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QUALIDADE DE VIDA E A AUTOPERCEÇÃO DA SAÚDE RELACIONADA COM A SAÚDE ORAL: O CASO PARTICULAR DE IDOSOS INSTITUCIONALIZADOS

QUALITY OF LIFE AND SELF-PERCEPTION OF HEALTH RELATED TO ORAL HEALTH: THE PARTICULAR CASE OF INSTITUTIONALIZED ELDERLY

CALIDAD DE VIDA Y AUTO PERCEPCIÓN DE SALUD RELACIONADA CON LA SALUD BUCAL: EL CASO PARTICULAR DEL ANCIANO INSTITUCIONALIZADO

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RESUMO

Introdução: A Organização Mundial da saúde (WHO) inclui a saúde oral (SO) no conceito global de saúde e considera-a essencial para a qualidade de vida (QdV). Avaliar a qualidade de vida relacionada com a saúde oral (QdVRSO) contribui para a aferição efetiva das necessidades.
Objetivos: Caraterizar as variáveis sociodemográficas, clínicas e comportamentais da amostra. Analisar a relação entre estas e a QdVRSO.
Métodos: Estudo quantitativo, transversal e correlacional. Realizaram-se entrevistas estruturadas fundamentadas num questionário sociodemográfico construído para o efeito e na versão traduzida e adaptada para a população portuguesa do *Oral Health Impact Profile* (OHIP-14-PT) a 151 idosos de 9 Estruturas Residenciais para Pessoas Idosas (ERPI).
Resultados: Predomínio do género feminino e viúvos. A média da idade é de 84.4 ± 6.4 anos. A quase totalidade dos inquiridos tem antecedentes patológicos e toma medicação.
A maioria tem dentes naturais (65.6%), mas 31.8% nunca escovam os dentes e a boca.
O *score* médio do OHIP-14-PT é de 18.22. Os itens mais pontuados foram a *Sensação de desconforto no ato de comer* e a *Necessidade de interromper as refeições*. Há diferenças estatisticamente significativas entre o *score* total do OHIP-14-PT e a literacia dos inquiridos.
Conclusão: A amostra autorrelatou um nível moderado de QdVRSO. O edentulismo e a ausência de uso de prótese dentária predizem pior QdVRSO. Há dificuldade no acesso dos idosos aos cuidados de saúde oral.

Palavras-chaves: saúde bucal; qualidade de vida; idoso; instituição de longa permanência para idosos; enfermagem em saúde comunitária;

ABSTRACT

Introduction: The World Health Organization (WHO) includes oral health (OH) in the global concept of health and considers it essential for the quality of life (QoL). Assessing the quality of life related to oral health (QofLROH) contributes to the effective measurement of needs.
Objectives: To characterize the sociodemographic, clinical and behavioral variables of the sample. Analyze the relationship between these and the QofLROH.
Methods: Quantitative, cross-sectional and correlational study. Structured interviews were conducted based on a sociodemographic questionnaire built for the purpose and in the translated and adapted version for the Portuguese population of the Oral Health Impact Profile (OHIP-14-PT) to 151 elderly people from 9 Residential Structures for the Elderly (RSfE).
Results: Predominance of the female gender and widowers. The average age is 84.4 ± 6.4 years. Almost all respondents have a pathological history and take medication.
Most of them have natural teeth (65.6%), but 31.8% of them never brush their teeth and mouth.
The average OHIP-14-PT score is 18.22. The most scored items were the feeling of discomfort in the act of eating and the need to interrupt meals. There are statistically significant differences between the total OHIP-14-PT score and the literacy of respondents.
Conclusion: The sample self-reported a moderate level of QofLROH. Edentulism and the absence of use of dental prosthesis predict worse QofLROH. There is a great difficulty in the elderly's access to oral health care.

