http://dx.doi.org/10.1590/1981-22562017020.170010

Perception of oral health in home care of caregivers of the elderly

Karla Bonfá[1]
Soraya Fernandes Mestriner[2]
Igor Henrique Teixeira Fumagalli[2]
Luana Pinho de Mesquita[3]
Alexandre Fávero Bulgarelli[4]

Abstract

Objective: to analyze the perception of caregivers of elderly persons regarding their own oral health care and that of the elderly individuals. *Method:* a descriptive-exploratory study with a qualitative approach was carried out. Semi-structured interviews with 13 caregivers were conducted, recorded and transcribed, and the Content Analysis technique was applied. *Results:* All respondents were informal caregivers, most of whom were female, aged over 50, married, had some degree of kinship with those receiving care, an incomplete elementary school education and no other occupation or job. After analyzing the interviews, the data were grouped into the following categories: a) home visits and health professionals; b) caregiver experience and care of the elderly; and c) the caregiver and their self-care. *Conclusion:* knowledge of caregivers' perception of their own oral health and that of dependent/semi-dependent elderly persons assists in planning, promotion, prevention and health recovery. The work of a multi-professional team is therefore essential in the seeking out and instruction of these individuals.

Keywords: Oral Health. Primary Health Care. Elderly. Caregivers.

[1] Universidade de São Paulo, Faculdade de Medicina de Ribeirão Preto, Residência Multiprofissional em Atenção Integral a Saúde. Ribeirão Preto, SP, Brasil.

[2] Universidade de São Paulo, Faculdade de Odontologia de Ribeirão Preto, Departamento de Estomatologia, Saúde Coletiva e Odontologia Legal. Ribeirão Preto, SP, Brasil.

[3] Universidade de São Paulo, Escola de Enfermagem de Ribeirão Preto, Programa Enfermagem em Saúde Pública. Ribeirão Preto, SP, Brasil.

[4] Universidade Federal do Rio Grande do Sul, Faculdade de Odontologia, Departamento de Odontologia Preventiva e Social Porto Alegre, RS, Brasil.

Research funding: Unified Scholarship Program for Undergraduate Students of the Universidade de São Paulo. Process number: 644

Correspondence
Karla Bonfá
E-mail: bonfakarla@gmail.com

INTRODUCTION

Human aging is accompanied by cognitive and functional disorders such as decreased muscle tone, joint stiffening and a reduction in visual acuity, which can lead to the frailty of the elderly[1-3]. These changes are collectively known as senescence and can lead to limitations in the everyday life of individuals, leaving them unable to perform their daily activities independently[4,5].

The performance of common activities of daily living (ADL) are fundamental for quality of life, such as the autonomy to walk, bathe, eat and pick out one's own clothes.

Elderly persons with total or partial dependence in performing these activities need to be assisted by a caregiver[3]. Such individuals should have undergone professional training and be hired by the family. Caregivers are often informal, meaning care is informally performed by a family member who resides with the elderly person, such as a father, mother, wife, or child[6,7]. In both cases, caregivers should assist the elderly individual and provide a healthy and positive quality of life[4].

In Brazil a large number of elderly persons use the Sistema de Único de Saúde (the Unified Health System) (SUS)[8], whose priority strategy for the management of primary health care is the Family Health Strategy (FHS)[9]. The FHS is a model of health care that relies on multiprofessional teams which are responsible for the accompaniment and care of people and families in a defined territory. One of the activities of such teams is carrying out home visits, which enables professionals to identify the health and life needs of families[9]. According to the National Policy on Elderly Health[10], a dentist is integrated within the minimum FHS team and has responsibilities such as home care, oral hygiene guidance and the clinical examination, diagnosis and treatment of dependent elderly persons.

The oral health care provided by caregivers may impair the quality of hygiene of the oral cavity, due to limited knowledge of the mouth and repulsion towards cavity and denture hygiene[11]. The practices of oral health care that caregivers perform on themselves are the same as those they use with the dependent elderly person[5]. Understanding their perceptions contributes to the development of oral health promotion and prevention actions[12].

