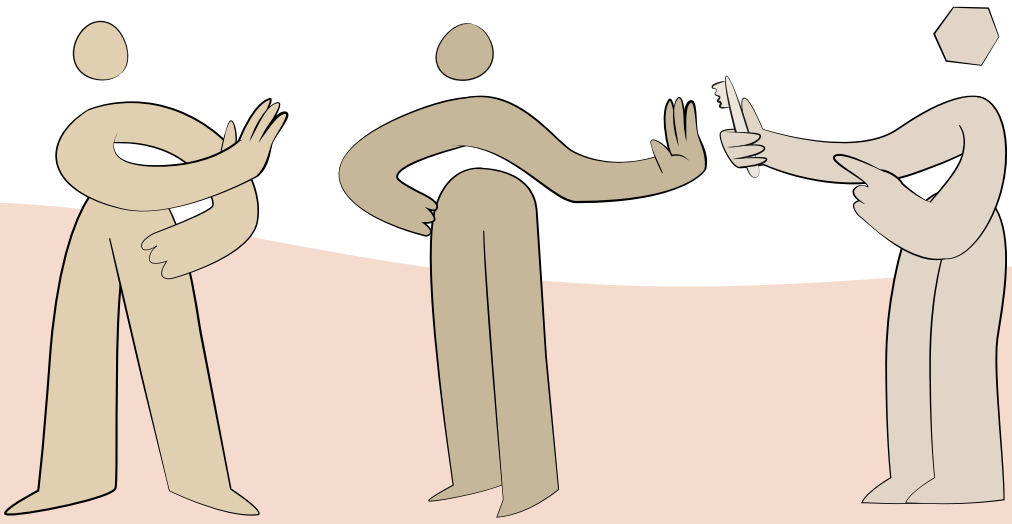
"At first, we thought it was a trivial matter, but we've learned that it requires professionalism, collaboration, and persistence."

Project Manager

From Low Prestige to Taking Ownership

A key finding of the project was that oral care suffered from low prestige. The task was viewed as subordinate to other forms of care, and responsibility for it was often assigned to care helpers and unskilled staff—rather than care assistants—a distinction frequently highlighted by the participants themselves. This pattern, evident throughout the material, reflects the existence of hierarchies regarding tasks and professions within the care system—hierarchies in which oral care has occupied a low position. Through the project's design and diverse initiatives, we have therefore sought to challenge these hierarchies by demonstrating that the barriers to good oral health cannot be attributed to specific professional groups alone but exist across organisational levels and professions.

At the beginning of the project, we found that groups of caregivers were unwilling to contribute to certain project activities, as they did not consider oral care to be part of their role. This challenged the project's fundamental premise of co-creation and the involvement of all relevant stakeholders. In our efforts to engage them, the project managers and we were sometimes rebuffed with comments telling us to "let us do our actual work" rather than spending time on project activities. However, as the project progressed and the task came to be seen as more important, the caregivers increasingly took ownership of the project, expressing growing professional pride and a sense of purpose in their participation.



"It's pointless to think of tooth brushing as an easy task that can just be done in passing. It is a very challenging care task that requires professionalism if we are to succeed."

Care Staff

Specific Changes:
Prioritisation, Documentation, and Collaboration

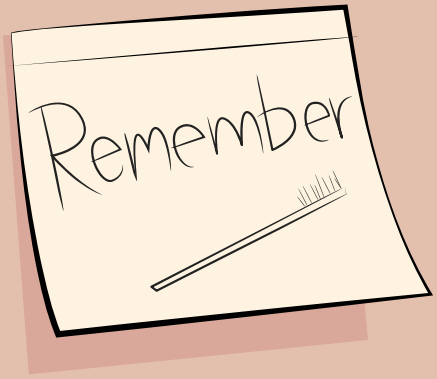
From an Invisible Task to Taking Higher Priority