Keywords: oral health; quality of life; old person; long-stay institution for the elderly; community health nursing

RESUMEN

Introducción: La Organización Mundial de la Salud (WHO) incluye la salud oral (SO) como concepto global de salud y la considera esencial para la calidad de vida (CdV). Evaluar la calidad de vida relacionada con la salud oral (CdVRSO) contribuye para constatar las necesidades efectivas.
Objetivos: Caracterizar las variables socio-demográficas, clínicas y comportamentales de la muestra. Analizar la relación entre estas y la CdVRSO.
Métodos: Estudio cuantitativo, transversal y correlacional. Se realizaron entrevistas estructuradas, fundamentadas en un cuestionario socio-demográfico construido para tal efecto en la versión traducida y adaptada para la población portuguesa del *Oral Health Impact Profile* (OHIP-14-PT) en 151 ancianos de 9 Centros Residenciales para ancianos.
Resultados: Predominio del sexo femenino y viudos. La media de edad es de 84.4 ± 6.4 años. Casi el total de los encuestados tiene antecedentes patológicos y toma medicación.
La mayoría tiene dientes naturales (65.6%), pero 31.8% nunca cepillan los dientes y la boca.
El score medio del OHIP-14-PT es de 18.22. Los ítems más puntuados fueron la *Sensación de molestia al comer y* la *Necesidad de parar las comidas*. Hay diferencias estadísticamente significativas entre el *score* total del OHIP-14-PT y la literacidad de los encuestados.
Conclusión: La muestra auto relató un nivel moderado de QdVRSO. El edentulismo y la falta del uso de la prótesis dentaria predicen un peor QdVRSO. Hay dificultad de los ancianos al acceso para los cuidados de la salud oral.

Palabras clave: salud bucal; calidad de vida; anciano; centros de larga estancia para ancianos; enfermería en salud comunitaria

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INTRODUCTION

Although unevenly and at a slower pace, the world population continues to grow. Nowadays, due to the evidenced demographic changes and the inherent biopsychosocial characteristics, the elderly present themselves as a challenge for health professionals and services, and those who have greater health needs tend to be those who have less access to health care. Thus, the development of policies that overcome inequalities and that promote equity in the access to resources and services that enhance the health and the QoL of populations is emerging.

Oral Health (OH) is a fundamental human right that integrates health in general. Although, for decades, it has not been considered a matter of priority interest for political agendas, OH has significance in the physical and psychological dimensions, so that assessing health-related quality of life through the impact of oral condition contributes to the improvement of prevention and intervention strategies in OH. (Zucoloto, Maroco, & Campos, 2016; Dallasta, Medina, & Dallepiane, 2019).

The objective was to characterize the sociodemographic, clinical and behavioral variables and their relationship with QofLROH.

1. LITERATURE REVIEW

Aging reflects the socioeconomic development of public health of each nation, representing, at the same time, the enrichment of individuals. However, a new aging paradigm emerges that makes it imperative to guarantee the best possible health in old age in order to achieve sustainable development (WHO, 2017), as it, *if the extra years are dominated by the decline in physical and mental ability, the implications for older people and for society are much more negative* (WHO, 2015, p. 5). Thus, aging with health, autonomy and independence is an individual, collective and multisectoral challenge that translates itself into the countries' economies, as it is a progressive and continuous process throughout the individual's life cycle with changes in his biological, psychological and social structure.

A WHO (1999) defines the elderly as the individual aged 65 years old or over for developed countries, with this cutoff point being reduced to 60 years old when the population analysis concerns developing countries.

Likewise, it considers very elderly people to be chronologically aged 80 years old or more. However, more than a temporal definition of the elderly, it is imperative that society and policymakers have a critical and directed eye to the needs of this population setting and the challenges that are inherent to it.

As a result of the functional changes inherent to the progression of chronological age, there is a change in the skills of the elderly with regard to the response to external stimuli, which is why, throughout the life cycle, it is important to promote active and healthy aging based on positive experiences, so that the extension of life reflects opportunities for health, participation and safety instead of the social segregation of the elderly (Penetro, 2017).

Health in the elderly results from experiences lived throughout life and is influenced by a set of factors that define the level of health of the person in old age, encompassing areas as distinct as genetics and molecular changes, but also the economic, technological and cultural aspects. Although, in isolation, none of these variables can be enunciated as an etiological cause of the aging process or of the health and well-being status of the elderly, its multidimensional analysis predicts the way the individual and communities age.

