

ORIGINAL ARTICLE

The district nurse's perceptions of elderly patients' oral health: A qualitative interview study

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Abstract

Objective. The aim of this qualitative study based on interviews was to explore the perceptions that district nurses have of the oral health of elderly patients. **Material and methods.** The criterion for inclusion was being a district nurse working in a primary health-care centre in the County of Stockholm. The respondents were asked open-ended questions about their perceptions of oral health and about the impact of oral problems on the general health and well-being of elderly patients. The analyses started at the first interview and proceeded in parallel until no further relevant information could be obtained. Analysis of the open-ended questions was inspired by grounded theory methodology and comprised four stages: native reading, open coding, axial coding, and selective coding. **Results.** The one core category identified, namely indistinct professional duties of the district nurse, formed the central meaning of the district nurse's perceptions of oral health in elderly patients. This related to two other categories labelled 'insights into the district nurse's professional role' and 'obstacles for the district nurse', with sub-categories. **Conclusion.** Although the district nurses in this study were aware of the impact of oral health in old age, their attitude was that this was a matter for dentistry.

Key Words: Attitude, frail elderly, holistic health, nurse's role, qualitative research

Introduction

More and more elderly people in many industrialized countries retain their natural dentition well into old age, with improved living conditions appearing to have an impact on attitudes to health and behaviour [1]. In Sweden, where the percentage of elderly people in the population is one of the highest in the world, there has been a rapid decrease in edentulousness over the last quarter of the past century. Nowadays, many more elderly people are dentate. This improvement in oral status is appraised in the context of improved living conditions, enhanced general health, higher economic status and access to affordable medical and dental services [2–4].

With increasing age and frailty, many people become medically compromised; their oral health is at risk [5] and this in turn may threaten their general health. Data from clinical and epidemiolo-

gical studies indicate associations between chronic oral conditions such as dental caries and periodontitis and medical diseases [6–10]. Challenges emerging for the health-care system include how good oral health can be supported and maintained into old age.

Care of the elderly in Sweden is divided between the county council, responsible for medical care, and the municipality, responsible for nursing. Many elderly people receive the services of a district nurse (DN), who works with their overall health situation. During the 1990s, a change established in the professional work area of Swedish DNs [11] meant that DNs now work more closely with general practitioners (GPs) and in a more dependent position than previously. The care of patients receiving primary-care home nursing is complex [12]. The aim of this study was therefore to explore the DN's perceptions of oral health in elderly patients.

Material and methods

A qualitative method was used, with individual in-depth interviews.

Study population

The criterion for inclusion in the study was DNs working in Primary Health Care Centres (PHCCs) in the County of Stockholm. Strategic selection was based on geographic spread. The secretary at each PHCC reported the names of the DNs working at the PHCC, and after receiving verbal and written information they were invited to take part in an interview. They were also informed that participation was voluntary and that they could withdraw at any time, without explanation. Fifteen DNs accepted the invitation to participate. The study was approved by the local ethics committee at Huddinge University Hospital.

The interviews

The interviews were conducted at the PHCCs and were based on an interview guide, with the respondents being given free scope for their own reflections. Semi-structured background questions followed by open-ended questions inquired about the DN's observations and perceptions of their elderly patients' oral health.

The interviews, which were conducted by the first author (K.A.), lasted 45–60 min and were tape-recorded and transcribed verbatim by the interviewer. Each interview was read and discussed with the second author (G.N.) before the next interview was conducted. The content was then analysed and discussed in close collaboration with all the authors. Collection and analysis of the data were carried out in parallel – the process starting with the first interview and proceeding until no new relevant information was forthcoming [13,14].

Analysis of data

The open-ended questions were analysed using a method inspired by grounded theory (GT), which develops social issues and patterns and is suitable when studying any new perspective of a topic [13,14]. The process in four parts is carried out in a step-by-step manner:

1. Native reading to grasp the content.
2. Open coding – the data are read line-by-line and substantive codes are identified. Substantive codes with similar content are grouped to form more abstract categories.
3. Axial coding – connections between categories are sought. Every category is developed and described by identifying its dimensions; sub-categories are identified.