In view of such assumptions, the objective of the present study was to analyze the perception of informal caregivers of the elderly about their oral self-care and the oral health care of the elderly.-

METHODS

A descriptive study with a qualitative methodological approach was performed, based on the participation of informal caregivers of dependent/semi-dependent elderly persons enrolled in the family health strategy of the municipal region of Ribeirão Preto. Through a partnership between the Ribeirão Preto Municipal Health Department and the Faculty of Medicine of Ribeirão Preto six family health units were created, known as Núcleos de Saúde da Família (Family Health Nuclei) (FHN). The FHN represent teaching and research areas for undergraduate and postgraduate students from the Universidade de São Paulo (the University of São Paulo). They have a minimal family health team and do not provide for the inclusion of oral health staff[13]. The participants were caregivers of the elderly registered with a FHN with a multiprofessional team. Although this unit does not have a dental health team in the mold of the Ministry of Health, it does include oral health professionals.

The caregivers were accessed through the registration of the elderly from the area covered by and under the responsibility of the FHN. In the period from May to September 2016, 20 elderly individuals aged 60 years or more and registered in the aforementioned Center, who potentially needed caregivers, were randomly selected. This was the initial process of sample construction. During home visits, the presence of caregivers and the frailties of these elderly persons were identified through the Katz-modified index[14,15] for the evaluation of ADL, in order to classify these individuals as dependent, semi-dependent and independent. Of these, 18 were eligible and their caregivers were invited to participate in the study. The researcher followed a guiding script of subjects and questions that dealt with: home care, home visits from dentistry professionals; needs of

caregivers regarding the oral health of the elderly; self-care in oral health; and oral health care practices.

With this initial number of participants, data was collected following the construction of an intentional sample by theoretical saturation. This sample is described as intentional due to the seeking out of actors that correspond to the established criteria, and based on theoretical saturation in relation to the object of study in the context of the oral health care of the elderly[16,17]. The conclusion of data collection occurred when the researcher believed, following a reading of the interviews, that the richness of the data collected was sufficient to achieve consensus on the research object in question, together with the theoretical contexts surrounding the same. As this saturation point was based on the cut-off point in relation to the object of the research, combined with the level of depth required and the homogeneity of the studied population, the number of caregivers interviewed was 13.

The interviews were audio recorded and transcribed. For ethical reasons, the identity of the individuals was preserved, with the nomenclature of Caregiver 1-13 adopted.

The process of data analysis began when the researcher came into contact with the reality being studied during the verbal production of the data in the researcher and researched interaction. Then, the systematization and analysis of the data was performed through the Content Analysis Technique, based on all the textual production. Analysis was performed in three stages, which were: the pre-analysis and exploration of the material; the treatment of data through the construction of thematic categories; and the inference and interpretation of the categories[18].

In pre-analysis, a general reading of the interviews was carried out to make first contact with the content and to organize the data. In this exploration of the empirical material the units of register and of context were identified, aiming to reach the nucleus of the general comprehension of the texts[18]. In data treatment, the data were transformed into categories according to emerging themes in the discourse of the caregivers. Through the inferences made by the researcher, based on their experiences in relation to the research object, the thematic categories were interpreted according the guidelines of the National Oral Health Policy[19].

The present study was approved by the Ethics Committee under number 51370815.8.0000.5414. All participants were invited to participate of their own free will and signed the necessary free and informed consent forms. The confidentiality of information that could identify any participant was respected.

RESULTS AND DISCUSSION

Charts 1 and 2 present the results of the socioeconomic variables of the 13 caregivers of the elderly, obtained through the completion of a questionnaire to determine the socioeconomic profile of each caregiver.

Chart 1 shows that all 13 caregivers were informal, while most were female, aged between 30 and 82 years and married. In relation to kinship, the majority were daughters or spouses of the elderly person. Two people were hired to serve as domestic staff and informal caretakers, and did not live in the same household as the elderly.

Chart 2 shows the socioeconomic data of each caregiver. Incomplete elementary school was the most cited level of schooling, with only one caregiver declaring themselves illiterate. It was observed that the majority did not have another occupation/job, while others worked as: domestic staff, day worker, laundry worker and cook temporarily absent from work.

Chart 1. Profile of caregivers according to the categories: demographic, social, kinship and formality of care. Ribeirão Preto, São Paulo, 2016.

