

ORIGINAL ARTICLE

Oral hygiene care in Intensive Care Unit: perceptions of nursing staff*

HIGHLIGHTS

1. Professionals report material shortages and workload.
2. Continuous training is essential to improving practice.
3. Standardized oral hygiene protocols are still limited or absent.
4. Invasive devices make care difficult and increase risks.

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ABSTRACT

Objective: Investigate the perceptions of nursing professionals about oral hygiene care performed in patients in intensive care. **Method:** Descriptive, qualitative study, conducted in the Intensive Therapy Unit of a hospital in North Minas Gerais, among nursing professionals. The data were collected by semi-structured questionnaires and analyzed using IRaMuTeQ (*Interface of R Pour les Analyses Multidimensionnelles de Textes et de Questionnaires*), in the period from October to November 2024. **Results:** 41 nursing professionals, aged from 24 to 55 years old, participated in the study, who reported difficulties in performing oral hygiene care of patients in the intensive care unit, including: the lack of materials and heavy workload. **Conclusion:** Nursing professionals perceive oral hygiene in intensive care patients as an essential but often neglected care due to lack of materials, overload and lack of protocols.

DESCRIPTORS: Oral Hygiene; Nursing; Intensive Care Units; Hospital Infection Control Program; Health Promotion.

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INTRODUCTION

Oral hygiene is a fundamental component of maintaining overall health and quality of life, playing a fundamental role in the prevention of oral diseases such as caries, gingivitis and periodontitis, which are directly related to the presence of bacterial biofilm and the lack of preventive care¹. Oral hygiene is recognized as a crucial role in the health of patients admitted to Intensive Care Units (ICUs), being considered an essential practice for the prevention of systemic complications and for the promotion of well-being during hospitalization. Critically ill patients are at greater risk of developing oral diseases, such as ventilator-associated pneumonia (VAP), one of the most common and severe healthcare-associated infections in ICUs, which may be associated with the accumulation of bacterial biofilm in the oral cavity².

Furthermore, inadequate oral hygiene can lead to systemic complications, such as cardiovascular diseases, diabetes and respiratory infections, especially in hospitalized patients or in situations of greater vulnerability, such as ICUs. Oral health is closely related to overall health, and an interprofessional approach that integrates health professionals in the promotion of preventive practices and in the awareness of patients about the importance of daily oral care is increasingly needed².

The lack of oral hygiene in hospitalized patients, especially in intensive care environments, favors the proliferation of pathogenic microorganisms that can be aspirated into the respiratory tract, significantly increasing the risk of lung infections and other complications. In addition, the presence of oral diseases such as periodontitis and untreated caries can lead to the spread of pathogens into the bloodstream, leading to bacteremia and potentially worsening patients' clinical conditions³.

Oral hygiene care can be carried out by nursing professionals, who play a crucial role in the promotion and maintenance of oral health of hospitalized patients, especially in the ICU. In this context, the Nursing team is responsible for performing and monitoring the oral hygiene of patients, aiming to prevent the accumulation of bacterial biofilm and, consequently, the occurrence of infections, such as VAP and bacteriemia⁴.

Therefore, this study aimed to investigating the perceptions of nursing professionals about oral hygiene care performed in patients in intensive care.

METHOD

This was a descriptive study of qualitative approach, conducted in a hospital in the North of Minas Gerais, in the period of October to November 2024. The place of study is characterized by a private, philanthropic and non-profit unit. The hospital has 134 beds, of which 123 are intended for the Unified Health System (SUS) and 11 for privately insured and self-paying patients, and has a staff of 325 employees, of which 200 are part of the Nursing team. The ICU of the hospital consists of 19 beds and a multi-professional team made up of doctors, physiotherapists, psychologists and nursing professionals (technicians, auxiliaries and nurses).

The methodology adopted followed the guidelines of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ), an internationally recognized instrument to ensure rigor and transparency in qualitative studies⁵.

