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Opinion

Golden Smiles: Ensuring Oral Health in the Elderly

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Opinion:

Poor oral care correlates with an increase in systemic diseases such as aspiration pneumonia. Lack of education and oral care knowledge in caregivers raises the risk of poor oral care among elderly patients residing in long-term care facilities. A study investigated the results of an education program provided by speech-language pathologists for certified nursing assistants (CNA). Data pre and post oral healthcare knowledge education program was collected on 54 CNAs. Data on oral health of their patients prior to and subsequent to the education was also collected. Results revealed that positive changes were significant and an education program can have immediate results and is important for overall patient care and management. Healthcare facilities should consider having an education program on oral care.

Summary

Long-term care/nursing home (LTC) residents require various levels of assistance with oral care. Some long-term care residents are independent while others are totally dependent on the oral care provided by certified nursing assistants. This population can exhibit cognitive and motor deficits that impact their ability to provide self-oral care. LTC residents with motor planning deficits may be unable to physically place a toothbrush within the oral cavity. In addition, cognitive deficits can result in this population not understanding the consequences and importance of oral hygiene. Memory deficits prevent LTC residents from remembering activities of daily living for self-care. These residents are placed at a greater risk for oral diseases, because such institutions have difficulty providing good oral health care to their residents. There are barriers to implementing oral care. Staff may have a lack of knowledge about what comprises good oral care. The oral care performed may not be based on standardized methods of providing oral care. An example of this may be the use of lemon glycerin or foam swabs to clean teeth and oral mucosa, instead of a soft bristled brush. High staff turnover and a high resident to staff ratio make oral care a low priority for nursing staff and the nursing home administration. LTC facility administrators may not understand the implication of poor oral care/hygiene in the population; therefore funds may not be allocated to allow for the provision of good oral care. According to the 2004 National Nursing Home Survey conducted by the CDC, 80% of nursing homes report the presence of dental services (dentist, oral hygienist), but only 19% of all nursing home residents receive dental services.

LTC residents that have had a previous history of oral disease (periodontal disease, caries, and cavities) are at an increased risk for these types of oral diseases when oral care is not provided and plaque is not controlled. Oral hygiene is paramount to preventing oral diseases, which can adversely

affect quality of life. Oral health problems are not due to aging but can be prevented. As an adult ages, oral diseases become more evident, which may be due to a decline in general health, decreased physical ability, neurologic conditions, use of multiple medications, a decline in cognitive ability and functional dependence. There is a lack of formal protocol and accepted standards for best practices in oral care in LTC facilities. A standardized assessment tool, in addition to intervention guidelines is imperative because CNAs receive limited education and training on oral care.

This study explored the relationship between improving knowledge of oral hygiene and the impact it has on improving the oral health of the patient. The educational program included the definition of oral hygiene and comprises good oral care, the overlooked patient population (NPO, dysphagic), and patients with behavior problems. A 25 item oral health knowledge test (OHKT) was created and reliability analysis was conducted. Post test scores on the 25 item oral healthcare knowledge test was assessed for internal consistency reliability and achieved a coefficient alpha of 0.63, which exceeded the conventional criterion of acceptable reliability of 0.60.

The oral healthcare knowledge test (OHKT) was administered to 54 CNAs prior to their participation in the education program. The OHKT post-test was administered following the education program. Knowledge gained was assessed by comparing pre-test and post-test scores on the OHKT. Participants demonstrated a gain of 5.29 points from pre-test to post-test scores. The number of CNAs who participated in the program was 54(85.7%), the number of RNs was 7 (11.1%) and LPNs was 2 (3.2%). Participants in the education program were primarily CNAs with a small number of RNs and LPNs. No analyses were conducted comparing RNs' and LPNs' outcomes, because of the small number. The mean years of experience of the participants was 10.51 (SD=6.97). The number of years of experience had no relationship to knowledge outcomes. Twenty CNAs were selected from the 54 participating CNAs with one CNA per long-term care unit in the facility. The patients were randomly chosen from the CNAs' regular assignment roster from their units, resulting in a patient pool of 112. The 112 patients' oral cavities

were assessed prior to and following the educational program. Patients were evaluated on a 4-point scale on the following oral health characteristics: lips, tongue, teeth, dentures, saliva, and gingival-oral mucosa. Significant positive changes from pre-test and post-test were found.

This study looked only at short-term immediate results of an education program. The study indicates that an education program can have immediate results and positive changes and is important for overall patient care and management.

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