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Home care for older adults with dysphagia: integration of speech-language pathology, dentistry, and family caregivers for safe oral feeding

Cuidado domiciliar à pessoa idosa com disfagia: integração entre Fonoaudiologia, Odontologia e cuidador familiar para a segurança da alimentação por via oral

Cuidado domiciliar a la persona anciana con disfagia: integración entre Fonoaudiología, Odontología y cuidador familiar para la seguridad de la alimentación por vía oral

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Abstract:
Oropharyngeal dysphagia is common among older adults and may compromise the safety and efficiency of oral feeding, being associated with malnutrition, pneumonia, increased use of health services, and mortality. In the home setting, these risks are influenced by swallowing pathophysiology, oral health status, and the way professional recommendations are implemented in daily care. This integrative review with a structured search analyzed how coordination among speech-language pathology care, dental care, and family caregiver involvement may contribute to safer oral feeding for older adults with dysphagia. The search was updated on August 20, 2026, in PubMed/MEDLINE, SciELO, and the Cochrane Library and was supplemented by Brazilian official documents and reference tracking. The final corpus comprised 17 scientific publications, published from 2018 to 2026, and three official/regulatory documents. The evidence supports the central role of speech-language pathology in swallowing assessment and management; indicates associations between dental, prosthetic, salivary, and oral hygiene conditions and aspects of oral function; and shows that family caregivers play an important operational role in the daily implementation of the care plan and in communicating clinical changes to the healthcare team. Safe oral feeding at home should therefore be understood as the result of integrated, individualized, and periodically reassessed care, without attributing to any single intervention the ability to prevent multifactorial complications such as aspiration pneumonia.

Keywords: Deglutition Disorders; Aged; Home Care Services; Oral Health; Caregivers.

Resumo:
A disfagia orofaríngea é frequente na população idosa e pode comprometer a segurança e a eficiência da alimentação por via oral, associando-se à desnutrição, à pneumonia, à maior utilização de serviços de saúde e à mortalidade. No domicílio, esses riscos são influenciados pela fisiopatologia da deglutição, pelas condições de saúde bucal e pela forma como as orientações profissionais são executadas no cotidiano. O objetivo desta revisão integrativa com busca estruturada foi analisar como a articulação entre assistência fonoaudiológica, cuidados odontológicos e atuação do cuidador familiar pode contribuir para a segurança da alimentação por via oral de pessoas idosas com disfagia. A busca foi atualizada em 20 de agosto de 2026

nas bases PubMed/MEDLINE, SciELO e Cochrane Library, complementada por documentos oficiais brasileiros e rastreamento de referências pertinentes. O corpus final reuniu 17 publicações científicas, de 2018 a 2026, e três documentos oficiais/normativos. As evidências sustentam o papel central da Fonoaudiologia na avaliação e no manejo da deglutição; indicam associações entre condições dentárias, protéticas, salivares e de higiene bucal e aspectos da função oral; e mostram que o cuidador familiar desempenha papel operacional relevante na aplicação cotidiana do plano e na comunicação de mudanças clínicas à equipe. Conclui-se que a segurança da alimentação por via oral no domicílio depende de cuidado integrado, individualizado e reavaliado periodicamente, sem atribuir a uma única conduta a capacidade de prevenir complicações multifatoriais, como a pneumonia aspirativa.

Palavras-chave: Transtornos de Deglutição; Idoso; Serviços de Assistência Domiciliar; Saúde Bucal; Cuidadores.

Resumen:
La disfagia orofaríngea es frecuente en la población anciana y puede comprometer la seguridad y la eficiencia de la alimentación por vía oral, asociando la desnutrición, la neumonía, la mayor utilización de servicios de salud y la mortalidad. En el domicilio, esos riesgos son influenciados por la fisiopatología de la deglución, por las condiciones de salud bucal y por la forma como las orientaciones profesionales son ejecutadas en lo cotidiano. El objetivo de esta revisión integradora con búsqueda estructurada fue analizar como la articulación entre asistencia fonoaudiológica, cuidados odontológicos y actuación del cuidador familiar puede contribuir para la seguridad de la alimentación por vía oral de personas ancianas con disfagia. La búsqueda fue actualizada el 20 de agosto de 2026 en las bases PubMed/MEDLINE, SciELO y Cochrane Library, complementada por documentos oficiales brasileños y rastreo de referencias pertinentes. El corpus final reunió 17 publicaciones científicas, de 2018 a 2026, y tres documentos oficiales/normativos. Las evidencias sustentan el papel central de la Fonoaudiología en la evaluación y en el manejo de la deglución; indican asociaciones entre condiciones dentales, protéticas, salivares y de higiene bucal y aspectos de la función oral; y muestran que el cuidador familiar desempeña un papel operacional relevante en la aplicación cotidiana del plan y en la comunicación de cambios clínicos al equipo. Se concluye que la seguridad de la alimentación por vía oral en el domicilio depende de cuidado integrado, individualizado y reevaluado periódicamente, sin atribuir a una única conducta la capacidad de prevenir complicaciones multifactoriales, como la neumonía aspirativa.

