# Oral Hygiene Care Plan

**The Oral Hygiene Care Plan outlines what each person needs to receive adequate and appropriate oral care every day.**

**This care plan should be reviewed and updated each time the Oral Health Assessment Tool (OHAT) is completed.** It helps staff communicate about each person's oral health needs and keeps track of changes over time.

## Assessment of Dentures:

Circle whether the person has upper dentures, lower dentures, both, or no dentures. Indicate whether their dentures are full or partial. Record if their dentures are labeled or not.

| Assessment of Dentures: *(please circle)* | | | | | |
|---|---|---|---|---|---|
| | UPPER | FULL | PARTIAL | NOT WORN | NO DENTURE |
| | | ***Name on denture:*** Yes | No | | |
| | LOWER | FULL | PARTIAL | NOT WORN | NO DENTURE |
| | | ***Name on denture:*** Yes | No | | |

## Assessment of Natural Teeth:

Indicate whether the person has any natural teeth in the upper or lower part of their mouth. Also note if any 'root tips' are present (the part of the tooth that remains after the top part of the tooth breaks off the gumline). Root tips are often stable in older adults and not a concern, but they should be checked regularly.

| Assessment of Natural Teeth: *(please circle)* | | | | |
|---|---|---|---|---|
| UPPER | YES | NO | Root tips present | |
| LOWER | YES | NO | Root tips present | |

## Level of Assistance:

Record if the person is able to perform oral care independently and/or the level of help they need.

| Level of Assistance *(please circle)* |
|---|
| **Denture Cleaning:** Independent / some assistance / fully dependant |
| **Teeth Cleaning:** Independent / some assistance / fully dependant |

## Interventions for Oral Hygiene Care:

Common oral hygiene interventions are listed to guide care providers to the best way of supporting each person's oral health needs.

| Interventions for oral hygiene care *(check all that apply and indicate frequency as needed)* |
|---|
| ☐ Mouth swab..... ☐ a.m. ☐ p.m. |
| ☐ Electric toothbrush..... ☐ a.m. ☐ p.m. |
| ☐ Suction toothbrush..... ☐ a.m. ☐ p.m. |
| ☐ Regular toothbrush ..... ☐ a.m. ☐ p.m. |
| ☐ Use 2 toothbrushes..... ☐ a.m. ☐ p.m. |
| ☐ Interproximal toothbrush / floss.... ☐ a.m. ☐ p.m. |
| ☐ Regular fluoride toothpaste..... ☐ a.m. ☐ p.m. |
| ☐ Do not use toothpaste |
| ☐ Scrub denture/s with denture brush..... ☐ a.m. ☐ p.m. |
| ☐ Soak denture/s over night in water with denture tablet |
| ☐ Scrub denture bath weekly |
| ☐ Dry mouth products as needed _____ |
| ☐ Fluoride varnish or other fluoride products (Rx by dentist or physician) |
| ☐ Chlorhexidine mouth rinse (Rx by dentist or physician) |
| ☐ Other: |

## Regular Barriers to Oral Care:

This list helps identify behaviours that may occur during oral care.

| Regular barriers to oral care *(check all that apply)* |
|---|
| ☐ Forgets to do oral hygiene care |
| ☐ Refuses oral hygiene care |
| ☐ Won't open mouth |
| ☐ No compliance with directions |
| ☐ Aggressive / kicks / hits |
| ☐ Bites toothbrush and/or staff |
| ☐ Can't swallow properly |
| ☐ Can't rinse / spit |
| ☐ Constantly grinding / chewing |
| ☐ Head faces downwards / moves |
| ☐ Won't take dentures out at night |
| ☐ Dexterity or hand problems / arthritis |
| ☐ Requires financial assistance |
| ☐ Other: |

See the **Oral Hygiene Care Plan** video for more information.