The change from the pre-intervention to post-intervention response as Fair, Poor or Very poor to the post-intervention response as Very good or Good was defined as positive change in the rating of residents' oral health over the study period. The percentage of the positive change in the oral health rating for the residents who received both dental treatment and dental hygiene care over the study period was much greater than that of those who received daily oral hygiene only (p=0.019, Chi-square test) (Figure 6).

Figure 6: The positive change in the rating of resident’s oral health by receipt of dental treatment

Four items of the OHIP-9 showed reduced in their prevalence in the last four weeks (P<0.05, McNemar test) (Figure 7).

Neither the overall extent (the average number of impacts reported), nor the overall severity (the scale score) of OHIP-9 impacts changed significantly.

The baseline OHIP-9 scale score and the mean number of impacts decreased significantly (P<0.001, paired t-test) in residents with adverse impacts at baseline (Figures 8, 9).

The changes in the overall extent and severity of OHIP impacts were not associated with the level of residents’ contribution to reporting.

Discussion

The project advocated a team approach involving RNs, care workers and dental professionals to maintain residents’ oral health.

The availability of oral screening and referral by RNs, subsequent oral hygiene care by care workers and dental treatment, provided substantial effect on oral health status and self-reported oral health.

It has been documented that where elders’ views are difficult to obtain due to their impaired cognitive condition, a proxy (care or family member) rating of oral health status and oral health-related quality of life is a feasible alternative.

The participants in RCFs were largely composed of functionally dependent and cognitively impaired older adults. As many of them had difficulty in answering the questions alone, the proxy (their main carer or family member) report was a necessary approach to collect information on the resident’s oral health and OHIP-9.

The variation of the level of residents’ contribution to the questions on their oral health offered the opportunity to investigate the inclusion of proxy versus self-reported information on the impacts of oral disorders and their change from pre-intervention to post-intervention.

Conclusion

An improvement in oral health status and self-reported oral health was achieved after RNs, oral hygiene care and referral for dental treatment.

Improvement in oral health related quality of life only occurred for elders with adverse impacts pre-intervention.

Nursing care can make a significant difference to residents’ oral health.

References