Palabras clave: Trastornos de Deglución; Ancianos; Servicios de Asistencia Domiciliar; Salud Bucal; Cuidadores.

1 Introduction

Population aging increases the relevance of clinical conditions that interfere with autonomy, nutrition and the safe stay of the elderly in their own home. Among these conditions, oropharyngeal dysphagia deserves attention because it compromises the safe and efficient transfer of food, liquids, saliva and medications through the oral and pharyngeal phases of swallowing, with potential repercussions on hydration, nutritional status, respiratory health and quality of life (Yang et al., 2023). In a meta-analysis involving adults aged 60 years or older,

Banda et al. (2022) estimated a clustered prevalence of oropharyngeal dysphagia of 46% and showed an association with a higher risk of pneumonia, malnutrition and mortality.

The magnitude of the problem becomes particularly important in home care. Montero et al. (2025), when evaluating 1,002 elderly and functionally committed people inserted in a community home care program, identified prevalence of oropharyngeal dysphagia of 25.95%. The alteration was associated with a history of pneumonia and a higher frequency of medical visits, reinforcing the need for screening also outside hospitals and institutions. In another cohort of 162 elderly people with dysphagia followed at home, Furuya et al. (2025) observed that severe dysphagia was the main factor associated with interruption of home care due to pneumonia; malnutrition and previous history of pneumonia were identified as potential contributing factors and, therefore, should be interpreted with less certainty.

Despite the strong association between dysphagia and respiratory events, aspiration pneumonia should not be interpreted as a linear and inevitable consequence of an aspiration episode. A recent scope review identified a broad set of associated factors, including dysphagia, aspiration, malnutrition, dehydration, neurological conditions, changes in mobility and functional dependence, as well as factors related to hospitalization (Rossi et al., 2026). This multifactorial nature is especially relevant at home, where clinical conditions, available resources, knowledge of the caregiver, organization of meals and access to the health team interact continuously.

In this context, Speech-Language Pathology occupies a central position in the care of people with dysphagia. Clinical guidelines recommend systematic evaluation, identification of compromised mechanisms and selection of therapeutic and compensatory strategies according to the swallowing profile (Yang et al., 2023). In Brazil, Resolution CFFa no. 719/2023 assigns to the speech therapist, among other competencies, the identification of the risk for dysphagia, evaluation of the swallowing biomechanics, definition of the speech therapy diagnosis, elaboration of the therapeutic plan, indication of consistency, posture, utensils, volumes and, when necessary, prescription of the degree of thickening, always focusing on the safety and efficiency of the oral offer (Federal Council of Speech Therapy, 2023).

Home care, however, requires that swallowing assessment be articulated with factors that precede and accompany swallowing. Chewing, formation and lubrication of the bolus, presence and condition of the teeth, stability of the prostheses, strength and mobility of oral structures and availability of saliva can modify the efficiency of the preparatory and oral phases. The systematic review by Drancourt et al. (2022) found at least one positive association between dental, salivary or muscular components of oral health and dysphagia in 18 of the 19

included studies, although the predominance of observational designs prevents causal inference.

Brazilian data reinforce this interface. In a population study with 5,432 ELSI-Brasil participants, Aquino et al. (2024) found a prevalence of self-reported dysphagia of 30% among non-institutionalized elderly individuals; participants with 10 to 19 permanent teeth had a higher prevalence of the complaint compared to those with a higher number of teeth. In institutionalized elderly people, Morais et al. (2026) identified associations between dysphagia and fewer functional teeth, absence of occlusal pairs, caries, gingivitis and important xerostomy. In a broader scope, Morales et al. (2026) mapped relationships between tooth loss, inadequate prosthetic hygiene, reduced bite force, reduced lingual pressure, xerostomy and swallowing, nutrition and respiratory health aspects. Thus, dental participation is not restricted to the treatment of isolated oral diseases, but it integrates the evaluation of factors that can interfere in food preparation, comfort and oral function.