In view of the above, it is permissible to affirm that health and aging are social and cultural constructions with biological determination and with repercussions on the self-perception of health. This is a relevant aspect to consider when assessing people's health level, since self-perception demonstrates, through an integral sphere perceived by the individual, their true health level. Román, Toffoleto, Sepulveda, Salfate and Grandon (2017) point out that the main component of satisfaction with the life of the elderly is self-perceived health, and a positive perception of the health conditions in which the elderly is essential for the balance and the maintenance of social roles and interaction with the family and society. Dichotomizing the health condition of the Human Being in health and disease is a complex process and permeable to a set of multidimensional factors, so it is important to interpret health as a positive concept, sensitive to the individual's personal, social and environmental resources and that integrates the measuring QoL and self-definition of health status (Zucoloto et al., 2016).

Watt, Heilmann, Listl and Peres (2016) highlight the relevance of the role of social determinants in inequalities in OH and add that it is the biological, socio-behavioral, psychosocial and political factors that dictate the contexts where the individual is born, grows, lives, works and finally ages. The association between these factors is continuous throughout the life cycle and transversal to different countries, regardless of their degree of development, which results in inequality and social injustice. In 2012, the International Dental Federation reflected on the future of OH in the world and set a goal for 2020 to adopt a more salutogenic model based on the prevention of disease and the promotion of a high OH index to the detriment of the traditional curative model. At the same time, it aims for a more targeted and comprehensive approach that includes all actors that can contribute to the improvement of the population's OH (FDI, 2015). Thus, governments and non-governmental organizations must join forces in order to find constructive solutions that aim to reduce social inequalities in the OH and that respond to the growing need and demand for OH care, guaranteeing access guided by equity and opportunity (FDI, 2015; WHO, 2019).

Considering the specific characteristics of the aged person, it is understood that there is an added set of barriers in the care of OH for the elderly, and WHO (2019) values the mobility deficit as a factor that hinders access to OH care essentially in residents in

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rural areas, the financial difficulties resulting from the transition to retirement aggravated by the costs of OH care, the precarious behaviors related to the surveillance and care of teeth and mouth and the solitary residence without support from friends, family or caretakers who are responsible for this need. Thus, it is essential to recognize the importance of maintaining OH throughout the entire life cycle in order to guarantee a growing and healthy life expectancy, so that, in the case of dependent or institutionalized elderly, caretakers assume an epicentric role in surveillance and provision of oral care (Zanesco, Bordin, Santos, Muller, & Fadel, 2018).

According to Cardoso (2014), there is a growing demand for OH professionals by individuals over 65 years of age. However, with regard to institutionalized elderly, there is a prevalence of a worse state of OH, which is associated with reduced oral hygiene care and the restriction of medical and dental care to urgent situations, with dental hygiene not being assumed. as a priority (Cardoso, 2014; Rekhi & et al., 2016). The evidence reported in the aforementioned studies contributes to the institutionalized elderly referring to low self-perception of health with the inevitable repercussion in the different dimensions while being holistic and in their QoL (Jerez-Roig & et al., 2016). In this way, it is important to ensure that RSfE managers establish plans and actions that promote and protect the OH of residents and raise awareness among caretakers, family members and the elderly themselves about the OH needs of these individuals.

2. METHODS

In order to observe the relationship between the variables resulting from or influencing the self-perception of QofLROH of elderly people institutionalized in RSfE, an empirical, cross-sectional and correlational study was undertaken, with a quantitative approach.

2.1 Sample

Among the elderly in the municipality of Bragança - Portugal, in January 2019, about 800 were institutionalized in the 22 RSfE available. The final sample of the research carried out includes 151 individuals, which represents 31.8% of the institutionalized elderly in the RSfE that integrate it and 18.7% of the institutionalized elderly in the municipality of Bragança.

2.2 Data collection

Data collection, which took place in the period from December 2019 to January 2020, was achieved by conducting, by a single researcher, a survey in the form of a structured interview based on the data collection instrument, taking place at the premises. the RSfE where the elderly person lives. On site, the identification of the elderly candidates to be part of the study was carried out by the technical director or person indicated by him, and the moment of data collection started by confirming the fulfillment of the inclusion criteria and signing the informed, free and clarified consent. The data collection instrument included a sociodemographic questionnaire built for this purpose and the OHIP-14-PT, this version being translated and adapted for the Portuguese population by Afonso (2014) of the Oral Health Impact Profile developed by Slade (1997). The OHIP-14-PT scores were interpreted based on the addition method for all items and dimensions, justifying this option as this is a method with better performance compared to the simple counting method.

The OHIP-14-PT includes two questions for each of the seven dimensions of the original version and has similar psychometric properties (Rodrigues, 2015).