Research participant	Age	Gender	Color/ Ethnicity	Marital status	Informal caregiver	Kinship	Live together
Caregiver 1	72	Female	White	Married	Yes	Wife	Yes
Caregiver 2	63	Female	White	Married	Yes	Daughter	Yes
Caregiver 3	57	Female	White	Single	Yes	Daughter	Yes
Caregiver 4	52	Female	White	Married	Yes	Daughter	Yes
Caregiver 5	58	Female	Black	Single	Yes	Domestic worker/Caregiver	No
Caregiver 6	30	Female	Black	Single	Yes	Daughter	Yes
Caregiver 7	82	Male	White	Married	Yes	Husband	Yes
Caregiver 8	68	Female	White	Married	Yes	Wife	Yes
Caregiver 9	46	Female	White	Married	Yes	Daughter in law	No
Caregiver 10	70	Female	White	Married	Yes	Wife	Yes
Caregiver 11	68	Female	White	Married	Yes	Domestic worker/Caregiver	No
Caregiver 12	56	Female	White	Divorced	Yes	Daughter	Yes
Caregiver 13	28	Female	White	Single	Yes	Daughter	Yes

Chart 2. Profile of caregivers according to categories: schooling, occupation/work, working day, time spent as caregiver and income. Ribeirão Preto, São Paulo, 2016.

Research participant	Schooling			Other occupation/job			Working day (hours)	Time spent as caregiver (years)	Income (Minimum salary)
	Illit.	Incomp Element.	Comp High.	Yes	No	Which?			
Caregiver 1		Yes			No		24	6	1
Caregiver 2			Yes		No		24	10	
Caregiver 3		Yes		Yes		Cook (off work)	24	2	2
Caregiver 4		Yes			No		24	1	<1
Caregiver 5		Yes			No	Domestic worker	8	3	Did not say
Caregiver 6	Yes			Yes		Day worker	9	2	< 1
Caregiver 7		Yes			No		24	10	2
Caregiver 8		Yes			No		24	1	1
Caregiver 9			Yes		No		10	1	None
Caregiver 10		Yes			No		24	2	1
Caregiver 11		Yes		Yes		Domestic worker	8	2	Did not say

The daily working time was 24 hours (69.23%) and eight to ten hours (30.76%). All those who reported working all day had some degree of kinship. The time spent working in the profession of caregiver ranged from one to three years (30.76%), four to six years (7.69%) and seven to ten years (23.07%).

The majority of caregivers had an individual income of at least one minimum salary from their pensions, while the others did not provide this information.

The profile of caregivers found in literature is similar to that obtained in this study, with mainly female informal caregivers, in the age group of 30 to 80 years, who are daughters or wives, have a low level of schooling and no other occupation/work[20-22].

From the data analyzed in the interviews, three categories of analysis emerged: a) home visits and health professionals; b) caregiver experience and care of the dependent/semi-dependent elderly; and c) the caregiver and his/her self-care.

Home visits and health professionals

The caregivers believed that home visits and greater commitment on the part of the FHN team to the health care of the elderly was important, despite limited knowledge about the role of the professional dentist. According to the National Oral Health Policy[19], oral health actions are home visits to people who are bedridden or have difficulty walking, for the follow-up, treatment and evaluation of possible health risks[19].

Some caregivers reported receiving a home visit from FHN professionals, especially community health agents and doctors. They also said that they had never been visited by a dentist or were not aware of the role of this professional in the FHN territory. Although the caregivers were unaware of the dental surgeon, home visits by such professionals are fundamental for assessing oral health status and providing care guidelines[23].

> "because they always come, don't they [...] like the other day the (family doctor) came [...], the community health agent came [...], they always come and see how we are..." (Caregiver 2).

> "Yes, the doctor comes" (Caregiver 8).

Other caregivers, meanwhile, received frequent visits from the dentist (undergraduate student, resident or preceptor):

> "yes... I'd always go... it was... in February (the student visit)" (Caregiver 1).

> "Ah, the (preceptor dentist) always comes" (Caregiver 12).

The professionals who performed oral health activities in the FHN are residents of the Multiprofessional Residency Program in Integral Health Care in Dentistry, 5th year students of the School of Dentistry of Ribeirão Preto of the University of São Paulo and a professional contracted by the respective college to acta as a preceptor to the students and residents.

The absence of oral health professionals who perform visits can be observed in the reports, as there is no oral health team hired for the FHN. The inclusion of a dentist in the team would allow planning of risks, the need for treatment and longitudinal follow-up[3,24].