All 52 nursing professionals working at the ICU were invited to participate in the study. The inclusion criteria were: to be a nursing professional (nurse, technician or nursing

assistant), to work in the ICU and to provide direct assistance to patients. Professionals who were on leave and those who exercised exclusively administrative activities were excluded from the study. The invitation to participate was made electronically, with the objectives of the study and the steps of data collection presented.

The data collection took place through the through semi-structured questionnaires, conducted by the researcher, with a duration of 30 minutes, from open questions to explore participants' perceptions about oral health care carried out at the ICU: 1 - How do you perceive the oral health care performed by the Nursing team, here in this sector? 2 - What difficulties do you encounter in performing oral hygiene of patients admitted to the ICU? 3 - Regarding the state oral health protocol, what strategies do you consider important to implement in the care of the ICU patient? The practitioners answered the questionnaire in the hospital at the appropriate time, without compromising their work activities.

The data collection was carried out by the researcher, who actively participated in all stages of the process, from the recruitment of participants to the analysis of the results. All responses derived from the participants' description were transcribed in full and a textual corpus was generated processed in the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ), which allowed the analysis in a thorough and statistically robust manner⁶. For the processing of the *corpus* in IRaMuTeQ, at least 20 participants are indicated. Thus, for this study, the theoretical saturation of the data was estimated as limiting the number of professionals included in study⁷.

Similarity analysis and Descending Hierarchical Classification (DHC) were used for analysis. DHC correlates segments and vocabulary forming a hierarchical scheme of classes making an analysis of groupings over text segments. The qui-square test (χ^2) aims to analyze the association between words and lexical classes, considering significant when $p < 0.0001$ ⁶.

The Descending Hierarchical Classification (DHC) structured the speeches of nursing professionals in classes, grouping them based on their similarities and differences, which made it possible to organize the data into relevant thematic categories^{6,8}.

Words that presented highly robust statistical significance ($p < 0.001$) were prioritized in the detailed analysis, ensuring an in-depth approach to the findings.

The Similitude analysis enabled the identification of the occurrences between the words and their result, presented by means of a graph, indicated the connection between them, demonstrating the relationships between the linguistic forms of the *textual corpus*⁹.

The dendrogram analysis was calculated from the formula used to calculate textual utilization⁶:

$$\text{Utilization (\%)} = \frac{\text{Classified Segments}}{\text{Total Segments} \times 100}$$

The study was approved by the Research Ethics Committee with Opinion No. 7.113.209. All participants signed the Free and Informed Consent Clause, ensuring the voluntariness and confidentiality of the information provided. The research followed all ethical precepts in accordance with Resolution 466/12 of the National Council of Health.

RESULTS

The study involved 41 nursing professionals, 31 (75.6%) women and 10 (24.4%) men, with ages ranging from 24 to 55 years. The weekly workload was 12 hours daily and 44 hours weekly for all participants, working on a 12x36 scale. The service time of professionals in the analyzed sector varies considerably, from 50 days to 14 years.

In the textual corpus derived from professionals' descriptions of oral healthcare provided in the ICU, IRaMuTeQ identified 41 texts, 80 text segments, and 2,712 word occurrences, comprising 519 distinct forms, of which 376 were hapax legomena.

The similarity chart visualizes the complex interrelationships between the key terms, highlighting the main challenges faced by Nursing professionals in the ICU and the proposed strategies to improve oral care (Figure 1).