Another relevant component is the microbial load of the oral cavity. Potential pathogenic microorganisms present in the biofilm and oral secretions may integrate the aspirated material. Khadka et al. (2021), in a systematic review with elderly people living in long-term institutions, identified oral colonization by microorganisms associated with respiratory infections and lower occurrence of aspiration pneumonia in groups undergoing professional oral care. However, the effect of oral hygiene interventions on pneumonia remains uncertain. The Cochrane de Cao et al. review (2022), with six randomized trials and 6,244 participants from long-term care institutions, classified as low certainty the evidence to reduce the incidence of pneumonia, although it has identified a possible reduction in pneumonia-associated mortality in some follow-up. Therefore, oral hygiene should integrate a risk reduction plan, but cannot be presented as an isolated measure capable of preventing pneumonia.

At home, professional recommendations only produce effect when they can be incorporated into the routine. The family caregiver participates directly in the preparation and offer of food, oral hygiene and daily observation of the elderly person's response to the orientations received. Belmonte et al. (2024), in a Brazilian qualitative study conducted after dehospitalization, identified strategies of caregivers related to the safe supply of food, oral hygiene and the continuity of speech therapy monitoring, highlighting the role of the caregiver in the hospital-house transition.

Daily responsibility, however, can produce overload. Rangira et al. (2022) estimated, in a systematic review, that approximately 71% of caregivers of adults with dysphagia had some

degree of overload, with reports of fear of aspiration, changes in the preparation of meals, effects on social life and lack of support. Namasivayam-MacDonald and Shune (2018) found convergent findings among family caregivers of elderly people with dysphagia living in the community. Therefore, the caregiver's training should be accompanied by support, accessible communication and periodic reassessment, avoiding the simple transfer of technical responsibility.

The Brazilian home care policy also favors an integrated approach. The Home Care Program for the Elderly (Padi), established by the GM/MS Ordinance no. 9.584 of December 22, 2025, provides for multidisciplinary home care, multidimensional evaluation, elaboration, execution and monitoring of the care plan and guidance and support to the family and caregivers (Brazil, 2025). Convergently, Resolution CFFa n. 644/2021 regulates educational and care speech therapy actions at home directed to the attended person, family members and caregivers, including in a multidisciplinary team (Federal Council of Speech-Language Pathology, 2021).

Despite the existence of relevant evidence on dysphagia, oral health and the role of the caregiver when analyzed separately, studies that evaluate, in the same home intervention, the systematic integration between Speech-Language Pathology, Dentistry and Family Caregiver are less frequent. This gap justifies a synthesis that connects clinical mechanisms and practical responsibilities without extrapolating the strength of available evidence.

Therefore, this review has as guiding question: how the integration between speech therapy, dental care and family caregivers can contribute to the safety of oral feeding of elderly people with dysphagia in the home environment? The objective is to analyze the evidence related to these three components and discuss an individualized home care organization, focused on safety, food efficiency, care continuity and early recognition of clinical changes.

2 Method

This is an integrative review of the literature, descriptive and analytical, with structured search, designed to gather evidence of different study designs on home care for elderly people with dysphagia. The option for this method was based on the proposal of Whittemore and Knafl (2005), according to which the integrative review allows to gather and synthesize sources of different methodological approaches, provided that the process of identification, analysis and presentation of evidence is explained with rigor. This characteristic proved to be adequate to this question, which articulates epidemiological, clinical, dental, care and qualitative evidence, as well as normative documents relevant to Brazilian practice.

The guiding question was organized through an adaptation of the PICO strategy - Population, Phenomenon of Interest and Context -, used in this study as a resource of conceptual delimitation of the question, and not as a criterion to restrict the corpus to qualitative studies (Munn et al., 2018). The following were defined: population (P) - elderly people with dysphagia; phenomenon of interest (I) - integration between speech therapy, dental care and family caregivers; and context (Co) - home environment and safety of oral feeding. The electronic search was updated on August 20, 2026 in the bases PubMed/MEDLINE, SciELO and Cochrane Library, complemented by consultation with official acts and documents of the Ministry of Health and the Federal Council of Speech-Language Pathology and Audiology and by tracking the references of relevant studies.

Search terms and descriptors were used in Portuguese and English, combined by Boolean operators. The preserved search records allow identifying the following main thematic blocks: dysphagia OR "oropharyngeal dysphagia" OR "deglutition disorders"; aged OR olderly OR "older adults"; "home care" OR "home care services" OR caregiver*; "oral health" OR dentistry OR "oral hygiene"; "aspiration pneumonia"; and "speech-language pathology". The combinations were organized according to the axes of dysphagia and home care, dysphagia and oral health, aspiration pneumonia and oral hygiene/health and dysphagia and caregivers, as well as searches directed towards guidelines and normative documents. Since the complete history of searches carried out on each base has not been preserved, no retrospectively reconstructed integral strings are presented, avoiding attributing to the process a documentary accuracy that cannot be proven.

