Health Care Plan: Oral Hygiene

Factors to consider in design of an individualized Daily OH Plan

Problem- Retained Oral Bacterial Plaque/Food Debris (Disease, Pain, Social Stigma, Loss of Function)	
❑ Daily oral hygiene complicated by: a) behavioral, b) medical, c) habitual ❑ Halitosis: ❑ High caries rate: ❑ Periodontal Disease:	❑ Dry mouth: ❑ Dietary Consistency (thickening agent): ❑ GERD: ❑ Other:

Prevention or Therapy Goal- Daily Removal of Plaque

- ❑ Goal: Will have no newly diagnosed dental issues in the next 6 months
- ❑ Goal: Will have documented improvement in oral hygiene by dentist in next 6 months
- ❑ Goal: Will show reduction in physical resistance/increase cooperation or tolerance of daily brushing.
- ❑ Goal: Will have no bleeding gums during oral care in _____
- ❑ Goal: Will maintain/achieve ability to perform own oral care with/without cueing supports in next __.

Approaches: Select the appropriate approaches listed below. Individualize plan to meet the persons needs.	**Responsible Staff**

Individual Considerations

1. Classification of Cleaning Skills:
   - Requires significant/total assistance
   - Has some dexterity but insufficient cleaning techniques (prompting, hand over hand, completion by caregiver)
   - Can effectively brush with supervision (reminders, prompting, timing)
   - Can effectively brush without assistance
2. Toothpaste use: yes__ no__
   If yes, type: (tartar control, desensitizing, flavored, low foam, etc.)
   If no: (dry brush, moist brush, mouthwash dampened, training period, etc.)
3. Patient able to rinse: yes__ no__
4. Patient able to floss: yes__ no__
5. Toothbrush choice/modification: (soft bristle, powered, angled, dual head, etc.)
   - Suction brush: (justify need, risk/benefit):
   - Use suction machine with soft catheter to remove toothpaste/fluids
6. Brushing Method (describe/review with all staff): (sulcular, gentle vibration, angle 45 degrees, quadrant order, etc.)

Physical/Positional Considerations

1. Individual position:
   - Seated preferential (WC, kitchen chair, bathing chair, lounge chair/recliner, etc.)
   - Standing
   - Torso support
   - Neutral head position
   - Chin/jaw support/position
2. Provider position

NAME _____ DOB_____

Nurse Signature_____ Plan Date:_____

Reviewed: _____

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- To the side
- Towards the back
- Cradle head
- Support jaw
- Retract lip/cheek with gloved finger
- Additional staff needs to assure safety: _____

Behavioral Support

1. Scheduled time: activities or __ AM __ AM __PM __ PM
   - Brush ____ times per day
   - Allow ____ minutes for proper brushing and support
   - Rest periods
2. Place (room and location) for comfort, lighting, accessibility positioning: _____
3. Verbal instructions/explanation to individual: _____
4. Participatory inclusion to the extent of abilities: (which one is your toothbrush? Etc.)
5. Environmental: (presence/absence of distracters)
6. Reinforcers: (music, TV, promised activity)
7. Designated plan of reinforcement, compliments to build self-esteem, increase coping skills
8. Plan for monitored support for those needing supervision:
9. Oral touch or desensitization prior to/separate from brushing: (toothette, gloved finger, wash cloth, etc.)

Special Adjuncts

1. Use prescribed oral treatment_____ Frequency (_____) Stop date_____
2. Flossing: self____ assisted _____
3. Edentulous: (tissue cleaning toothette, wash cloth, etc.)
4. Edentulous/partially edentulous with removable prosthesis:
   - Partial natural dentition: remove prosthesis prior to brushing natural teeth per above plan
   - Remove prosthetics at night, use denture brush to clean and rinse over sink filled with water, store over night in denture cup filled with 50/50 white vinegar/water or commercial solution
   - Prosthetics may need removal after meals for teeth and dentures to be cleaned of food debris
5. Follow additional Dental Plan provided by dentist or hygienist :
6. Dietary sugar intake:
   - Assess intake and frequency of food and drinks that have sugar.
   - Limit sugar intake to mealtimes.
   - Are sugar filled snacks or sodas being used as behavioral reinforcers?

☐ Watch for and report to nurse/dentist: bleeding gums; change in appearance of gums or tongue; dark, broken, loose or missing teeth; bad breath, swelling or apparent oral pain, refusal to eat or drink hot/cold food or liquids_____

NAME _____ DOB_____

Nurse Signature_____ Plan Date:_____

Reviewed: _____