2.3 Inclusion criteria

The following criteria were defined for the standardization of the analysis units: To be able to understand and sign the informed, free and clarified consent; to be 65 years of age or older; to have Portuguese nationality; to be institutionalized in RSfE in the municipality of Bragança.

All individuals who answered incorrectly to at least one question were excluded from the assessment of the orientation related to time, space and person included in the data collection instrument.

2.4 Procedures

In order to carry out the study, a favorable decision was obtained from the Ethics Committee of the Health Sciences Research Unit: Nursing at the Escola Superior de Enfermagem de Coimbra, according to Opinion nº P624 / 11-2019.

The integration of RSfE in the study was preceded by a request for authorization to perform the same addressed to the technical director.

Participants were asked to read, reflect and sign the informed, free and clarified consent that is attached. Anonymity, data confidentiality and the possibility of giving up at any time during the study were guaranteed, and the data collected will only be used in the present investigation and were destroyed at the end.

The use of OHIP-14-PT was preceded by the author's authorization.

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The statistical treatment of the data was processed in the Statistical Package for the Social Sciences® version 23 software, and the analysis of the use of descriptive and inferential statistical measures emerged. For statistical inference, non-parametric tests were used with a significance level of 0.05. The Chi-Square Adjustment Test was chosen to analyze the association of nominal and ordinal variables and Pearson's Correlation Coefficient to measure the degree of association between two quantitative variables.

3. RESULTS

The carried out investigation focused on 9 RSfE with a 100% occupancy rate at the date of data collection. Regarding the oral health of residents, this is a variable of concern for the leaders of all participating institutions, although only 3 regularly assess the oral condition of the elderly.

151 elderly people participated in the study, the youngest was 65 years old and the oldest was 99 years old, with an average age of 84.4 years (± 6.4 years). It was found that the median is 85.0 years, which allows us to affirm that it is a very aging population according to the definition adopted by WHO (1999). By age distribution according to gender, it was found that, on average, female participants are older than male participants (84.8 years, ± 0.64 years and 83.7 years, ± 0.89 years, respectively). When age groups are established according to the percentiles, 46.4% of the elderly respondents (n = 70) are between 86 and 99 years old and 27.2% (n = 41) are between 82 and 85 years old.

By analyzing the sociodemographic variables, it was confirmed that all participants are currently retired, that the vast majority are widowed (70.2%, n = 106) and have attended education up to the 1st Cycle of Basic Education (53.6%, n = 81) . With regard to the place of residence prior to institutionalization, 79.5% of the elderly (n = 120) lived in rural areas, which supports the type of activity performed by individuals, insofar as agriculture was the professional activity mentioned as occupation during active life for 43.7% of the sample (n = 66), followed by the profession of domestic worker (29.8%, n = 45), which makes the primary sector of activity the most representative (74.8%, n = 113).

Among the units of analysis, 96.0% (n = 145) reported having at least one pathology and 94.0% (n = 142) habitually taking some type of medication, with diseases of the circulatory system prevailing (71.5%, n = 108) and endocrine, nutritional and metabolic diseases (60.9%, n = 92).

With regard to addiction habits, it was aimed that 83.4% of the individuals (n = 126) never smoked and 13.3% (n = 20) smoked, but refer to no longer smoking while, in relation to alcohol consumption, 42.4% respondents (n = 64) never drank alcohol and 33.1% (n = 50) did so in the past.

Edentulism is present in 97.8% of respondents (n = 149), of which 34.4% (n = 52) have no teeth. Of the individuals with edentulous zones, the majority (53.7%, n = 80) do not use dental prosthesis.

Although the majority of respondents are in the habit of brushing their teeth and mouth (68.2%, n = 103), 31.8% (n = 48) never do so, and of the individuals who clean the oral cavity, 50.5% (n = 52) do it in the morning and 17.5% (n = 18) before bedtime. The remaining 32.0% (n = 33) brush their teeth and mouth more than once a day. Among the elderly who use dental prosthesis (45.7%, n = 69), 53.6% (n = 37) clean it more than once a day and 2.9% (n = 2) never do it.