Studies with elderly or predominantly elderly adult samples, focusing on oropharyngeal dysphagia, oral feeding, oral health, home care, experience or training of caregivers and related clinical complications, were considered eligible. Systematic reviews, meta-analyses, scope reviews and guidelines applicable to the adult population were included when they contributed directly to the interpretation of geriatric care. We excluded exclusively pediatric studies, studies with no direct relationship with swallowing or feeding and non-scientific materials without normative or care functions.

The selection was performed by reading titles and abstracts, followed by full reading of publications considered pertinent to the guiding question. The final analytical corpus of this synthesis was composed of 17 scientific publications, dated 2018 to 2026, and three Brazilian official/normative documents. Systematic and scope reviews were predominant, complemented by meta-analysis, clinical guideline, observational studies, qualitative study and household cohort. The methodological references used to support the design of the integrative review and

the structuring of the question were not accounted for in the analytical corpus. No formal tool was applied to assess the risk of bias of individual studies, which constitutes a methodological limitation of this integrative review and prevents comparative quantitative classifications of evidence quality.

The interpretation favored the correspondence between each statement discussed and the most appropriate study design to support it. For prevalence and prognosis, meta-analysis and community/domestic research were prioritized; for the interface between oral health and swallowing, systematic reviews and population study; for oral hygiene and pneumonia, systematic reviews and Cochrane review; and for the caregiver, home studies and reviews on overload. Evidence from long-term institutions was maintained when relevant, but treated as indirect evidence for the home context.

The findings were organized into six axes: (1) characterization of the evidence included; (2) dysphagia and clinical vulnerability of the elderly person at home; (3) contribution of Speech-Language Pathology to the safety of oral feeding; (4) contribution of Dentistry and oral health; (5) family caregiver as an operational link of the care plan; and (6) interdisciplinary integration. No meta-analysis was performed due to the heterogeneity of populations, interventions and outcomes.

3 Results and discussion

The set of 17 scientific publications showed heterogeneity of designs and scenarios, an aspect compatible with the integrative nature of the question. A relevant part of the evidence directly home focused on prevalence, continuity of care and practices of the caregiver, while studies on oral health and pneumonia prevention were often conducted in long-term institutions. This difference in context was considered in the interpretation, avoiding automatic transfer of institutional results to the household.

Table 1 - Characterisation of scientific publications included

Study	Design/context	Contribution to this review
Aquino et al. (2024)	Cross-sectional population study; 5,432 non-institutionalized elderly people (ELSI-Brasil).	Self-reported dysphagia in 30%; association between lower number of teeth and higher occurrence of the complaint.
Banda et al. (2022)	Meta-analysis; adults aged 60 years or older in different care settings.	It estimated a clustered prevalence of oropharyngeal dysphagia of 46% and an association with pneumonia, malnutrition and mortality.
Belmonte et al. (2024)	Qualitative study; caregivers of elderly people after dehospitalization.	He described safe offer strategies, oral hygiene and continuity of speech therapy follow-up.

Study	Design/context	Contribution to this review
Cao et al. (2022)	Cochrane review; 6 randomized trials, 6,244 residents of institutions.	Evidence of low certainty to reduce the incidence of pneumonia; possible reduction in mortality associated with pneumonia.
Drancourt et al. (2022)	Systematic review; 19 studies with elderly people.	Eighteen studies showed an association between at least one component of oral health and dysphagia; causality was not demonstrated.
Furuya et al. (2025)	Retrospective cohort; 162 elderly people with dysphagia in home care, follow-up of 2 years.	Severe dysphagia was the main factor associated with interruption of home care due to pneumonia.
Hansen et al. (2022)	Systematic review update; 3 randomized trials.	He found no convincing evidence that thickened fluids or modified diets prevent pneumonia or death.
Hsiao et al. (2022)	Preliminary cross-sectional study; 35 home patients with nasogastric tube and oral intake.	It identified an association between assisted feeding practices and factors related to aspiration pneumonia in a small and highly specific sample.
Khadka et al. (2021)	Systematic review; 12 studies in long-term institutions.	He related potentially pathogenic oral microorganisms to aspiration pneumonia; heterogeneity limited quantitative synthesis.
Montero et al. (2025)	Cross-sectional study; 1,002 elderly people in a community home care program.	Prevalence of dysphagia of 25.95%; association with history of pneumonia and greater use of consultations.
Morais et al. (2026)	Systematic review; 11 studies with institutionalized elderly people.	Lower number of functional teeth, absence of occlusal pairs, caries, gingivitis and xerostomy were associated with dysphagia.
Morales et al. (2026)	Scope review; 87 studies with people aged 60 years or older.	It mapped relationships between tooth loss, prosthetic hygiene, bite force, tongue pressure, dry mouth and swallowing, nutrition and respiratory health aspects.
Namasivayam-MacDonald and Shune (2018)	Systematic review; family caregivers of community elderly.	It evidenced the impact of dysphagia on caregiver overload.
Rangira et al. (2022)	Systematic review; 17 studies with caregivers of adults with dysphagia.	Meta-analysis suggested that about 71% had some degree of overload.
Remijn et al. (2022)	Systematic review; 8 studies of oral health interventions in dysphagia.	He found heterogeneous interventions and little evidence of reduced aspiration pneumonia.
Rossi et al. (2026)	Scope review; 56 studies.	It mapped multifactorial factors associated with aspiration pneumonia in adults and the elderly.
Yang et al. (2023)	Clinical practice guideline; 19 key questions on oropharyngeal dysphagia.	It gathered evidence-based recommendations for evaluation, management and prevention of complications.