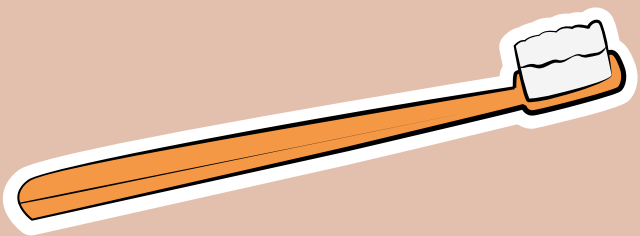
During the fieldwork, it was striking that oral and dental care were largely invisible in the everyday lives of residents, their relatives, and the care staff alike. Such care was absent from the brochures, information screens, and welcome materials encountered by residents and their relatives—and it was equally absent from the work-related systems used by care staff in their daily routines, such as the boards structuring their work and their written workflows. It also quickly became apparent that oral care was not a subject of dedicated staff meetings, triage processes, or systematic knowledge sharing. Just as it was missing from conversations within the care units, oral care was also absent from the materials and systems found at the facilities.

> "It is a very important element. It shows us that we need to rethink how we train our students and staff to prioritize holistic personal care. There must be time to address the difficult emotions associated with it. […] Perhaps this is where we should start, because, quite simply, it is more vital than bathing or brushing hair."
>
> Manager

Consequently, a wide range of the project's initiatives has focused on making oral care more visible within local care units. For instance, care units have produced various brochures and posters, as well as updates for information screens and websites, to raise awareness about oral care. Initiatives such as magnets featuring toothbrush icons have also been developed and implemented; these are placed on the boards listing each resident's health status and care needs, thereby clearly indicating who requires assistance with toothbrushing. Some units have introduced oral care baskets for individual bathrooms, which also contain pocket-sized cards noting specific oral care requirements. Furthermore, the units have established oral care as a standing agenda item for various types of meetings across different organisational levels. Collectively, these measures have resulted in, among other things, a significant increase in the number of residents registered for special dental care, as well as a substantial rise in the number of residents receiving assistance with daily toothbrushing.

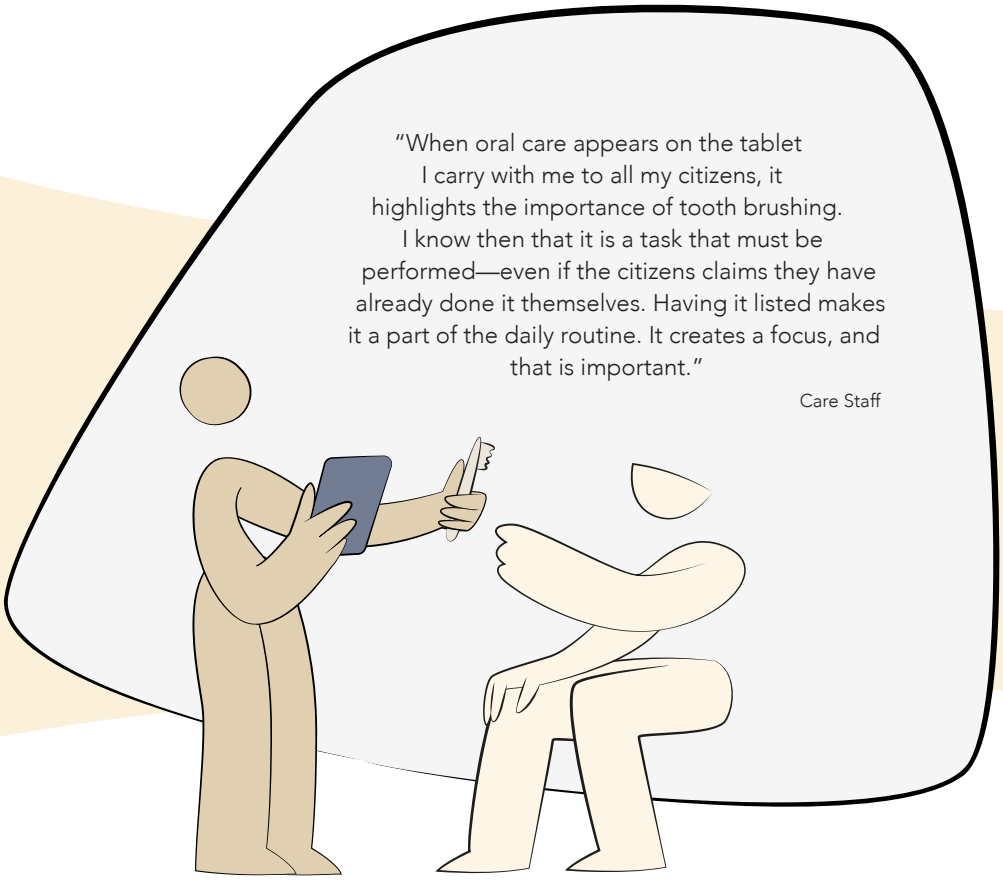
Furthermore, the project has resulted in oral care—in certain care units—not only becoming more visible within the organisation of care work but also being assigned a markedly different priority compared to other care tasks. For instance, the sequence of care tasks performed during home care visits has been altered to ensure more time to address the difficult emotions and uncertain situations that oral care can give rise to.





