Care providers’ perceptions of the importance of oral care and its performance within everyday caregiving for nursing home residents with dementia

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Background: The oral caregiving in nursing homes for persons with dementia often becomes complicated due to the patients’ lack of compliance, which in turn can result in giving oral care a low priority in daily care. Furthermore, directives for responsibilities are unclear.

Objective: The aim of this article was to describe care providers’ perception of and reasoning for the oral care for nursing home residents with dementia and to describe registered nurses’ reasoning in relation to their responsibility for monitoring oral care interventions within the regular caregiving routines for nursing home residents with dementia.

Methods: Two sub-studies were carried out; focus group discussions with nine care providers and interviews with four nurses. All participants were staff in nursing home units specialized in dementia.

Results: The focus group discussion revealed three themes: Art of caregiving, Barriers and Treatment strategies. Themes related to the nurses’ statements about oral hygiene within caregiving were Care, Responsibility for care and Information.

Conclusion: Three main findings from the study are discussed: Unclear responsibilities of different staff members related to daily oral care for the nursing home patients; a lack of guidelines and routines for oral hygiene and a lack of guidelines for sharing information between the different professional groups.

Keywords: dementia, care

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Introduction

The proportion of elderly in the Swedish population is increasing as it is in the other Scandinavian countries and most other industrialized regions. Improved living conditions have an impact on health perceptions and behaviour (1, 2). For example, edentulousness is decreasing, and the proportion of elderly individuals with natural teeth, restored with fillings, crowns and bridges including implants is increasing. It is possible to maintain a healthy natural dentition lifelong, but this requires adequate lifelong oral hygiene as well. With increasing age and frailty, many people become medically compromised and dependent on care provided by others and thereby their good oral health is at risk if their oral hygiene is not sufficiently well cared for.

An increasing amount of evidence links oral health to general health (3, 4) and indicates that oral hygiene among older people in nursing homes is poor (5) and often neglected by health care providers. Oral health affects eating ability, diet, weight changes, speech, nutrition, behavioural problems, appearance and social interactions; these are concerns not only for the older person but also for their family and carers (6, 7). The maintenance of oral health is important for older adults with dementia, not only to ensure their quality of life, but also for meeting their needs of eating and talking, and preventing oral infection and disease that can profoundly affect their daily lives (6, 7). The overall objectives of the Swedish Dental Services Act of 1985 are good oral health and dental care for the whole population. Dental services are to be of high quality, provided on equal terms and be easily accessible to all. The services shall be based on respect for patients’
integrity and their right to make their own decisions. These goals include residents in nursing homes as well, but the prerequisites are altered as the residents are dependent and cannot act as an autonomous person but have diminished autonomy. These individuals must rely on others, and in nursing homes, care is mainly provided by nurse aids. In Sweden, nursing assistants and enrolled nurses (in this article, they are called ‘care providers’) are governed by the Social Services Act, while nursing care by registered nurses (RN) is regulated by the Medical Services Act, supervised by the National Board of Health and Welfare. In nursing home settings, RNs are responsible for directing, monitoring and ensuring adequate care for the residents.

For residents in nursing homes, moderate to severe dementia can have a deleterious effect on their oral health (8). Oral caregiving often becomes complicated due to the patients’ lack of compliance, which in turn can result in giving oral care a low priority in nursing care for persons with dementia (9–11). Reasons for inadequacy of oral care have been reported to include lack of time and staff, residents refusing oral care and care providers’ unwillingness to perform oral care (12).

The aim of this article was to describe care providers’ perception of and reasoning for the importance of oral care and to describe RNs’ reasoning in relation to their responsibility for monitoring oral care interventions within the regular caregiving routines for nursing home residents with dementia.

Method

To catch the aims, two sub-studies were carried out: I. Focus group discussions with care providers; II. Interviews with RNs.

Selection

Altogether, staff from nursing home units specialized in dementia care was included. The units were located in four different areas within the city of Stockholm. In sub-study I, the sampling was purposive to catch informants working with patients with dementia, with more than 1 year’s experience working in elderly care and of various ages and representing different professional positions (Table 1). In sub-study II, four RNs, one from each of four units agreed to participate. Those staff members who participate in the study were informed both orally and in writing about the study aim and how it would be carried out. The study was approved by the local Ethics Committee and conformed to Helsinki Declaration. Participation was voluntary, and one could withdraw from the study at any time without giving reason. Secrecy in the manuscript for the participants was guaranteed. The interviewer was one of the authors (HK), a registered nurse with experience of caring of patients with dementia but with no connection to the participating nursing homes.