Source: elaboration of authors from the included publications.

3.1 Dysphagia and clinical vulnerability in the home environment

The synthesis of evidence confirms that dysphagia in the elderly should not be interpreted only as an isolated symptom. Conditions such as frailty, sarcopenia, neurological impairment, loss of independence and other comorbidities may coexist with dysphagia and increase clinical vulnerability. Banda et al. (2022) demonstrated an association between oropharyngeal dysphagia and pneumonia, malnutrition and mortality, while Rossi et al. (2026) confirmed that aspiration pneumonia results from the interaction of multiple clinical, nutritional and functional factors.

At home, the lower availability of continuous professional monitoring makes it important to recognize changes that justify reassessment. Coughing or choking during meals, vocal alteration after swallowing, increased meal time, fatigue, reduced intake and changes in breathing pattern are clinical findings that deserve attention. When clinical evaluation is not sufficient to clarify the mechanism of dysphagia or guide the conduct, instrumental methods may be necessary as the case may be (Yang et al., 2023).

Household studies also highlight the importance of nutritional status. Furuya et al. (2025) identified severe dysphagia as the most clearly associated factor with interruption of home care due to pneumonia; malnutrition and previous history of pneumonia were suggested as potential contributors, as confidence intervals indicated less precision for these factors. These findings support the monitoring of food and water intake, weight, acceptance and meal time, with integration of Nutrition and the medical team when signs of insufficient intake or clinical deterioration appear.

Another critical aspect is to avoid the simplification that every elderly person with dysphagia automatically needs a pasty diet and thickened liquids. Hansen et al. (2022) found no convincing evidence that thickened liquids or modified texture diets prevent pneumonia or death, nor that they improve quality of life, nutritional status or oral intake. Texture and viscosity modifications may be useful in specific situations, but should result from individual evaluation of swallowing and be reassessed in the light of hydration, acceptance, adherence and clinical evolution.

The safety of oral feeding should therefore balance airway protection, maintenance of sufficient intake, comfort, possible autonomy and quality of life. A strategy that improves a safety parameter during evaluation, but significantly reduces acceptance or ingestion in daily

life, may create other risks. This balance reinforces the need for individualized and shared decisions with the elderly and their care network (Hansen et al., 2022).

3.2 Speech therapy: evaluation, management and individualization of oral feeding

In the field of dysphagia, Speech-Language Pathology has central technical skills for the functional evaluation of swallowing and for the definition of strategies directly related to the oropharyngeal transit of bolus. Resolution CFFa no. 719/2023 establishes competencies that include risk identification, screening, biomechanical evaluation, speech therapy diagnosis, development of a therapeutic plan, referral to other professionals and definition of consistency, posture, utensils, volume and thickening when clinically indicated (Federal Council of Speech Therapy, 2023). These attributions are consistent with guidelines that recommend systematic evaluation and selection of interventions according to the mechanism of dysphagia (Yang et al., 2023).

At home, speech therapy evaluation should consider not only performance at a specific time, but also the concrete conditions in which feeding occurs. Level of alertness, positioning, available utensils, consistency of diet and participation of the caregiver may interfere in the safety and feasibility of the plan. This contextual view approximates the technical orientation of its daily application (Federal Council of Speech-Language Pathology, 2021, 2023; Belmonte et al., 2024).

Compensatory strategies may involve postural adjustments, volume adequacy per offer, rhythm control, selection of utensils, and texture or viscosity modification. The indication should not be standardized, as the effect of each strategy depends on the pathophysiological pattern and individual response; recommendations maintained indefinitely without reassessment may become unnecessarily restrictive or insufficient (Federal Council of Speech-Language Pathology, 2023; Yang et al., 2023).

