ORAL HYGIENE CARE PLAN for LONG TERM CARE

Resident:	
Completed by:	**Date:**
Dentist:	**Dentist Phone #:**
Date of last dental appointment:	**Date for next oral hygiene care plan review:**

Assessment of Dentures: *(please circle)*	UPPER	FULL PARTIAL NOT WORN NO DENTURE ***Name on denture:*** Yes No	**Level of Assistance** *(please circle)* **Denture Cleaning:** Independent some assistance fully dependant
	LOWER	FULL PARTIAL NOT WORN NO DENTURE ***Name on denture:*** Yes No	
Assessment of Natural Teeth: *(please circle)*	UPPER	YES NO Root tips present	**Teeth Cleaning:** Independent some assistance fully dependant
	LOWER	YES NO Root tips present	

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 *(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:

(Modified from Chalmers, 2004)

Brushing Up on Mouth Care