Sub-study I

Sub-study I aimed to investigate care providers’ perceptions of and reasoning for the importance of oral care.

Data collection for sub-study I. Data were collected through the use of focus group discussions (FGD) as this method was regarded as appropriate for studying the participants’ views and opinions in interaction and exchange with one another (13, 14).

The groups consisted of nursing home staff at various ages and representing different professional positions (Table 1). The interviews were recorded and later transcribed verbatim for analysis. The interviews were semi-structured and carried out in the form of a dialogue. During the discussions, the care providers were encouraged to share their perceptions, feelings and views on the meaning of oral hygiene. The care staffs were also given the opportunity to share their views on, for example, how oral hygiene should be handled on their units, the level of knowledge about oral hygiene and any possible educational needs they felt existed.

### Table 1 Participant data for focus group interviews

<table>
<thead>
<tr>
<th>Ward</th>
<th>Experience in health care (years)</th>
<th>Of which in elderly care (years)</th>
<th>Professional level</th>
<th>Age (years)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-1</td>
<td>10</td>
<td>10</td>
<td>Nursing assistant</td>
<td>40</td>
<td>F</td>
</tr>
<tr>
<td>A-2</td>
<td>3</td>
<td>3</td>
<td>Enrolled nurse</td>
<td>21</td>
<td>F</td>
</tr>
<tr>
<td>A-3</td>
<td>18</td>
<td>18</td>
<td>Nursing assistant</td>
<td>60</td>
<td>F</td>
</tr>
<tr>
<td>B-1</td>
<td>20</td>
<td>20</td>
<td>Enrolled nurse</td>
<td>46</td>
<td>F</td>
</tr>
<tr>
<td>B-2</td>
<td>3</td>
<td>3</td>
<td>Enrolled nurse</td>
<td>47</td>
<td>F</td>
</tr>
<tr>
<td>B-3</td>
<td>13</td>
<td>13</td>
<td>Enrolled nurse</td>
<td>47</td>
<td>F</td>
</tr>
<tr>
<td>C-1</td>
<td>8</td>
<td>8</td>
<td>Enrolled nurse</td>
<td>25</td>
<td>F</td>
</tr>
<tr>
<td>C-2</td>
<td>3</td>
<td>3</td>
<td>Enrolled nurse</td>
<td>24</td>
<td>F</td>
</tr>
<tr>
<td>C-3</td>
<td>9</td>
<td>5</td>
<td>Enrolled nurse</td>
<td>53</td>
<td>F</td>
</tr>
<tr>
<td>Average</td>
<td>9.7</td>
<td>9.1</td>
<td></td>
<td>40.3</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>3–20</td>
<td>3–20</td>
<td></td>
<td>21–60</td>
<td></td>
</tr>
</tbody>
</table>
Sub-study II

Sub-study II aimed to illuminate how RNs reason about their responsibility in relation to oral hygiene being carried out as a part of regular caregiving work.

Data collection sub-study II. Semi-structured interviews with the four RN’s were carried out and conducted at a time and place according to the informant’s wishes. All interviews were recorded and later transcribed verbatim for analysis.

Data analysis

Data from sub-studies I and II were analysed through qualitative content analysis according to Graneheim and Lundman (15). The transcribed interviews were read sentence by sentence and text that was relevant to the study’s aim or research question was denoted. Demarcated expressions and/or statements were condensed by using open codes and analysed as either manifest expressions by highlighting what the text said or as latent expressions by interpreting what the texts talked about, i.e. the underlying meanings in the text. Thereafter, codes that were related to the same areas were identified and grouped according to sub-themes. The sub-themes were related to one another and then to the main theme (Tables 2–3).

Results

Sub-study I

An analysis of the texts from the FGD revealed three themes: Art of Caregiving, Barriers and Treatment Strategies (Table 2).

The art of caregiving. Participants discussed the art of caregiving from three main perspectives: the patients’ integrity, well-being and the staff’s knowledge about dementia. According to the participants, the patients’ integrity involves seeing the patient as a person and having a holistic view of caregiving, wherein oral hygiene is also a part. Although the discussions focused on oral hygiene, they could also be generalized to apply to all caregiving activities. It was emphasized that a healthy mouth could be good for patients as this leads to the individual’s well-being, which is one of the pillars of the art of caregiving. During the discussions, participants also pointed out that it is important that the art of caregiving departs from the patient’s autonomy and human value. Good care, according to the participants, is care that does not violate the patient. Participants also discussed the importance of being knowledgeable about dementia. Examples were given of how they adapted their actions to the disease’s symptoms and handicaps, which indicated that they possessed knowledge, and used this in the clinical situation.