4. Selective coding – the core category is subsequently identified. A working theory evolves by forming categories and sub-categories and also by seeking connections between them. The theory, expressed by the core category, is developed and modified throughout the collection and analysis of data and with ongoing discussions between the authors.

Results

The mean age of the DNs (all female) was 53 and all had been working at PHCCs for a mean of 15 years.

Contextual circumstances

The DNs' work included an open reception and they acted as intermediaries in contact with the GP. They were also responsible for the district home care run by the county council. This part of the DNs' tasks involved visiting the elderly at home to distribute medication, give injections, place catheters, apply bandages and give advice. They acted as medical supervisors for the nursing work among the elderly run by the municipality. Their elderly patients were generally between 80 and 90 years of age.

According to the DNs, patients around the age of 80 report deteriorating health, while those aged 90 and over generally experience more rapid deterioration. Common complaints among the elderly were cardiovascular disease, diabetes, osteoporosis, and tobacco-related diseases, and symptoms such as joint and muscle pain, depression, sleeping problems, anxiety, and stress. Loneliness and isolation were frequent problems, and often led to depression and anxiety. The DNs reported that most of their elderly patients took many prescription drugs and that control of medication was inadequate.

Special dental regulations for the elderly in Sweden, i.e. free oral examinations on home visits and subsidized necessary dental care for dependent individuals, were not known in the case of 8 and 6, respectively, of the 15 DNs.

Perceptions of the elderly patients' oral health

There are several factors playing a role in the DNs' perceptions of their elderly patients' oral health. In the analysis, a core category labelled "indistinct professional duties" illustrated the DNs' frustration in their professional role. This core category was related to two categories: "insights into the DNs' professional role" and "obstacles for the DNs" (see Table I).

Many of the DNs argued that their professional role had taken on a more medical focus and that their responsibility for health promotion had decreased. A fairly high workload created frustration because they could not care for their patients wholly

Table I. Categories identified after in-depth interviewing 15 district nurses (DNs) about their perceptions of oral health in elderly patients. The analysis of the data was inspired by grounded theory.

Core category	Indistinct professional duties	
Categories	Insights into the DN's professional role	Obstacles for the DN's
Sub-categories	<i>Being responsible</i> <i>Leading without control</i> <i>Thinking of wholeness</i> <i>Being aware of oral health</i> <i>Ensuring the elderly patients' integrity</i> <i>Supporting empowerment for self-care</i>	<i>Inadequate resources</i> <i>Inadequate organization</i> <i>Working as teams</i> <i>Lack of oral knowledge</i> <i>Priority between tasks</i>

in the manner expected of them in their profession, which would include an overall picture.

“The municipality's approach to care can be frustrating, as it does not match ours (DNs). Everything is so compressed that there isn't any scope for care and caring. We only have time for the most urgent things. Oral health and oral care belong to other professionals.”

Insights into the DN's professional role

Factors discussed by the DN's in terms of their professional role and tasks were responsibility, leadership, patient integrity and supporting self-care. There was an awareness of the fact that oral health had an impact on the general health and well-being of their elderly patients, but that patient integrity was perceived by DN's as a barrier to patients freely talking about their oral health and oral problems. This category comprises six sub-categories (Table I).

Being responsible

The DN's were ambivalent about what caring should include. Nowadays, they had to focus on being responsible for medication and for passing on important information about their patients to the physicians. These medical responsibilities could sometimes be experienced as overwhelming. Oral health and oral care were not included by any of the respondents.

“I think it's difficult sometimes. After all, we have the medical responsibility, but . . . we don't have time to take overall responsibility and provide comprehensive care and work in a way that helps to promote health . . .”

“I don't think that the oral cavity and oral problems are our responsibility.”