From Lack of Documentation to Emerging Systematic Practice

Oral care also proved to be invisible and disorganised within the digital documentation systems. Oral care lacked a clear, specific infrastructure within these systems, and furthermore the systems used by older care services and the special dental care do not communicate with one another. Oral care was significantly under-documented, resulting in a substantial loss of information—for instance, when special dental care staff visited a resident, without the care staff receiving any information regarding the resident's oral care or treatment needs following the visit. Given the pivotal role digital documentation systems play in organising daily care, a major focus of the project has been to make oral care more visible and better structured within these systems. Consequently, several local initiatives within care units—along with numerous local project meetings—have addressed how this could be achieved in practice. This proved easier said than done, as care units lack the authority to alter the infrastructure and navigation pathways of the digital systems used by the municipalities. It has therefore been difficult to streamline documentation processes, both internally within the participating units and across the various units in the municipality. Nevertheless, the municipalities have settled on standardised workflows, though these have entailed some ad hoc solutions.



"When oral care is listed in Cura *[a digital documentation system]*, it becomes a formal task. And that makes the actual act - brushing someone else's teeth - feel much less intrusive. It feels incredibly unnatural to walk into someone's home and ask if you should brush their teeth. But once it is documented, it simply becomes part of your job.""

Care Staff

The changes that despite the challenges have taken place have significantly impacted how care staff experience performing oral care. In mobile home care units, for instance, oral care was previously not specified at all in the so-called visit schedule—a digital task list on the tablet that care staff carry with them when visiting each citizen. As part of the project, oral care was explicitly included and placed at the top of the list.

This increased visibility has influenced not only the prioritisation of the task but also the emotional experience of the care situation. Consequently, even minor adjustments to digital systems can have a significant impact on prioritisation, practice, and the emotional work associated with oral care.

"For 30 years, I have wondered why oral care wasn't being performed properly. I must admit it used to frustrate me; I assumed the caregivers just didn't care. Now, I have a better understanding of why it often doesn't get done."