Barriers. According to the participants, oral hygiene care is a difficult element in the care regime. The barriers that crystallized through the discussions can be divided into two sub-themes: limited time and patients’ refusal to comply. Assisting people who are slow and who do not fully understand what is going on takes time, according to the participants. They explained that the working situation in elderly care is characterized by a time crunch and that rather than allowing a patient to carry out an activity by him- or herself, they often take over as the task will go faster. An example given of a patient refusing help was when the individual refused to open his/her jaws, and became defensive and aggressive. When the interaction between care provider and patient breaks down, this leads to major problems.

Lack of time is a reality within elderly care and can be a substantial barrier for carrying out good care. The breakdown in cooperation between care provider and patient in the caregiving situation is a barrier that can be influenced by a number of factors. Participants emphasized that both these barriers lead to frustration because the caregiver is unable to carry out his/her duty in a calm and dignified manner.

Treatment strategies. Participants commented on the problematic treatment situation, emphasizing how one does things contra what one does. They discussed what to do when the patient refuses to cooperate and how to conduct one’s self when such a situation arises. Some meant that one cannot give up, that one should coax the patient and try again, while others stated that they did give up when they encountered such resistance. More concrete strategies for what to do in such situations were also discussed. Some suggested that to handle the patient, two care providers should be on hand, or that protective aids can be used when opening a patient’s mouth to avoid being bitten. Many felt that when a situation was not manageable, it was important that this was documented. Consequently, three treatment strategies emerged from the discussions: 1) that through patience, one should try to provide oral hygiene; 2) that treatment should be delivered with physical help; or 3) give up and document this in the patient’s record.

Sub-study II

Themes related to the nurses’ statements about oral hygiene within caregiving were Care, Responsibility for care and Information.

Care. The care theme covered two sub-themes: (i) the effect of oral hygiene and (ii) how it should be carried out (Table 3). With respect to sub-theme 1, nurses recognized
that good oral hygiene is important for patient’s nutrition, communication and mood, while poor hygiene can have a negative effect on both how the patient approaches others, communication and appetite. Poor oral hygiene, which was equated with poor oral health, was also regarded as posing a risk of infection in addition to creating problems for eating, chewing, speaking and feeling well.

The nurses felt that care providers generally carried out oral hygiene quite well and that this worked much better today within health care than it did twenty years ago. Examples given of when things did not work well were described as when medications in a solid form were crushed and mixed in sweet jams or applesauce, which can be done whether or not the evening’s dental care is carried out. This routine could seem contradictory, and one of the participants who was questioned about this suspected that oral hygiene in the evenings was not handled quite as well as it was during morning personal care routines.

Responsibility for care. This theme covered two sub-themes: (i) division of responsibility and (ii) boundaries between health care and care work (Table 3).

Views on the division of responsibility surrounding oral hygiene varied. Some felt that oral hygiene was a part of basic caregiving needs and as such was the sole responsibility of care workers, while others felt that it is the RNs that are tasked with giving instructions and this implies a latent overall responsibility. Others felt that there was a