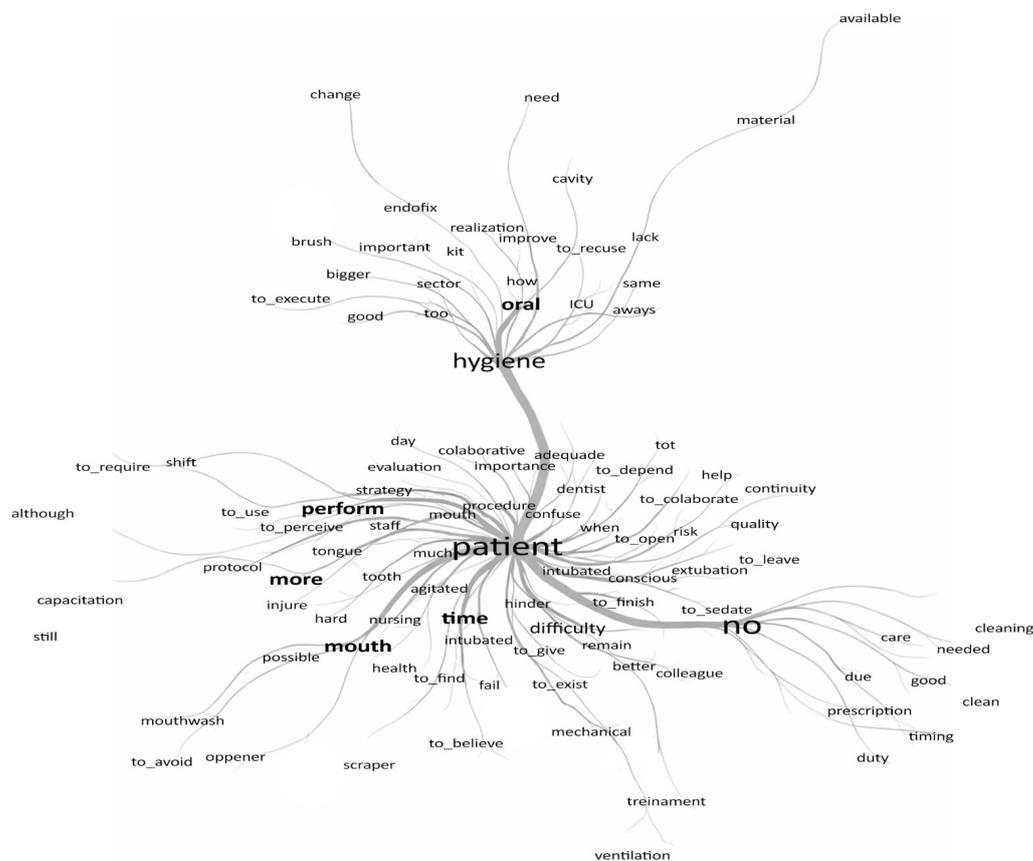


Figure 1. Similarity analysis, Niterói, RJ, Brazil, 2024

Source: Research data (2024).

In the similarity analysis, the central terms, such as oral hygiene, which appears directly connected to patients, professionals and material, refer to the difficulties faced by professionals when performing care with oral hygiene in patients. The connection between material and resources reflects a common concern among professionals about the availability and suitability of the materials needed for oral hygiene. The lack of suitable materials, such as chlorhexidine, is seen as a significant barrier to the effective execution of care.

Often in bad quality, as we don't always have materials available. (P3)

Chlorhexidine should stay in the sector, it is not necessary to leave the sector to

pick up this item. (P5)

I perceive the difficulty of some professionals to perform this procedure, either due to lack of time, lack of material or lack of patient care. (P5)

I see that they make a lot of effort to exercise oral hygiene, but they often leave to be desired. The difficulty lies in the lack of proper material, I always see the lack of it (P14).

The difficulty of accessing the oral cavity, the presence of invasive devices, such as orotracheal tubes, and the need for training were questions widely described by the participants, indicating barriers in the work process and in health care that directly impact the performance of oral hygiene in the ICU.

The difficulty I encounter is when the patient is restrained and not sedated and in the patient's consciousness agitated. (P2)

Conscious patient, often by his own refusal, intubated patients, sometimes with stiff jaw. (P6)

The terms training and professional development are related to the need for continuous education of professionals to ensure that oral hygiene techniques are performed effectively and safely. The connection of these terms with protocol and POP (standard operational procedure) suggests the importance of following clear guidelines and conducting frequent training sessions.