It is stated in the National Oral Health Policy Guidelines[19] that health education should be performed by a dental surgeon, dental hygiene technician and/or dental assistant, and consider cultural differences, food, hygiene instruction and attention to care to the body itself. These activities may involve professionals from other health areas[3], especially during home visits.

Some caregivers described their views of the dentist in relation to the care model. They described dental treatment as the main activity to be performed with the elderly:

> "Interviewer: For your husband. What can the dentist do to help care for your husband?
>
> Interviewee: His teeth aren't good. If it was up to me I'd pull them all out" (Caregiver 10).

The lack of guidance regarding oral health may be associated with the perception of the need for the total extraction of the teeth of the elderly. This negative view regarding the health of the elderly involves aspects such as the difficulty of hygiene, greater ease in preparation of paste-based foods or difficulty of locomotion to visit the clinic (in this case the elderly person is semi-dependent and uses a wheelchair). The lack of instruction on techniques of bed-based oral hygiene with facilitating instruments was also a factor[25].

As the caregiver does not report pain or discomfort, the caregiver's perception may be associated with not knowing about the actions that the dentist can perform by relating the role of the dentist to curative practices. According to Dutra and Sanchez,[24] the care model is an active presence in the life of the elderly and interferes with their oral health, as they have experience of curative and invasive dentistry.

Two actions that contribute to care for the elderly perceived by caregivers were oral hygiene orientation and home visits by the dentist or the FHS team.

> "Guidance, for example, we need more, the more we learn the better we can deal with people, I think the most difficult thing is when the person has bad breath, it bothers people" (Caregiver 3).

> "I think so, brushing instructions should be written, not manual. This is oral hygiene for those who are bedridden, and it would help a lot" (Caregiver 11).

In contrast to the care model, actions should be created to promote oral health aimed at the elderly population[26], especially those directed at caregivers, as these individuals are mainly responsible for the oral health care of dependent/semi-dependent elderly persons[24].

The analyses performed in this category reveal the need for home visits by FHS oral health professionals, as the bonding, orientation and exchange of information and knowledge of these professionals with caregivers can contribute to the care of the elderly and their quality of life.

Caregiver experience and care of the elderly.

The adaptation of the activities carried out by caregivers to provide better oral health care and an improved diet for the elderly were described as part of their care routine. According to caregivers, most dependent/semi-dependent elderly persons use some type of dentures and pain or discomfort leads them to less frequent use or non-use.

According to caregivers, totally edentulous elderly persons who do not use dentures are fed with paste-based food. Tooth loss leads to changes in eating habits and food preparation by the caregiver. Some caregivers perceive the eating difficulties of dependent elderly and prepare paste-based foods so that they can feed themselves and have a better quality of life. On the other hand, in the perception of the caregivers, the absence of teeth makes it easier to clean the oral cavity and avoids complaints of pain and the need for transportation to the dental clinic.

One of the caregivers has worked for 40 hours a week for two years as the domestic staff and caregiver of a dependent elderly woman. She said that this elderly woman said that her dentures were causing pain and so has adopted new ways of preparing food:

> "She has to chew, for example, she can't chew apples. Even beef or other meat I prepare in the pressure cooker" (Caregiver 11).

Another difficulty reported by a caregiver to a health professional (speech therapist) was the length of time the elderly person took to eat. In this case, the elderly person could not put food in their mouth, depending on the caregiver, leading to physical and mental fatigue.

Changes in the oral cavity of the elderly may affect physiology, social interaction and the exercise of masticatory function and speech[4,11]. The preparation of food can lead to a good or bad diet and influence digestion. These authors also state that the lack of instruction on how to perform the oral health care of the elderly, their physical limitations and the excessive time devoted to this task generates poor care among caregivers.

Caregivers perceived aspects related to speech and aesthetics as important in the quality of life of the elderly. Chewing and swallowing were reported as difficulties in a study of elderly people with some type of dependence, as well as dissatisfaction with dental aesthetics[3]. In addition, a good physiognomy and suitable oral health care raise self-esteem, provide well-being and quality of life[11].

The majority of caregivers described examining the oral cavity of the elderly, but without the guidance of an oral health professional. The examination of the mouth is important when evaluating alterations such as spots or lesions, and the caregiver requires training and the guidance of a dentist to perform this task[27].-

The appearance of herpes-like wounds in the oral cavity of a dependent elderly woman was noticed by her caregiver, who used baking soda as a form of treatment, based on her beliefs and knowledge.