Leading without control

The DN's did not have any formal control of the staff working in the municipal home health-care service,

but they still regarded themselves as guarantors of the medical care within this service. They complained about the standard of caring knowledge among nursing assistants in the municipal home health-care service.

“The home health-care service's staff who I am responsible for supervising . . . well, I'm their medical supervisor, but it isn't easy to supervise staffs who have no knowledge.”

Thinking of wholeness

DN's need information from other professionals if they are to create a good life situation for their patients, but only one believed that the dental aspect should be included.

“As a DN, I try to see the big picture, but I have to focus most of my attention on medical needs . . . I need a contact network around the elderly person in case something happens . . . Then the patient's needs are the starting point and I use the channels I have, the home health-care service and relatives.”

Being aware of oral health

Asked for their opinions on the oral health of their elderly patients, the DN's largely agreed about its importance, even though they did not generally give it much attention. There was an awareness of oral problems and their importance for general health, but there was also an attitude that oral health was not part of the responsibility of the DN's care.

“I think there is a connection between oral problems and general condition and, if the condition of the oral cavity is poor, other diseases can primarily be affected negatively . . . but we don't focus on the oral problems.”

Ensuring the integrity of elderly patients

Several of the respondents talked about integrity in general and felt that comments on oral problems

could be especially insulting for the patient. They considered that health care and dental care were different professions and believed that their elderly patients felt the same way.

“I go to people’s homes, I’m a guest in their homes and it isn’t so easy to inspect their mouth unless someone asks you to The mouth is very private . . . it’s much easier to look at people’s eyes or noses than their mouths. Talking about the mouth is sensitive, difficult, I think they are ashamed, don’t want to show me, they’re probably aware of their oral health and the shortcomings in their mouths. It’s difficult when it’s associated with appearance. I would compare it with being overweight.”

Supporting empowerment for self-care

The DNs believed that it was important to strengthen the patient’s own capacity to take care of him/herself and to teach the patient how to act. Wherever possible, patients were to take responsibility for their own health care.

“I can discuss things and lead the conversation so that the elderly person receives the support he/she needs to meet his/her daily needs and cope more effectively with everyday life. I try to use preventive care to strengthen people’s self-respect. They have to try to take care of themselves.”

Obstacles for the district nurse

Obstacles preventing good district nursing were reported as frustrating. This category is composed of five sub-categories (Table I).

Inadequate resources

The respondents emphasized lack of time as the reason for not performing their duties as caring experts. This was unsatisfactory, since acquired knowledge could not be used and professional development was impossible.

“We put on ‘blinkers’, do what we can and do the things we have to do . . . simply distribute medicine and then leave. In the evening, I sometimes feel bad when I realise that I didn’t have time to find out how an elderly patient was actually doing. But then I tell myself that I’ll do it next time.”

“We are under a great deal of pressure. We don’t have time to develop our skills and that’s a real shame.”

Inadequate organization

The DNs believed that nowadays the elderly are kept in home health care for municipal financial reasons, even though they are compromised and should be cared for in nursing homes.

The situation of counties and municipalities as two different principals was regarded as poorly organized elderly care, with the DNs preferring only one principal. The fact that dental care had yet another organization was another troublesome factor in the care of the elderly.

“We have the problem of different principals, different legislation and different economic prerequisites between medicine, dental care and care for the elderly who still live in their own homes. I personally think we should have the same principal after all, we are working towards the same objectives.”

“Many elderly people remain in their own homes far longer than they should in terms of what is good and safe for their situation It’s frustrating to see this.”

Working as teams

Teamwork was reported within the PHCCs, but on different levels depending on time and individuals. The municipal case managers were hard to reach and their decisions were seen as being based more on social care than on medical care. The need for cooperation with dental professionals was described mostly as unnecessary, but some respondents also found it strange that skills of this kind were missing in the team working with elderly patients.