Though training on the subject is carried out, it is still deficient. (P16)

More training and qualification. (P21)

It would be important to see a dentist at least once a week or every fifteen days for further evaluation. (P2).

Terms such as evaluation and monitoring highlight the need to continuously monitor oral hygiene practices, ensuring that protocols are followed and that gaps are identified and corrected quickly. The inclusion of dentists for evaluation and the use of *checklists* are seen as important strategies to improve the quality of care. Dentist appears connected with evaluation and professionals, indicating that the presence of dentist in the ICU is considered essential to ensure more specialized care to patients, in addition to offering technical support to the Nursing team.

Regular dental evaluation and follow-up. (P31)

More visits from a healthcare professional, a dentist and not only when the patient's case or oral situation is already compromised. (P38)

Have more professionals in this area who can help more, as a dentist. (P40).

Based on the analysis of the presented dendrogram, the textual corpus obtained an utilization of 78.75%. An utilization above 75% is considered good, as it indicates that most segments were used in the analysis of the Hierarchical Descending Classification. The dendrogram demonstrates the division of the corpus into two main subgroups, which unfold into specific classes with their respective percentages of representation. The first subgroup includes classes 2 (14.3%), 5 (14.3%), 1 (14.3%) and 6 (19.0%), totaling 61.9% of the corpus. It is observed that classes 1, 2 and 5 are strongly grouped, indicating greater similarity among themselves, while class 6, although related, presents slightly more distinct characteristics, appears as an extension of this group.

The second subgroup includes classes 3 (20.6%) and 4 (17.5%), representing 38.1% of the corpus. This subgroup stands out for dealing with aspects more related to the need for materials and improvement strategies in oral hygiene, evidencing a more focused approach to resource management and the importance of training of health professionals. The sum of the percentages of the two subgroups confirms the consistency of segmentation, totaling 100% of the corpus.

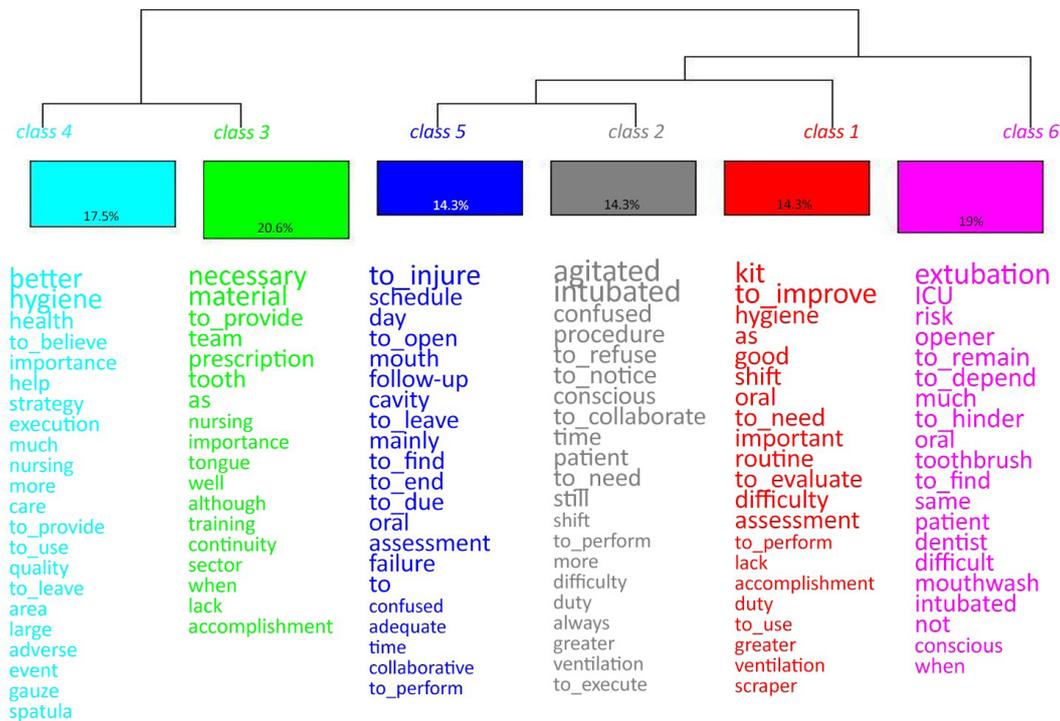


Figure 2. Descending Hierarchical Classification (DHC), Niterói, RJ, Brazil, 2024
 Source: Research data (2024).