Another form of care provided was that related to the oral hygiene of the elderly, which is performed in different ways:

"Ah, I brush the teeth with toothpaste, then I use dental floss to clean his teeth" (Caregiver 1).

"In the shower I brush her teeth and tongue and inside the cheeks, and tell her to rinse and I wash the dentures in the sink" (Caregiver 11).

Another caregiver described not cleaning her mother's oral cavity as she had never received any instruction in this matter. A lack of confidence and the skills to perform this function were also mentioned[26].

It can be seen from this category that most caregivers were not instructed to perform essential actions in oral health care, such as the oral examination and hygiene of the elderly. There is therefore a need for planning and follow-up care by a multiprofessional team, including a dental surgeon.

The caregiver and his/her self-care

In order to better understand the care given to the elderly it is important to know the caregivers' perception of their oral health related self-care.

In the present study, most of the caregivers were older than 50 years, used some type of denture and did not feel pain or discomfort in the oral cavity. Some presented dissatisfactions such as difficulty with adaptation to dentures or the fracturing of the same, the non-use of dentures in one of the arches or non-use for financial reasons.

When the caregiver is older, the workload is greater, which can also influence their health conditions and self-care actions[4]. This age group seems to have experience of the invasive care model, which may explain the high rate of denture use. The oral health status of the caregiver is related to their perception of health and conception of oral health, socioeconomic conditions, insufficient income and limited schooling, which reduces the demand for dental services[12,24].

Few caregivers reported experiencing pain or discomfort in the oral cavity, cited tooth sensitivity to cold water, tooth remains or the sensation of a raised tooth. When they experienced any of these problems in the oral cavity, however, their self-perception of oral health was negative, affecting their quality of life[28].

One of the caregivers, who takes care of her mother and works as a day worker, said that she performed oral hygiene correctly and complained about having had teeth removed, but noticed that a piece of the tooth remained in her mouth and that there was gingival bleeding in this region. She also said she sometimes felt pain.

Most caregivers expressed no masticatory, speech or aesthetic difficulties. Those who had complaints described problems relating to the use of orthodontic appliances, greater dental loss in a quadrant of the oral cavity or dislike of their smile:

"Ah I can't eat properly, especially on the side where I have more missing teeth, on the left side" (Caregiver 5).

"I miss my smile. Because your smile is everything" (Caregiver 3).

In general in this study the self-perception of the oral health of the caregivers indicated an absence of discomfort or pain or masticatory, communication or aesthetic difficulty. The caregivers described, however, a desire to undergo some type of dental treatment. A retired caregiver who cared for her husband reported general health issues such as scoliosis and Chagas' disease and, dissatisfied with her mouth, seemed concerned about her oral health and revealed that she wanted dental treatment and new dentures.

Another caregiver reported problems with denture teeth. A younger woman, however, described dissatisfaction with having stopped her orthodontic treatment. She had completed high school but had no individual income and dedicated herself to the care of her mother 24 hours a day.

The willingness of caregivers to undergo dental treatment and inability to do so may be related to the time they dedicate to their roles, with little time to take care of themselves and a low income, resulting in mental and physical alterations and interfering with their well-being and role in society [4,22].

Maintaining good oral health is important for well-being and aging and the avoidance of oral and extra-oral diseases[11]. Some caregivers believe that an unsatisfactory oral cavity leads to changes in the body[29]. In addition, the constitutional principles of the SUS recognize that the oral health component is inherent to general health[30].

Most of the caregivers reported carrying out an oral self-examination, with some describing undergoing such an examination at the annual public dental clinic event or in their own home. FHS health professionals should provide guidance on how to perform oral self-examination and explain the importance of preserving the teeth in the oral cavity to consume foods essential for the functioning of the body[3]. Some authors have related oral self-examination to the positive or negative self-evaluation of oral health[12]. The interference of oral health on general health was discussed with caregivers. The absence of the lower teeth of the caregiver makes it difficult to chew, meaning that she feels that she does not have the same capacity to chew food, interfering with her diet.

In contrast to the findings regarding care for the elderly, most caregivers received instruction from the dentist on how to care for their mouths, said they did not experience difficulties during oral hygiene, and used toothpaste and a toothbrush. Some used dental floss and mouthwash, effervescent tablets and baking soda or vinegar for cleaning the prosthesis. Many performed their hygiene procedures according to their life experience.