Dentist

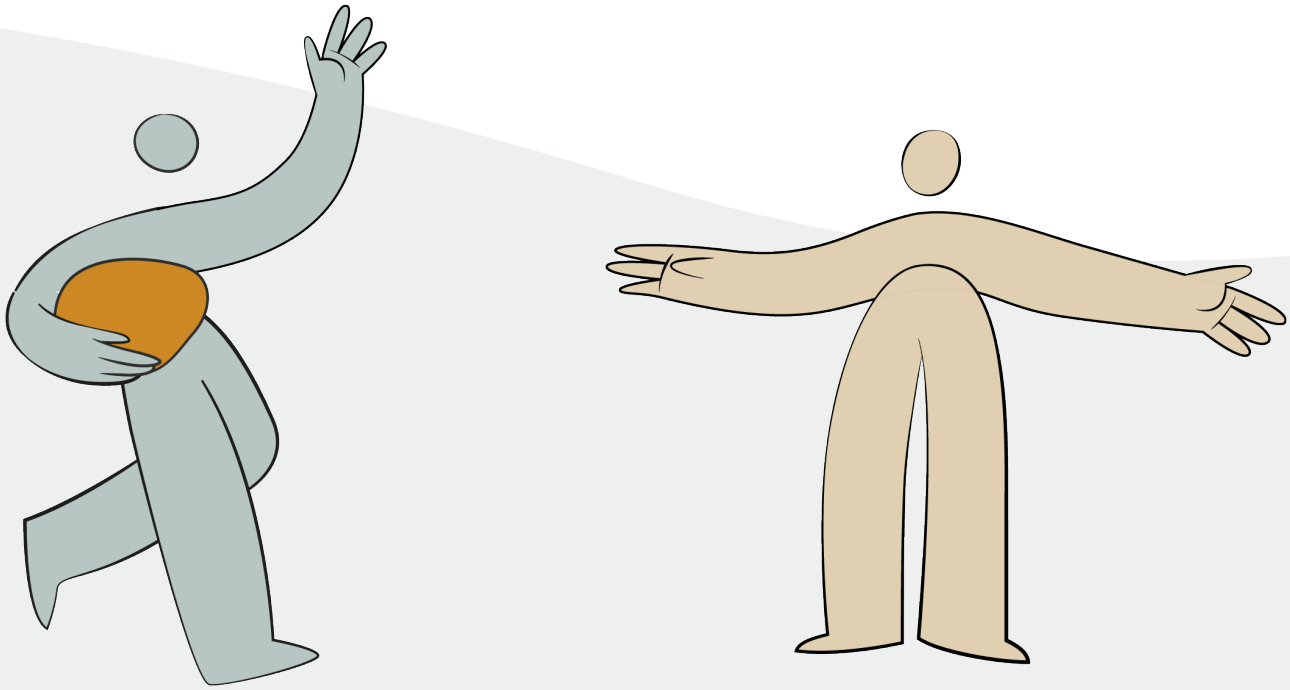
From a Single-Discipline Approach to an Interdisciplinary One

A recurring finding of the project was that, prior to its inception, collaboration between older care services and the special dental care was hampered by a lack of mutual familiarity and unclear divisions of responsibility. The two entities had limited insight into each other's workflows and day-to-day operating conditions, and the collaboration was often perceived as difficult. For instance, care staff did not always know when the dental care team was scheduled to visit, which could disrupt daily planning and cause frustration in an already high-pressure work environment. Conversely, staff from the dental care service expressed that they did not feel properly welcomed or integrated into the care units' daily routines. At the same time, tensions arose because both parties tended to view oral care as the other's responsibility. However, several project participants have noted that the project and its joint activities have gradually contributed to improved collaboration and greater mutual understanding between older care services and the special dental care.

As part of the project, a number of initiatives have also been introduced to ensure that the collaboration is maintained and further developed beyond the project's conclusion. Representatives from older care and the special dental care now meet more frequently and within a more formalised framework—including joint forums, thematic meetings, and local project groups—where specific challenges can be discussed and workflows coordinated. At the same time, the project has facilitated better, albeit still fragile, coordination of visits and interventions through adjustments to systems and workflows. However, both parties have noted that coordinating dental care visits remains difficult in an everyday environment characterised by urgent and unforeseen situations. Nevertheless, our experience shows that when the complexity and emotional pressure associated with oral care are mutually acknowledged, and when professional groups meet regularly and receive support in their collaboration, new opportunities emerge for a more collective and institutionally embedded approach that transcends professional and organisational boundaries.

"Our collaboration with the municipal dental care service has definitely improved. We now reach out to them whenever citizens refuse oral care. They help us motivate the citizens when things get difficult."