Classes: Class 1, Class 2 and Class 5 form a group with interrelated topics. In these classes, the predominant lexical forms are associated with the implementation and maintenance of nursing protocols and practices in an ICU. Terms such as protocol, training, registration, technique, evaluation and documentation are highlighted, reflecting the emphasis on training strategies, practical evaluation and registration of oral hygiene activities and other intensive environment care. Classes: Class 3 and Class 4 are also very close, indicating a distinct group from the other classes. Terms related to Nursing in oral health at ICU included words such as: staff, patient, care, hygiene, nursing and staff.

Thus, based on their lexical and thematic characteristics, the two subgroups were named, namely: 1: Challenges and Limits in Mouth Hygiene in ICU; 2: Strategies for Improving and Importance of Care.

Group 1 includes classes that highlight the difficulties, barriers and limitations found in performing oral hygiene, including lack of materials, insufficient training and technical challenges.

It is not effective due to lack of proper material and lack of training. (P26)

The difficulty lies in the lack of proper material, I always see the lack of it. (P14)

There could be more investment and training. (P32)

In addition, structural and organizational barriers directly affect the delivery of care. Overwork and insufficient staff creates a scenario in which oral hygiene is often put in the background. Under such circumstances, professionals tend to prioritize procedures considered more urgent, while oral care, although essential for the patient's health, is treated as secondary. This reflects a lack of institutional priority and clear protocols that integrate oral hygiene as an indispensable part of intensive care.

I notice that often good hygiene is not carried out due to the lack of collaboration of patients and also due to the lack of care of professionals. (P1)

Mouth hygiene is a failure, especially in the execution of the procedure, which is not always performed successfully. (P24)

Another critical point are the patients' clinical conditions, such as sedation, intubation and agitation states, which often make access to the oral cavity difficult and make the oral hygiene procedure challenging. The presence of invasive devices, such as endotracheal tubes, further complicates the scenario, increasing the risks of adverse events, such as accidental extubations. These factors require the team not only to have advanced technical skills, but also specific strategies to deal with these situations, which are not always available or well disseminated.

Here at CTI we rely heavily on the physiotherapist in intubated patients, as the risk of extubation is very high. (P3)

Some patients are not completely sedated, which makes it difficult to manage the patient's mouth, risking accidental extubation. (P5)

Patient doesn't open his mouth, conscious. Patient doesn't accept sometimes. Patient intubated, risk of extubation. (P39).

The participants' remarks highlight a perception of negligence and frustration with the irregular quality of care, suggesting an urgent need for structural reorganization and greater investment in training and resources. In the general context, the challenges identified reveal deep problems in the organizational environment and in the management of ICU resources.

The implementation of this care is not prioritized, compromising the patient's health status. (P11)

The main barriers faced are the mechanical resistance of some patients, lack of collaboration of others, team members and even the patient with high risk of extubation. (P11)

The difficulty is found in agitated intubated patients. (P12)

Realized to the extent possible, in some patients there is the need to perform more often and is not always possible in some shifts due to number of procedures. (P19).

The speakers highlight faults in the consistency and quality of oral care, mentioning problems such as the lack of collaboration of patients and negligence by some professionals. These speeches indicate a frustration with the variation in the quality of care, which suggests the need for more standardized practices and greater individual accountability within the teams. The lack of consistency may be related to the lack of proper training or the absence of strict protocols that ensure uniformity in the provision of care.