> "Ah, I wash every day, after lunch too, once I went to the dentist and she gave me some pebbles (effervescent tablets) that you put in the glass with water and put the dentures in to clean them, so I do this". (Caregiver 12).

> "Interviewer: And how do you use baking soda?
> Interviewee: Ah ... we put it in the lemon and spread it.
> Interviewer: squeeze the lemon in the baking soda?
> Interviewee: yeah" (Caregiver 1).

> "I rinse, brush first with the toothbrush and toothpaste, then after I put on the toothpaste, I clean the dentures. I leave the dentures once a week in baking soda with water, or vinegar" (Caregiver 8).

Oral health care is complex and involves prior knowledge and life experience[11], as described in the accounts of the caregivers. Therefore, the principles, experiences and beliefs of the caregiver and the elderly person must be respected in order to align their cultural practices with the guidelines[27].

It can be seen that the caregivers have a positive self-perception of their oral health and perform self-care actions. They also show an interest in dental treatment due to aesthetic and/or functional issues. However, in addition to restricted knowledge about the role of the FHS dental surgeon, they have difficulties seeking out dental care.

The study presents limitations in that only informal caregivers of elderly people receiving care through the FHS were studied. As it is a study of the content of the textual material and the perception of the subjects, it cannot be said that such findings reflect phenomena, oral health care cultures or even theories about the object of the research.

CONCLUSION

The present study provides important results on the issue of oral health from the perspective of caregivers of the elderly. These results are relevant for the reality of the care to be adopted in relation to caregivers, so that they can provide adequate care for the oral health of the dependent elderly.

Understanding the perceptions of caregivers regarding oral health is essential for the planning of oral health promotion and prevention actions aimed at such caregivers and the elderly. The presence of a dental health team in family health units is essential to meet these needs, which will increase in coming years due to the growth of the elderly population.

REFERENCES

1. Anjos KF, Boery RNSO, Pereira R, Pedreira LC, Vilela ABA, Santos VC, et al. Associação entre apoio social e qualidade de vida de cuidadores familiares de idosos dependentes. Ciênc Saúde Coletiva. 2015,20(5):1321-30.
2. Santos PLS, Fernandes MH, Silva Santos PH, Borges STD, Cassoti CA, Da Silva CR, et al. Indicadores de desempenho motor como preditores de fragilidade em idosos cadastrados em uma Unidade de Saúde da Família. Motricidade. 2016,12(2):1-9.
3. Pedreira LC, Oliveira AMS. Cuidadores de idosos dependentes no domicílio: mudanças nas relações familiares. Rev Bras Enferm. 2012;65(5):730-6.
4. Saliba NA, Moimaz SAS, Marques JAM, Prado RL. Perfil de cuidadores de idosos e percepção sobre saúde bucal. Interface (Botucatu) [Internet]. 2007 [acesso em 31 jan. 2017];11(21):39-50. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832007000100005&lng=en.
5. Ciosak SI, Braz E, Costa MFBNA, Nakano NGR, Rodrigues J, Alencar RA, et al. Senescência e senilidade: novo paradigma na atenção básica de saúde. Rev Esc Enferm USP. 2011;45(n. Esp 2):1763-8.
6. Vargas AMD, Vasconcelos M, Ribeiro MTF. Saúde bucal: atenção ao idoso. Belo Horizonte: Nescon UFMG; 2011.
7. Fonseca MP, Rocha MA. Desvelando o cotidiano dos cuidadores informais de idosos. Rev Bras Enferm. 2008;1(7):801-8.
8. Reis SCGB, Marcelo VC. Saúde bucal na velhice: percepção dos idosos, Goiânia, 2005. Ciênc Saúde Coletiva. 2006;11(1):191-9.
9. Brasil. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da atenção básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Biblioteca Virtual de Saúde; 2011 [acesso em 31 jan. 2017]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html.
10. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica [Internet]. Caderno de atenção domiciliar. Vol. 1. Brasília, DF: Ministério da Saúde; 2012. [acesso em 31 jan. 2017]. Disponível em: http://189.28.128.100/dab/docs/publicacoes/geral/cad_vol1.pdf.
11. Pereira KCR, Guimarães FS, Alcauza MTR, De Campos DA, Moretti-Pires RO. Percepção, conhecimento e habilidades de cuidadores em saúde bucal de idosos acamados. Saúde Transform Soc. 2015;5(3):34-41.
12. Martins AMEBL, Barreto SM, Pordeus IA. Auto-avaliação de saúde bucal em idosos: análise com base em modelo multidimensional. Cad Saúde Pública. 2009;25(2):421-35.
13. Universidade de São Paulo, Faculdade de Medicina de Ribeirão Preto. Regimento do Centro de Atenção Primária e Saúde da Família e Comunidade (CAP) da Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo [Internet]. Ribeirão Preto: USP; 2015 [acesso em 20 jan. 2017]. Disponível em: http://cap.fmrp.usp.br/index.php?option=com_content&task=view&id=5&Itemid=6.
14. Pinto AH, Lange C, Pastore CA, Llano PMP, Castro DP, Santos F. Capacidade funcional para atividades da vida diária de idosos da Estratégia de Saúde da Família da zona rural. Ciênc Saúde Coletiva. 2016;21(11):3545-55.
15. Faleiros AH, Santos CAD, Martins CR, Holanda RAD, Souza NLSAD, Araujo CLDO. Os Desafios do Cuidar: Revisão Bibliográfica, Sobrecargas e Satisfações do Cuidador de Idosos. Janus. 2015;12(22):59-68.
16. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesqui Qualitativa. 2017;5(7):1-12.
17. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saúde Pública. 2011;27(2):389-94.
18. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
19. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica e Coordenação Nacional de Saúde Bucal. Diretrizes da Política Nacional de Saúde Bucal [Internet]. Brasília, DF: MS; 2004. [acesso em 31 jan. 2017]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_brasil_sorridente.pdf
20. Vieira CPB, Fialho AVM, Freitas CHA, Jorge MSB. Práticas do cuidador informal do idoso no domicílio. Rev Bras Enferm. 2011;64(3):570-9.