In addition to compensatory measures, the plan may include rehabilitation intervention aimed at specific deficits in strength, coordination or swallowing efficiency, according to evaluation and therapeutic objectives (Yang et al., 2023). The speech therapist should also establish criteria for monitoring and reassessment, especially in the face of clinical worsening, recurrent infections, altered level of consciousness or functional decline.

The CFFa Resolution no 644/2021 recognizes that the work in home care may include educational and care actions directed to the attended person, family members and caregivers. Resolution CFFa no 719/2023 also includes, among the competencies in dysphagia, the development of educational actions for interprofessional team, caregivers, family members and

clients. In this context, caregiver training integrates the therapeutic process. Based on the synthesis of this review, it is recommended that the guidelines be explained and demonstrated in a practical manner and that their understanding and applicability at home be reassessed periodically (Federal Council of Speech-Language Pathology, 2021, 2023; Belmonte et al., 2024).

3.3 Dentistry, oral function and risk related to oropharyngeal secretions

The oral feeding phase depends on the integration between teeth, prostheses, tongue, mucosa, saliva, muscles and sensory-motor control. When these conditions are compromised, cake formation and manipulation may become less efficient. Drancourt et al. (2022) demonstrated an association between oral health components and dysphagia in elderly people, and Morais et al. (2026) identified a higher risk of dysphagia associated with a lower number of functional teeth, absence of occlusal pairs, caries, gingivitis and important xerostomy in institutionalized elderly people.

The Brazilian study by Aquino et al. (2024) adds population relevance to this interface. Among 5,432 non-institutionalized elderly people, the prevalence of self-reported dysphagia was 30%, and the group with 10 to 19 permanent teeth presented a higher prevalence of the complaint compared to participants with a higher number of teeth. Because this is a cross-sectional study, causality cannot be established; however, the data reinforce the need to consider dental and prosthetic conditions in the investigation of eating difficulties.

Morales et al. (2026), in a scope review with 87 studies, expanded this perspective by mapping evidence that relates tooth loss, inadequate prosthetic hygiene, reduced bite force, reduced lingual pressure and xerostomy to changes in swallowing function. In the whole of the literature reviewed, unfavorable oral health conditions were also related to nutritional and respiratory outcomes. In home care, this reinforces that pain, unstable prosthesis, important dry mouth, lesions and masticatory limitation should not be treated as peripheral elements, but as conditions capable of modifying the comfort, choice of foods and efficiency of the oral phase.

The second dental interface involves oral microbiota. Khadka et al. (2021) identified colonization of the oral cavity by microorganisms potentially associated with respiratory infections in institutionalized elderly people. In individuals who aspire to oropharyngeal secretions, the microbial load of the aspirated material is a biologically plausible component of respiratory risk. However, because it is predominantly derived from long-term institutions, this evidence should be extrapolated to the household with caution.

The strength of evidence on oral hygiene interventions remains limited. Remijn et al. (2022) found heterogeneous interventions and little evidence of reduced aspiration pneumonia in people with dysphagia. Similarly, Cao et al. (2022) classified evidence of reduced incidence of pneumonia by professional oral care in institutions as low certainty, although they have observed a possible reduction in mortality associated with pneumonia in some studies. Thus, this review does not support oral hygiene alone preventing pneumonia; it maintains that oral health and biofilm control integrate a multifactorial set of risk reduction measures.

In summary, the available evidence justifies the inclusion of oral health in the care of the person with dysphagia, but do not authorize attributing to oral hygiene, alone, a guaranteed preventive effect on pneumonia. Oral care should integrate a broader strategy that considers dental and prosthetic conditions, xerostomy, functional capacity for hygiene, risk of aspiration and need for dental follow-up, always recognizing that much of the pneumonia data comes from long-term institutions and has indirect applicability to the household (Khadka et al., 2021; Remijn et al., 2022; Cao et al., 2022).

3.4 Family caregiver as operational link and safety observer

Oral feeding occurs several times a day and, at home, the caregiver often follows most of these situations. Therefore, the quality of the plan depends on its translation into clear and viable actions. Belmonte et al. (2024) showed that caregivers of elderly people with dysphagia after dehospitalization developed strategies related to the preparation and supply of food, oral hygiene and continuity of speech therapy follow-up, highlighting the importance of hospital-house transition.

The observation of feeding practices reinforces the need for training. Hsiao et al. (2022), in a preliminary cross-sectional study with 35 home patients who used a nasogastric tube associated with oral ingestion and had presented aspiration pneumonia in the previous year, identified associations between factors related to aspiration pneumonia and certain feeding practices, such as use of large spoon, offering more than 5 mL at a time and meals lasting more than 30 minutes. The sample was small and highly specific; therefore, these values should not be transformed into universal rules, but the study reinforces the need for individualized orientation of assisted feeding.