Group 2, named as Strategies of Improvement and Importance of Care, stands out in practices of improvement, training and the relevance of oral care in ICU, as well as specific strategies for its implementation. This group addresses the proposed strategies and the valuation of oral hygiene as a crucial element for the general well-being of patients in ICU. The speeches of the professionals reflect a broad understanding about the importance of this care and suggest concrete actions to overcome the limits identified in the implementation of this practice.

Good, as it is noted that it is held regularly. Unconscious patient, sometimes there is difficulty, as he remains with his mouth and teeth tightly closed, making cleaning difficult. More training and training. (P21).

It is worth awareness professionals and be able to change this reality with new attitudes and strategies for the achievement of better oral hygiene, so that each move more in favor of the patient, providing comfort and contributing to its improvement. (P41)

One of the main solutions pointed out is the implementation of regular training for the Nursing team, focusing on technical updating and improving the practices related to oral hygiene. The professionals emphasize that continuous training is indispensable, as it enables a more qualified and consistent execution of the procedures, in addition to promoting a greater awareness of their relevance in the prevention of oral and systemic complications. The creation of a Standard Operational Procedure (POP) was widely suggested, with the aim of standardizing care and ensuring uniformity in execution.

Regular training is essential to improve the technique and ensure patient safety. (P22)

I believe that training is always necessary to empower the team. (P17)

In addition, the importance of integrating specialists, such as dentist surgeons, in the ICU teams was reiterated. This proposal is seen as a way to bring greater specialization to oral care, allowing assessments to be carried out by professionals trained to identify and treat specific complications. The presence of dentists in the ICU is also pointed out as an opportunity for the development of educational strategies, benefiting both patients and nursing staff, who could learn directly from these specialists.

Another point raised was the absence of monitoring tools, such as daily *checklists*, to ensure consistency of care. These tools have the potential to create a more organized and responsive environment, in which all aspects of oral hygiene are systematically evaluated and met. It was also suggested to conduct regular dental evaluations for hospitalized patients, promoting a more preventive and proactive approach to care.

Implementing a daily checklist would ensure that the procedures were performed correctly. (P25)

Dentist visit and use of oral opener to facilitate care. (P7)

In this sector, oral hygiene is performed to the extent possible of good quality, in most patients it is performed 3 times a day. (P17)

Regular dental evaluation and follow-up. (P31)

Finally, professionals recognize that despite the challenges, oral care performed, when performed correctly, has a significant impact on the well-being of patients. This

recognition is aligned with the constant quest for improvement and reinforces the importance of investing in resources, training and clear protocols.

The institution should implement a Standard Operational Procedure (POP), along with training, with practices that make professionals collaborate even more with the prevention of adverse events. (P25)

As much as professionals know, the importance of doing oral hygiene still leaves much to be desired, we can improve a lot, always seeking to do the best for patients. (P28)

The desire to improve care reflects a culture of excellence in construction, where the appreciation of teamwork and commitment to patient health take a prominent place.

DISCUSSION

The difficulties referenced by nursing professionals raise an important concern, as oral health is directly linked to the quality of life of individuals, influencing not only the ability to feed and communicate, but also self-esteem and physical comfort. In hospitalized patients, especially in ICUs, regular practice of proper oral hygiene is essential to reduce the risk of infections, such as pneumonia associated with mechanical ventilation, and to prevent the development of periodontal diseases that may aggravate the clinical picture¹⁰.

The accumulation of bacterial biofilm and the colonization of the oral cavity by pathogenic microorganisms can compromise the patient's recovery and prolong the time of hospitalization. Therefore, oral health care should be recognized as an integral part of care, requiring a multidisciplinary approach to the implementation of oral hygiene protocols¹¹.

