# 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)

<table>
<thead>
<tr>
<th>Description</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily oral hygiene complicated by: a) behavioral, b) medical, c) habitual</td>
<td>Daily Hygiene complicated by:</td>
</tr>
<tr>
<td>Halitosis:</td>
<td>a) behavioral, b) medical, c)</td>
</tr>
<tr>
<td>High caries rate:</td>
<td>habitual</td>
</tr>
<tr>
<td>Periodontal Disease:</td>
<td></td>
</tr>
<tr>
<td>Dry mouth:</td>
<td></td>
</tr>
<tr>
<td>Dietary Consistency (thickening agent):</td>
<td></td>
</tr>
<tr>
<td>GERD:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

## 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.

### 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**

---

New Mexico Department of Health - DD Waiver  Revised 9.08
**Health Care Plan: Oral Hygiene**

- 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________________________________

**Health Care Plan: Oral Hygiene**

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>Nurse Signature</th>
<th>Plan Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviewed:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>