21. Gonçalves LHT, Nassar SM, Daussy MFS, Santos SMA, Alvarez AM. O convívio familiar do idoso na quarta idade e seu cuidador. Ciênc Cuid Saúde. 2011;10(4):746-54.

22. Warmling AMF, Santos SMA, Mello ALSF. Estratégias de cuidado bucal para idosos com Doença de Alzheimer no domicílio. Rev Bras Geriatr Gerontol. 2016;19(5):851-60.

23. Barros GB, Cruz JPP, Santos AM, Rodrigues AAAO, Bastos KF. Saúde bucal a usuários com necessidades especiais: visita domiciliar como estratégia no cuidado à saúde. Rev Saúde Comun. 2006;2(2):135-42.

24. Dutra CESV, Sanchez HF. Organização da atenção à saúde bucal prestada ao idoso nas equipes de saúde bucal da Estratégia Saúde da Família. Rev Bras Geriatr Gerontol. 2015;18(1):179-88.

25. Ferraz GA, Leite ICG. Instrumentos de visita domiciliar: abordagem da odontologia na estratégia de saúde da família. Rev APS. 2016;19(2):302-14.

26. Rocha DA, Miranda AF. Atendimento odontológico domiciliar aos idosos: uma necessidade na prática multidisciplinar em saúde: revisão de literatura. Rev Bras Geriatr Gerontol. 2013;16(1):181-9.

27. Gonçalves LHT, Mello ALSF, Zimermann K. Validação de instrumento de avaliação das condições de saúde bucal de idosos institucionalizados. Esc Anna Nery Rev Enferm. 2010;14(4):839-47.

28. Corrêa HW, Bitencourt FV, Nogueira AV, Toassi RFC. Saúde bucal em usuários da atenção primária: análise qualitativa da autopercepção relacionada ao uso e necessidade de prótese dentária. Physis. 2016;269(2):503-24.

29. Rovida TAS, Peruchini LFD, Moimaz SAS, Garbin CAS. O conceito de saúde geral e bucal na visão dos cuidadores de idosos. Odontol. Clín.-Cient. 2013;12(1):43-6.

30. Antunes JLF, Narvai PC. Políticas de saúde bucal no Brasil e seu impacto sobre as desigualdades em saúde. Rev Saúde Pública. 2010;44(2):360-5.

Received: February 11, 2016
Reviewed: July 04, 2017
Accepted: August 29, 2017