The absence of essential items such as proper toothbrushes and antiseptic solutions, including chlorhexidine, compromises the quality of oral hygiene, increasing the risk of complications, such as respiratory infections associated with mechanical ventilation¹². The referenced study also emphasizes and corroborates the importance of training health professionals to optimize the use of available resources and improve the assistance provided in ICUs, minimizing the aggravations arising from negligence with oral health¹².

Standardization can only be effective when professionals have adequate conditions and support to follow the established protocols, guaranteeing safe and humanized care, and preventing complications related to lack of oral hygiene, which directly impact the overall health of hospitalized patients¹³.

When healthcare professionals have access to quality materials in sufficient quantity, they can follow evidence-based protocols, implementing safer and more effective practices. This not only improves clinical outcomes, but also raises the quality of care and promotes the satisfaction of professionals, who feel more empowered and supported to perform their functions.

Patients in critical conditions or in situations of physical and cognitive impairment, who are often sedated, intubated or immobilized, present a high risk of developing oral and systemic diseases due to the lack of adequate oral hygiene¹⁴.

Therefore, the importance of carrying out this practice among critical patients is highlighted, aiming at minimizing infections, especially those associated with mechanical ventilation, such as pneumonia associated with mechanical ventilation (PAVM), which represents a significant risk for patients admitted to ICU. Proper oral hygiene contributes to reducing the microbial load in the oral cavity, reducing the risk of pathogen aspiration into the lower respiratory tract, as well as promoting patient comfort and general well-being. Regarding work-related aspects, a literature review conducted from 2018 to 2022 corroborates the scientific findings of this research, addressing that overload was pointed out as an important factor in the delivery of care, directly affecting the quality and frequency of oral hygiene¹⁵.

The high demand for care, coupled with the reduced number of professionals and the intense hourly load, can lead to the priority of interventions considered more urgent, causing preventive practices, such as oral hygiene, to be neglected or executed inappropriately. In addition, the lack of continuous training, the absence of standardized protocols and the scarcity of essential materials, such as toothbrushes, antiseptic rinses and chlorhexidine solutions, aggravate this scenario. To overcome these barriers, it is critical to invest in continuing education strategies, optimizing the available resources and implementing institutional policies that prioritize integral care, ensuring that oral health is effectively incorporated into the care routines of critical patients¹⁶.

Facing these adversities with appropriate strategies, such as continuous training of the staff, use of evidence-based protocols and integration of dentist surgeons into the multidisciplinary team, is essential to ensure the quality of care and provide greater comfort and safety to patients. Therefore, the insistence on performing oral hygiene, even in challenging scenarios, reflects the commitment to health promotion and effective patient recovery, ensuring complete and humanized care¹⁰.

The adoption of standardized protocols for practices such as oral hygiene allows all professionals to follow guidelines based on scientific evidence, ensuring that the procedures are carried out in a consistent and effective manner. However, the implementation and maintenance of these standards face significant challenges, such as the workload of the Nursing team and the lack of suitable materials¹⁰.

It is also worth noting that the inclusion of dental surgeons in the ICU team represents a significant advance in the quality of care provided to critical patients, providing more specialized and comprehensive assessments regarding oral health. The presence of these professionals in the hospital environment allows for a more targeted approach in the early identification of oral changes and diseases that, if not treated properly, can lead to serious systemic complications, such as pneumonia associated with mechanical ventilation and infections resulting from the spread of pathogens from the oral cavity to other parts of the body¹³. However, the unit where the study was conducted does not have this professional, which may be a barrier to the evaluation of oral hygiene of patients, according to reports of nursing professionals.

The technical support offered to nurses is also an important factor for continuous training of the staff, promoting a better understanding of the importance of oral health in patient recovery and minimizing the risks of complications associated with lack of proper hygiene. Therefore, the insertion of dental surgeons in the ICU not only complements the multidisciplinary team, but also raises the standard of care, contributing to a more integrated, humanized and targeted care to the specific needs of critical patients¹⁵.