<table>
<thead>
<tr>
<th>Statements</th>
<th>Codes</th>
<th>Sub-themes</th>
<th>Main themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When you are in their mouths, you are almost violating them”</td>
<td>Do not violate</td>
<td>Respect for person / Integrity</td>
<td>Art of caregiving</td>
</tr>
<tr>
<td>“You can’t force them!”</td>
<td>Do not force</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“But it’s also a private arena...my mouth is a sensitive place, even when you brush you don’t want someone to watch. So it is the same way for them (the patients), they don’t want someone going into their mouths”</td>
<td>Private area</td>
<td>Resident’s well-being</td>
<td></td>
</tr>
<tr>
<td>“Of course it feels good to have a fresh mouth”</td>
<td>Feel good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“It depends on how they refuse to open their mouth, then I generally show them by opening my own mouth since if you say ‘open wide’ they might not make the connection, but if I show them myself”</td>
<td>Be concrete</td>
<td>Knowledge of dementia</td>
<td>Art of caregiving</td>
</tr>
<tr>
<td>“If you just say ‘now we are going to brush your teeth’ and hand them a toothbrush and the toothpaste it can be too much at once, rather than taking things one step at a time”</td>
<td>One thing at a time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“It doesn’t work if you go too quickly”</td>
<td>Timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Come back and try again” (if refusal)</td>
<td>Distraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“sometimes I wait a while and then try again. It usually works”</td>
<td>Takes long time, take over</td>
<td>Lack of time</td>
<td>Barrier</td>
</tr>
<tr>
<td>“Try her happy”</td>
<td>Stressed work situation</td>
<td>Patient refuses</td>
<td>Barrier</td>
</tr>
<tr>
<td>“…you have to tell them all the time what you are doing”</td>
<td>&quot;They clamp their teeth together”</td>
<td>Refuse to open mouth</td>
<td></td>
</tr>
<tr>
<td>“It takes a lot of time. You try to let them do it themselves, but you often have to do it for them”</td>
<td>&quot;We have one who is really difficult, you are not even allowed to come into her room”</td>
<td>&quot;Sometimes they strike out with their hands”</td>
<td></td>
</tr>
<tr>
<td>“It can be difficult to remove dentures. Not all of them want to let go of them. Sometimes they clamp their teeth together so it is difficult to get to them”</td>
<td>&quot;Coax and try again”</td>
<td>Coax</td>
<td>How do you do things?</td>
</tr>
<tr>
<td>&quot;You try and try until you succeed”</td>
<td>Do not give up</td>
<td>Give up</td>
<td></td>
</tr>
<tr>
<td>“With some, there is just no way”</td>
<td>Protect one’s self</td>
<td>More caregivers</td>
<td>What do you do?</td>
</tr>
<tr>
<td>“Use protective aids and not hold your fingers between their teeth”</td>
<td>&quot;Sometimes you have to be two”</td>
<td>Report</td>
<td></td>
</tr>
<tr>
<td>“If they refuse, we note it in their file”</td>
<td>&quot;If you just say ‘now we are going to brush your teeth’ and hand them a toothbrush and the toothpaste it can be too much at once, rather than taking things one step at a time”</td>
<td>&quot;They clamp their teeth together”</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 Content Analysis sub-study I (Care providers)
shared responsibility for oral hygiene. The physician’s role was reported to be peripheral and was only relevant in relation to writing prescriptions or for writing referrals. All participants stated that when they did receive a report from a care provider regarding oral problems, they personally inspected the patient’s oral cavity. However, none had a mouth mirror among their examination instruments. Three of the four interview subjects used flashlights when they inspected oral cavities.

Many of the nurses reported that if patients did not have problems with their mouths or their teeth, then oral hygiene was the responsibility of care providers and that the nurses had to trust that this was carried out. Care providers were responsible for reporting deviations in a patient’s oral status to the nurses, who also felt that they were responsible in special cases such as for patients with terminal care. Nurses also felt responsible for patients who were diagnosed with an illness of the mouth or ran the risk of becoming afflicted by an oral disease during terminal care.

**Information.** This theme covered two sub-themes: (i) Routines and (ii) Communication (Table 3).

The RNs felt that each patients contact person (one of the care providers) were particularly responsible for informing them about oral hygiene care and for notifying them when dental care products needed to be ordered. One of the interviewed nurses suggested that there should...
be routines for managing the administrative division of labour between nurses and care providers.

Exchanges of information regarding dental issues did not take place routinely. Reports could be given at a meeting about a patient, but then only if there were problems with oral hygiene. None of the wards carried out routine meetings about patients’ oral status.

Information to residents on dental care benefits and routines for dental visits (free visits by the dental hygienist to the nursing home for dental exams and advice) could be provided by the nurse either in conjunction with planning for care or in conjunction with an information meeting upon moving in, while others had no routines for providing this type of information.

Discussion

We can conclude that the personnel we interviewed were knowledgeable about the importance of good oral hygiene for the health and well-being of patients. They seemed to be well-informed about the problems that can arise in the context of caregiving for those with dementia and reported using different strategies to handle these problems. However, there are three main findings from this study that should be discussed: (i) Responsibilities of different staff members related to daily oral care for the nursing home patients; (ii) A lack of guidelines and routines for oral hygiene and (iii) A lack of guidelines for sharing information between the different professional groups.

Staff responsibilities

Given the adverse effects of ignoring oral hygiene, the promotion of oral health for older adults with dementia is imperative for residential elderly care (6). Maintaining adequate dental hygiene seems to be problematic in other countries as well, and different reasons for poor oral hygiene in nursing homes are discussed in the literature. Some of the reasons given include the view that oral care assistance is a less favourable duty than other ward activities (11), workload (16), the available resources of dental care delivery and the standard of knowledge of those in a position to deliver the care (17), lack of knowledge (18) and lack of cooperation from residents.