Care Staff



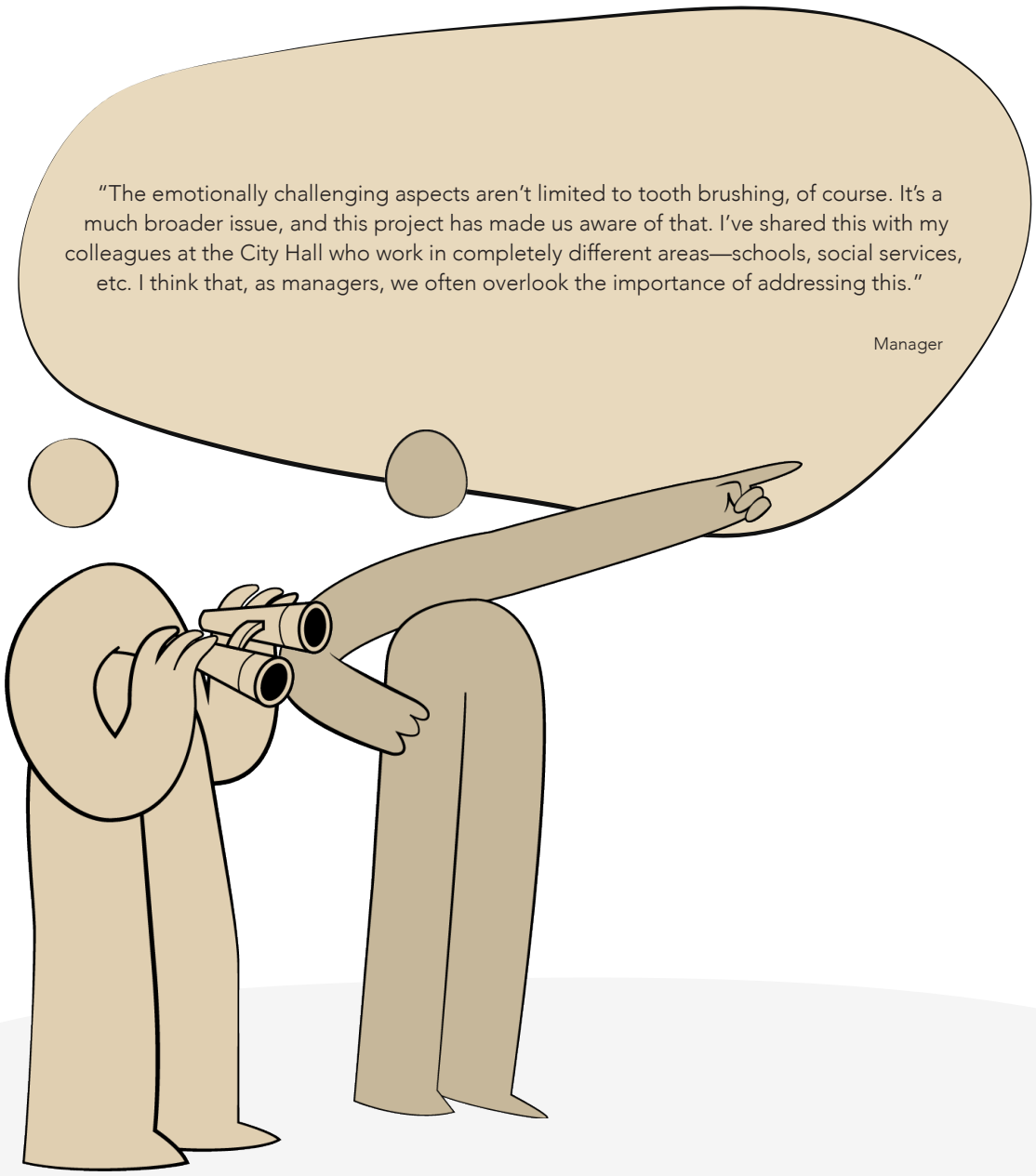
Broader Perspectives on Co-Creation

Although the SMUHL project has had a clear and specific focus on oral health and care, our experience indicates that the co-creation process has nonetheless had a much broader impact. Several managers describe how the project's working methods have contributed positively to the staff's professional expertise and general job satisfaction.

> "When we work the way we have in this project, it adds something to our employees' job satisfaction and general well-being. […] It contributes to their core professional skills. It really gives them something—and not just in terms of oral care. It also has a bearing on catheter care, personal hygiene, and so on. It offers them something much broader."
>
> Manager

It has become particularly evident that the co-creation process has contributed to developing a broader sensitivity toward care situations involving intimacy, resistance, shame, or discomfort. At the same time, the project has heightened management's awareness that the emotional dimensions of care work are not unique to oral care but are an inherent aspect of the work in general.

The experiences gained from the project have sparked broad reflection across organisational levels and professional disciplines. Consequently, the co-creation involved in oral care stands as a focal point for broader efforts addressing the relational and emotionally complex aspects of organising welfare work in general..