At the time of data collection, 45.7% of respondents (n = 69) answered Yes to the question *Do you have a problem with your mouth or dental prosthesis that make you think you need an appointment with an oral health professional*?, but 55.0% (n = 83) reported not having the habit of attending consultations with oral health professionals. Of those who have this habit, the majority (91.2%, n = 62) do it only when necessary and, of the total of elderly people, only 4.0% (n = 6) do it regularly. With regard to the date of the last appointment with an oral health professional, it was shown that 17.2% of the participants (n = 26) never went to an appointment with these professionals and 25.8% (n = 39) did it more than 3 years ago.

The respondents' QofLROH self-report was assessed using OHIP-14-PT, obtaining an average score, according to the addition method, of 18.22, with a Minimum of 0.00 and a Maximum of 50.00 (±10.66). Most of the respondents never had the perception of inability to carry out their activities (86.8%, n = 131) and difficulty to perform them (75.5%, n = 114) due to problems related to teeth, mouth or dental prosthesis. Likewise, 76.8% of participants (n = 116) reported that oral condition has no meaning in the interaction with others and 56.3% (n = 85) that it has never prevented them from relaxing.

The most scored items were *the need to interrupt meals and the feeling of discomfort in the act of eating* due to problems related to the mouth, the teeth or the dental prosthesis, and for the first 39.7% reported discomfort sometimes (n = 60) and for the second, 35.1% (n = 53) attributed the same answer. Thus, the vast majority of the sample considers that the feeling of discomfort during eating (62.3%, n = 94) and the need to interrupt meals (60.9%, n = 92) have an impact on QoL. The remaining items of OHIP-14-PT were assessed by most respondents as having no impact on their QoL.

It was found that there is statistical significance between gender and tobacco use (p = 0.000), alcohol consumption (p = 0.000), the presence of natural dentition (p = 0.040), edentulous areas (p = 0.029) and the use of dental prosthesis (p = 0.019).

In the correlation between sociodemographic variables and OHIP-14-PT, it was found that there is an association between education level and Dimension 7 (p = 0.001) and the total score (p = 0.003) of OHIP-14-PT, showing that a higher level of literacy results in better QofLROH.

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In the correlation of clinical variables with the self-report of QofLROH, there are statistically significant differences between individuals with and without pathological history in Dimension 2 (p = 0.044) and Dimension 4 (p = 0.011) of the OHIP-14-PT. In respondents with natural dentition there are differences with statistical significance in Dimensions 2 (p = 0.035) and 5 (p = 0.015). Paradoxically, there was no statistical association between total or partial edentulism and self-reported QofLROH. The study of the statistical relationship between behavioral variables and QofLROH shows that there are no statistically significant differences between the dimensions of OHIP-14-PT and brushing of teeth and mouth and brushing of dental prosthesis, but there are between Dimensions 6 (p = 0.040) and 7 (p = 0.032) and the behavior of seeking appointments of oral health professionals.

4. DISCUSSION

The investigation of QofLROH in the elderly translates into contributions that guarantee the best possible health in old age, allowing the achievement of sustainable development goals.

In the present study, the institutionalization of elderly people in RSfE based in rural areas prevails. The preference for this location may come from the offer, but also from the fact that the majority of participants come from rural areas maintaining their residence in contexts close to those that characterized their life path. As recommended by the Directorate-General for Health (2017), it is expected that the individual, although elderly, will participate in the social, economic, cultural, spiritual and civic life of the community in which he / she operates, with the institutionalization in contexts close to those experienced during adult life contributing to active and healthy aging.

The female participants reported worse QofLROH, which overlaps what was evidenced by Gomes, Teixeira and Paçô (2015) and Beldiman et al. (2017) but does not reflect what was found by Castrejón-Pérez, Borges-Yáñez, Irigoyen-Camacho and Cruz-Hervert (2017) and by Umniyati, Surachmin and Ambarsati (2018) who evidenced the absence of differences in OHIP-14 scores according to gender. The attitude of women towards OH and health in general, resulting from their role as an element that assumes family care, can contribute to this giving greater meaning to the subjective aspects of OH and the repercussions it translates on health in general.

In the correlation of sociodemographic variables with OHIP-14-PT, there was an association with statistical significance between the level of literacy in the sample and the total score of OHIP-14-PT obtained by the addition method. These data mirror those found by Gomes et al. (2015), Beldiman, et al. (2017), Castrejón-Pérez et al. (2017) and Dallasta et al. (2019), it should be noted that a higher level of literacy is a protective factor in the holistic paradigm of the concept of health in general and can be associated with increasing demand and better access to information on health promotion and prevention of oral disease, which has significance in the condition of OH and, consequently, in the QofLROH.