Few studies explicitly address oral health as a responsible part of caring. Frenkel (19) concluded from open-ended questionnaires that good oral health care was a part of the care provider’s role, but some of them commented on a lack of guidance from the nurses, which may indicate some kind of shared responsibility. One Norwegian study (20) noted that nursing homes are responsible for helping residents with their daily oral hygiene but no further information on the implications of this are given.

Our study indicated that directives surrounding this area are unclear, which makes the nurse’s role, in particular, uncertain. Nurses did not regard themselves as having primary responsibility, but rather regarded this as a responsibility that was divided among different personnel groups. Care providers regarded themselves as having responsibility for the good oral hygiene of patients, as a part of caregiving work. Despite this, it was not a wholly evident part of the routine meetings about patient care, but was discussed first when a decline had been observed. Should symptoms of oral disease or dental decay be observed, responsibility for diagnosing the patient and determining a solution is handed over to the nurses as this involves treatment.

Personal care in nursing homes may include help with eating and drinking, getting dressed and personal hygiene, and according to the Social Services Act, the municipal authorities are responsible for sheltered housing such as nursing homes. In Sweden, the Municipal Councils decide and are responsible for the work of the Social Services and The County Administrative Boards are tasked with supervision of the Social Services to ensure the individuals’ legal rights and the quality of the services provided. Thus responsibility for general care in nursing homes performed by care providers is governed by the Social Services Act while nursing care by RNs is regulated by the Medical Services Act, supervised by the National Board of Health and Welfare. This distinction between medical care and social care among the personnel categories in the nursing homes may be one explanation for the different opinions about responsibility in this study. In contrast, better insight into both teams could improve the issue of responsibility.

Other studies have found that in most institutions, the nurses are more involved in the residents’ oral assessments while the oral care itself is provided by other care staff (21). Some of the nursing staff regards oral care assistance less favourably than other ward activities; it is associated with more distasteful aspects (11). In this Swedish study, the attitude that oral care of others is repulsive tended to be reported more frequently by those who were less educated, such as the nursing assistants and aides, while they are the group that are primarily involved in assisting with oral care.

Guidelines and routines

Lack of routines for oral hygiene care provision was reported by the participants of this study. In many instances, both guidelines and routines are nonexistent for daily oral care. None of the participants used necessary instruments for registering status over time, and none of the nurses carried a mouth mirror for carrying out inspections.

An oral assessment tool for routine use by nurses could facilitate communication between the nursing staff about
the residents’ oral health and need of help with oral hygiene. For example, in the United States, nurses are required to carry out a national oral assessment, the Minimum Data Set when residents are admitted to a facility. The Revised Oral Assessment Guide (ROAG) is used and validated in geriatric care and has proven to be a clinically useful oral assessment tool for use in the nursing care of elderly patients (22). There is also good agreement between ROAG staff assessments and patients’ reported oral health in questionnaires. The patients in this study suffered from various forms of cancer and thus were cognitively intact (23).

Lack of protocols to meet the current standards of oral care has been identified in some other studies (3). However, a systematic review has shown that currently, there is no ‘gold standard’ of oral health for institutionalized older adults in residential care (6). Therefore, there is a great need to carry out systematic quality assurance work in this area.

Dissemination of information

Even when a guideline is available, research showed that just over half of staff read the guidelines that were available on the ward (17).

We observed that routines for reporting were lacking. Nurses thought that care providers should be responsible for reporting at the same time they lacked insight into their own responsibility for informing and instructing care providers on the importance of oral hygiene and how this fit in with daily care routines. As noted above, the importance of oral assessments can also be emphasized in the context of disseminating information. A literature review (24) supports the use of oral assessment tools by staff to quantify oral health status and these can, among other things, be used for providing information on the oral status of residents.

It would appear that the definitions of roles and responsibilities in nursing homes are rather unclear about the exact contribution of the nurses and care providers in performing oral care. Coleman (3) highlighted the same problem in the United States where no national standards existed to mandate specific practice expectations, content or competencies to prepare certified nurses aides to provide oral care for residents. However, it has been well-documented in both nursing and dental literature that the provision of oral hygiene care in residential/long-term care facilities is often the domain and responsibility of nursing assistants (nurses aides) (21, 25).

There is a gap in nursing education, especially in geriatric nursing practice (3). Although the need for the incorporation of training in oral health and disease into the undergraduate and postgraduate nursing curriculum has been heavily discussed (3, 26, 27), few nursing curricula have yet to include instruction in oral care by dental professionals (26–28). Moreover, one study (29) showed the importance of dental teams supporting and encourag-