Examples of Local Initiatives

Dialogue on Communication

- Local workshops with care staff regarding their experiences and professional needs concerning oral care, facilitated by a project manager with no direct personnel management responsibilities.
- Dialogue meetings where the project manager anonymously conveys the care staff's experiences and requests to management levels capable of ensuring institutional support for the oral care situations the staff encounter.
- Oral health and care as a standing agenda item at staff and management meetings across organisational levels and shifts.
- Informal conversations about oral health and care during everyday routines across organisational levels within the municipalities.
- Recurring meetings between care units and the municipal dental care service, focusing on understanding each other's professional expertise and work practices.

Teaching

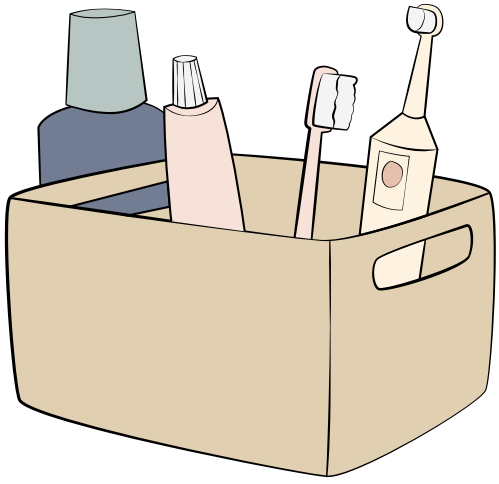
- Training and skills development initiatives tailored to local conditions—for example, presentations by the municipality's special dental care for care staff and managers.
- Peer-to-peer training, where experienced care staff assist colleagues and students during oral care procedures.
- An annual theme week where dental care students are invited to participate in the daily routine at care facilities and educate care staff on the specific oral care needs of individual older residents.

Visibility

- Raising awareness of oral care and the special dental care among citizens and their relatives through brochures, posters, information screens, websites, and welcome materials provided when older individuals are enrolled into care services.
- Raising awareness of oral care and the special dental care among care staff through clear information on notice boards, in written workflows, via magnetic icons on whiteboards, and as part of triage systems.

Practical Measures

- Changes to the sequence of daily care tasks to ensure oral care receives greater focus and sufficient time.
- Clear integration of oral care into digital documentation systems—for instance, by making it a standard part of home care visit schedules.
- Changes to oral care products, such as encouraging individuals to purchase electric toothbrushes or procuring higher-quality toothpaste.
- Consolidating the individual's oral care supplies in a specific location, such as a basket.



Conclusion

The *Lifelong Oral Health* project has shown that co-creation between research and municipal practice is demanding, but also that it can genuinely drive change and create value—for both research and practice. **Part I** of the report highlights that an ambitious co-creation project requires a well-planned organisational structure with clear mandates, broad involvement across disciplines and management levels, and ongoing investment in relationships. Concurrently, the project has demonstrated that even the most carefully designed structure cannot prevent unforeseen situations, shifts, and local variations. In practice, co-creation is a dynamic process characterised by negotiation, adaptation, and continuous project navigation—where trust, open communication, and strong collaborative relationships are just as crucial as formal agreements and plans.

Part II of the report demonstrates that when research insights are brought close to practice, they can drive tangible change—though rarely in a linear or predictable manner. The project's focus on oral health proved to encompass far more than just teeth: it touched upon emotions, shame, professional uncertainty, prioritisation, systems, leadership, and collaboration. Through the development of a shared language and understanding, oral care has—in several locations—been elevated from being unacknowledged and perceived as low status to having increased professionalisation, ownership, and institutional integration. At the same time, the varied experiences across care units demonstrate that change is always contingent upon local conditions, leadership, and commitment.

Overall, the project indicates that bringing about change in complex welfare tasks requires relational work, the courage to address emotionally challenging issues, and clear organisational support sustained over time. The perspectives offered by co-creation therefore extend beyond oral health. It can also foster broader changes, greater understanding, and new professional communities—particularly when complexity is acknowledged as a fundamental condition and a source of learning.