In addition to the importance of oral hygiene to prevent accumulation of secretions and improve breathing, more complex aspects of intensive care deserve to be considered. Recent evidence suggests that oral health can directly interfere with the

regulation of the gastrointestinal microbiota and the integrity of epithelial barriers, impacting the gut-brain axis and thus the emotional well-being of critical patients¹⁶. The reconstitution of the oral and gut microbiome has been linked to the modulation of regulatory T cells (Tregs) and the inflammatory response mediated by Th17 cells, which play a key role in mucous immunity and clinical recovery of patients in intensive care, including those with long COVID-19 or prolonged sepsis frames¹⁷⁻¹⁸. Changes in Th17/Treg balance have been associated with the duration of stay in the ICU and the severity of the clinical picture, interleucine-22 (IL-22) being one of the key mediators in the regulation of epithelial inflammation and neutrophil recruitment¹⁹. Therefore, nursing actions that promote the restoration of the oral and intestinal microbiota, through qualified oral care, the use of appropriate antiseptics and integrative strategies with nutrition and rehydration, can contribute to a more regulated immune response, prevention of dysbiosis and, consequently, to the functional and emotional recovery of the patient.

This study contributes significantly to nursing assistance in Intensive Therapy Units (ICU) by highlighting the challenges faced by professionals in the practice of oral hygiene, such as the scarcity of materials, the workload and the absence of standardized protocols. By capturing the perception of professionals, the research reinforces the need for structural and educational investments that support the systematic and safe execution of this care. The findings support the urgency of permanent training, the implementation of Standard Operational Procedures (SOP) and the inclusion of the dentist surgeon in the multidisciplinary team, promoting comprehensive, humanized and evidence-based assistance.

This study not only contributes to the practice of nursing in intensive care units, but also adds relevant knowledge to the area of collective health by highlighting structural, technical and educational gaps related to oral hygiene of critical patients. By giving voice to the perceptions of nursing professionals, the urgent need for effective integration with other professional categories, such as Odontology, is highlighted, and the potential of a truly interdisciplinary action is pointed out. Although the focus has fallen back on the dental contribution, it is possible to see the positive impact of the insertion of other professionals, such as nutritionists, physiotherapists and occupational therapists, whose complementary approaches can enrich the comprehensive care of the critical patient.

Thus, the study offers practical and theoretical subsidies to strengthen the safety of the critical patient, reduce infectious complications and improve the quality of intensive care provided by the Nursing team. For comparative purposes and considering the temporal context of the institutional routine, it is recognized the importance of presenting updates on the dynamics of ICU assistance. With the advancement of institutional policies and possible changes in the availability of care materials and protocols, it becomes relevant that future studies address the evolution of these practices over time. This would enable understanding whether the barriers identified in this study remain or have been overcome by management initiatives and permanent education, in addition to clarifying in which clinical situations certain oral hygiene practices are applicable or should be adjusted according to the complexity of the cases treated.

CONCLUSION

Faced with the perceptions of nursing professionals, difficulties and barriers were identified for the realization of oral hygiene care of patients in intensive therapy, with

emphasis on material resources, the clinical picture of the patient, related work and organizational aspects.

In this context, the provision of appropriate materials, training and the use of monitoring tools are practical steps that can be implemented to overcome the barriers found, improving oral health care and, consequently, contribute to the safety and recovery of critical patients. Thus, the continuous education and the action of the multidisciplinary team in the ICU environment emerge as fundamental strategies to ensure the quality of care, broadening the multidisciplinary approach and promoting a more holistic and efficient care.

In addition to technical aspects, the professionals demonstrate legitimate concern for the well-being of patients in recovery, reinforcing the importance of oral hygiene not only as preventive care, but also as a measure of comfort and immunological protection. The oral microbiota plays a significant role in antiviral immunity and in the maintenance of symbiotic processes, which reinforces the need for careful practices without causing injuries or discomfort. Simple procedures, such as gentle cleaning even without the use of toothpaste, can be effective and safe, especially in critical patients.

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