For operational purposes, the synthesis of this review organizes the participation of the caregiver in four moments: preparation, supply, monitoring and care after the meal. In the preparation, the individual plan should be followed for consistency, volume and mode of supply; during the meal, respect positioning, rhythm and defined utensils; in monitoring,

observe tolerance, fatigue, cough, choking, vocal alteration, difficulty breathing and reduced acceptance; and, after the meal, perform guided care, including oral hygiene. The team should explain which signs require interruption of the offer and professional reassessment (Federal Council of Speech-Language Pathology, 2023; Yang et al., 2023).

This paper requires bidirectional communication. The caregiver needs to be able to report low acceptance of certain consistency, sleepiness during the meal, reduced intake, difficulty in hygiene or any functional change. These comments may indicate that a previously appropriate plan is no longer viable and needs to be reassessed.

It is also necessary to recognize the emotional and operational burden imposed on the caregiver. Rangira et al. (2022) identified overload associated with fear of aspiration, changes in food preparation, limitation of social life and lack of support. Namasivayam-MacDonald and Shune (2018) found convergent results among caregivers of elderly people in the community. Education should be objective, demonstrative, repeated when necessary and compatible with the physical, cognitive and emotional capacity of the caregiver.

The family caregiver does not replace professional decisions. Its function is to perform previously defined care, observe changes and maintain communication with the team. In Brazil, the indication of the consistency of the diet, the definition of the volume from the perspective of the safety of swallowing and the prescription of the degree of thickening are speech-language skills; Resolution CFFa no. 719/2023 also provides for the participation of the speech therapist, together with the multidisciplinary team, in the suggestion of indication or removal of alternative feeding pathways. Decisions on maintenance or suspension of oral feeding should therefore consider the overall clinical picture and interprofessional activity, without being transferred to the caregiver (Federal Council of Speech-Language Pathology, 2023).

3.5 Integration between speech-language pathology, dentistry and caregiver: proposal for organization of care

The literature analyzed suggests that oral food safety at home can be understood as a chain of interdependent decisions. Speech-Language Pathology evaluates swallowing and defines the functional conditions of offer; Dentistry identifies and treats oral factors that can interfere in chewing, preparing cake, comfort and microbial load; and the caregiver applies the plan daily, observing its viability and communicating changes between professional evaluations. The guideline of Yang et al. (2023) contemplates the approach by multidisciplinary team as conditional recommendation, with low level of evidence, which supports integration without justifying statements of definitive clinical benefit.

This integration does not presuppose that all elderly people need the same intensity of follow-up by all professionals. Based on the synthesis of evidence, referral should be guided by the needs identified in each case. Oral pain, unstable prosthesis, relevant xerostomy, lesions or difficulty in hygiene indicate the relevance of dental evaluation; changes in swallowing or difficulty with the prescribed consistency indicate the need for speech therapy reassessment; weight loss, insufficient intake or signs of dehydration require nutritional and clinical evaluation; and acute respiratory symptoms or suspected infection require evaluation by the health team according to severity. This organization is consistent with the multifactorial nature of the risk and with the recommendation of a multidisciplinary approach, without representing an already demonstrated efficacy protocol (Rossi et al., 2026; Yang et al., 2023).

The home plan should be registered in operational language. Instead of vague orientations, such as "slow feeding", it is recommended to specify, according to individual evaluation, positioning, utensil, consistency, volume per offer when pertinent, pauses, signs to interrupt and care after the meal. Written communication can be complemented by face-to-face demonstration and educational materials, but should not replace the assessment of the case (Federal Council of Speech-Language Pathology, 2021, 2023; Belmonte et al., 2024).

Another principle is reassessment. The functional status of the elderly person may change after infections, hospitalizations, neurological events, drug changes or cognitive decline. An adequate consistency at one time may become unnecessarily restrictive or insufficiently safe in another. Similarly, changes in oral pain, adaptation of prostheses, xerostomy or masticatory efficiency can change the conditions of feeding and demand updating of the plan (Federal Council of Speech-Language Pathology, 2023; Morales et al., 2026).

The proposed integration also helps to avoid two extremes: the trivialization of risk signs as an inevitable part of aging and the excessive restriction of food without sufficient evaluation. The objective should be to achieve the safest and most efficient food possible under the conditions, preferences and objectives of the elderly, preserving participation and quality of life whenever clinically possible.