Among the study participants, individuals with pathology of the circulatory system or endocrine, metabolic or nutritional disease reported worse QofLROH. Although, in isolation, the association between the pathological history and the therapeutic regimen of individuals allows only a restrictive and directed inference, the data under analysis can be justified by the fact that the occurrence of oral disorders may be dependent on the pathophysiology or drug treatment of patients. referred pathologies. Mata, Allen, McKenna, Hayes and Kashan (2019) corroborate this position based on the study they developed where they concluded that elderly people with comorbidities have worse QofLROH and that the use of certain groups of drugs, such as antihypertensives, increases the risk of the individual of developing oral disease.

The oral condition of the respondents is characterized by precariousness and reflects what was found in the population-based study carried out by the “Ordem dos Médicos Dentistas” (2019) and in the study carried out on institutionalized elderly in Barcelona by Cornejo, Pérez, Lima, Casals-Peidro and Borrell (2013) that showed the high prevalence of OH problems in residents, associating them with low QofLROH.

Bearing in mind that the research carried out was directed at a specific population setting, it is essential to bear in mind that the oral condition of the elderly results from the health course during the individual's life cycle. Among biological factors, age is a variable with significance in health in general and in OR, and advancing age is synonymous with a decrease in the level of OH (Umniyati, Surachmin et al., 2018; WHO, 2019). At the same time, the chronological perspective of the definition of strategies related to disease prevention and promotion of OH reveals the segregation of the elderly as the target group for the intervention, adding the fact that many individuals depend on the caregiver for access to OH care. In this context, the results measured in the developed study should be read and interpreted with special interest, as 73.6% of the participants (n = 111) are 82 years old or more and, in Portugal, like in the rest of Europe and the worldwide, access to OH is characterized by the difficulty and inadequacy of resources in face of population demands, namely with regard to the response given by the National Health Service. However, there is an evolution in policies that favor equity and access to healthcare.

In the elderly, self-assessment of OH is a complex variable that links beliefs, life path, access to OH care and behaviors acquired from oral hygiene habits, with this set of factors being represented in the elderly's self-perception of OH. Thus, the awareness of caretakers and the individual is urgent to adopt protective behaviors and to seek OH care as vehicles for improving QofLROH.

With regard to the specificity of the sample studied, institutionalization in RSfE can be understood as a facilitating and promoting factor for health care seeking behaviors, as well as for appropriate oral hygiene habits. However, the importance of the caretaker's

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role is emphasized, since, in the case of a very elderly population and with some functional limitations, it is essential to guarantee the individual's motivation and education, without neglecting the supervision of care. As a professional who is part of the multidisciplinary team of individual care, the Specialist Nurse in Community Health assumes a prominent position in the prevention of disease and in the promotion of OH, and, basing his performance on the methodology of health planning, he must make a concise state of health assessment of the most vulnerable settings and promote the empowerment of the individual and caretakers through awareness and instruction actions. According to Cunha, et al. (2014), in the OH, the nurse's performance must be evident in primary prevention, and the predictors of QofLROH may support the structuring of a program to promote OH in the elderly.

CONCLUSION

The sociodemographic characterization of the studied sample is representative of the regional and national population indicators, with no statistical significance between the sociodemographic variables and the level of self-reported QofLROH.
It was concluded that chronic diseases with significance in QofLROH predominate and that edentulism and the absence of use of dental prosthesis represent a worse level of self-reported QofLROH.
The nurse, due to the inherent skills and as a health professional close to the individual, assumes a prominent position with regard to primary prevention. Thus, it is suggested that, based on the knowledge they have regarding the predictors of QofLROH, nurses structure programs to promote OR in the elderly, and it is pertinent to define an interdisciplinary plan that aims to improve QofLROH, promoting active aging.
The limitations of the study are recognized as the sample size that does not allow the generalization of the results to the population of institutionalized elderly in RSfE, the scarcity of previous studies in institutionalized elderly and the time horizon defined by not allowing the design of a longitudinal study that would allow the determination of a causal ratio between the variables studied and the QofLROH.

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