“Collaboration with the municipal home health-care service is sometimes a problem, as they are under so much pressure. The case managers make decisions relating to care, but they are more socially oriented and we (DNs) are more medically oriented I really feel there should be some form of collaboration with dental staff, as I don’t actually have anyone to discuss oral problems with.”

Lack of oral knowledge

All the respondents said that they had been taught little about oral diseases in the undergraduate education program for nurses and DNs. They felt a lack of knowledge about the oral health and oral problems of the elderly. They believed that more knowledge would render them better able to identify oral problems and deal with them in time.

"It is not included in my work because I don't have the necessary knowledge about the oral cavity and its diseases. I don't have enough knowledge about the mouth, what we should be looking for and what we can do in different situations."

Priority between tasks

Almost all the respondents talked about the lack of time and that they had to make priorities. The DNs explained that their schedules were overloaded; they could only deal with the most urgent care for the elderly, and that oral care was not included.

"We don't have the time, we are stressed and we aren't always able to observe more than the things that are clearly our responsibility. Dental care comes a long way down on my list of priorities."

"The mouth is quieter and so disappears... I don't have time to talk about the mouth when I see an elderly person for a short time at the health centre or on a home visit."

Discussion

In this study, we explored DN perceptions of the oral health of elderly patients. As most elderly patients are more likely to meet primary care providers than dental workers, DNs must be familiar with the oral health of the elderly and how this affects general health and well-being [15].

The vagueness of the professional role, the obstacles preventing good nursing and the problems associated with "doing good" that are experienced by DNs create frustration and have been labeled in the core category as "indistinct professional duties". This situation may explain the DNs' perception of the oral health of their elderly patients.

The study sample consisted of a strategically selected group of DNs, and the results are derived from the responses of this particular group and may not apply in the case of all DNs. The respondents' age span was fairly high, which is usual within the DN profession. The participants were all females, as no male DN worked at the PHCCs involved in this study. According to one Swedish study, there are few males working as DNs [16].

In a qualitative study, the researcher may be regarded as a research instrument, so it is important to clarify preconceptions and professional experiences in advance. There is a balance between the researcher's understanding based on professional experience and the respondent's perceptions, since interpretation is an integral part of qualitative inquiry [17,18]. The interviewer's profession as a dental hygienist was known to the participants and could have influenced their answers.

The DNs considered that their professional role had changed and that they had lost some influence and thus control of their working situation. They were frustrated to see how municipal staff took over the care of the elderly from a social aspect rather than a medical one. Traditionally, the DNs were responsible for the inhabitants of a particular geographical area, while now they work more closely with the GPs. Many of the DNs in this study felt that their professional role had lost the nursing focus and had expanded into medicine. Wilhelmsson et al. [11] reported that GPs and DNs working within this new system were generally more negative than those within a traditional primary care system.

Studies have shown that physicians' treatment decisions are based on universal rules and principles, while nurses focus on each patient's unique needs. Physicians more frequently relate ethical problems to action, while DNs relate ethical problems to relationships and to maintaining harmony [19–21].

It was not natural for DNs to talk about oral health and oral problems with their elderly patients because they considered this as bothersome for the patients, especially when the DNs visited the patients in their homes. Autonomy and integrity are important values in modern health care and the DNs respected the patients' ability to choose and take responsibility for their own oral health [22]. This standpoint can be a problem, as dental subsidies are meant for individuals unable to take such responsibility, especially as awareness of the dental regulations among the DNs in this study was inadequate.

In conclusion, the DNs in this study showed some awareness of the oral health of the elderly, but there were several obstacles preventing them from grasping this aspect of nursing care. They believed that oral health and oral problems were part of dentistry and thus as another profession. Improved understanding and cooperation between DNs and dental professionals are important issues ensuring that oral health is included in the well-being of the elderly. This highlights the need for interdisciplinary training and collaboration between the health-based professions in promoting oral care and improving the oral health and quality of life of elderly individuals.

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