The main gap identified is the scarcity of home studies that test integrated interventions of Speech-Language Pathology, Dentistry and Caregiver Education in a single protocol. Most evidence shows relationships between pairs of components - dysphagia and pneumonia, oral health and swallowing, oral hygiene and respiratory risk, dysphagia and caregiver overload - and supports the plausibility of an integrated approach. However, the available literature still does not allow us to state that this model, as a complete intervention, reduces pneumonia,

hospitalizations or mortality alone. Prospective studies specifically designed to evaluate interdisciplinary models at home remain necessary.

Table 2 - Components of an integrated plan for safe oral feeding at home

Component	Main contributions	Information to return to the team
Speech therapy	Evaluate swallowing; define consistencies, volumes, postures, utensils and individualized strategies; rehabilitate when indicated; train the caregiver.	Cough/engagement, vocal alteration, fatigue, change of acceptance, difficulty with the prescribed strategy, respiratory events or functional decline.
Dentistry	Evaluate teeth, occlusion, prostheses, mucosa, saliva/xerostomy, pain, masticatory function and hygiene; treat relevant oral conditions.	Pain, wounds, bleeding, unstable prosthesis, difficulty chewing, important dry mouth or inability to perform hygiene.
Family caregiver	Perform the plan; prepare and offer food as directed; maintain positioning; perform/supervise oral hygiene; observe warning signs.	Changes in routine, acceptance, meal time, ingestion, alert level, signs of difficulty, practical limitations and doubts.
Enlarged team	Integrate Nutrition, Medicine, Nursing and other professionals according to nutritional, respiratory, drug and functional needs.	Weight loss, signs of dehydration, fever, dyspnoea, infections, drug changes or change in level of consciousness/clinical condition.

Source: elaboration of the authors from the synthesis of the reviewed evidence.

3.6 Limitations of evidence and review

The interpretation of the findings should consider limitations in both the available literature and this review itself. A substantial part of the evidence on oral microbiota, oral hygiene and pneumonia was produced in long-term institutions, and its application at home is indirect. Household studies have heterogeneous populations and outcomes; Hsiao et al. (2022), for example, included a small and highly specific sample of people with nasogastric tube associated with oral ingestion. In addition, the relationship between oral conditions and dysphagia is predominantly observational, not allowing inferring causality (Drancourt et al., 2022; Morais et al., 2026). Since this review includes secondary reviews and primary studies, there may also be overlapping of basic studies among some syntheses, which is why the findings were not treated as independent estimates of effect.

This integrative review did not use a formal tool to assess risk of bias nor was it described as a systematic review of efficacy with complete quantitative flow of identification, duplication and exclusion of records. In addition, intermediate search counts referring to the number of records recovered on each base, duplicates removed, title/summary exclusions and exclusions after full reading were not preserved. For this reason, these quantitatives were not estimated or reconstructed retrospectively. The conclusions should be interpreted as a critical and integrative synthesis of the selected evidence, not as an exhaustive or quantitative estimate

of effect. This methodological delimitation is especially important given the heterogeneity of sources and the scarcity of studies that directly assess the integration between Speech-Language Pathology, Dentistry and Caregiver in the home context.

4 Final considerations

The safety of oral feeding of the elderly person with dysphagia in the home environment depends on factors that go beyond swallowing alone. The evidence analyzed supports an approach in which speech therapy evaluation, oral health, oral function and daily execution of guidelines by the caregiver are treated as complementary dimensions of the same care plan.

Speech-Language Pathology plays a central role in the identification of risk, in the evaluation of swallowing biomechanics and in the individualization of consistencies, volumes, postures, utensils and therapeutic strategies. Dentistry contributes to the evaluation of dentition, occlusion, prostheses, xerostomy, pain, hygiene and masticatory efficiency, besides acting on oral conditions related to the microbial load of potentially aspirated oropharyngeal material. The family caregiver, in turn, applies the professional guidelines in daily life and provides relevant information for the reassessment of the plan.

Literature does not support universal solutions. Fluid thickening, diet modification and oral hygiene should be used within individualized indications and not presented as isolated measures capable of preventing pneumonia. As aspiration pneumonia is multifactorial, a risk reduction approach should combine clinical evaluation, food adequacy, maintenance of sufficient intake, oral care, monitoring and response to changes in the general state, respecting the competencies of each professional.

The integration between Speech-Language Pathology, Dentistry and Family Caregiver is consistent with the available evidence and with contemporary principles of person-centered home care. However, a relevant gap remains: there are few studies that directly assess complete interdisciplinary protocols at home. Prospective studies should investigate whether structured models of professional integration and caregiver training reduce respiratory events, malnutrition and hospitalizations, decrease family overload and preserve autonomy and quality of life.

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