Form 4: Oral Health Care Plan

Name of Resident: _____

Last Oral Health Assessment (OHA) Date: ____/____/_____ (OHA) Review Due Date: ____/____/_____

Oral Health Care Considerations

Problems: _____

◯ Difficulty swallowing ◯ Difficulty moving head ◯ Difficulty opening mouth ◯ Fear of being touched

Interventions: _____

◯ Bridging ◯ Chaining ◯ Hand over hand ◯ Distraction (activity board/toy) ◯ Rescue ◯ Other

Daily Activities of Oral Hygiene

Natural Teeth	**Morning**	**After Lunch**	**Night**
◯ Yes ◯ No **Cleaned by:** ◯ Self ◯ Supervise ◯ Assist	◯ Clean teeth, gums, tongue	◯ Rinse mouth with water ◯ Antibacterial product (teeth & gums)	◯ Clean teeth, gums, tongue

Replace toothbrush (3 monthly) Date: ____/____/_____

Denture	**Morning**	**After Lunch**	**Night**
◯ Full ◯ Partial ◯ Upper ◯ Lower **Inserted/removed by:** ◯ Self ◯ Staff **Cleaned by:** ◯ Self ◯ Supervise ◯ Assist	◯ Clean teeth, gums, tongue ◯ Brush denture	◯ Rinse mouth with water ◯ Rinse denture ◯ Antibacterial product (gums)	◯ Clean teeth, gums, tongue ◯ Brush denture with mild soap ◯ Leave dentures out overnight ◯ Soak denture in cold water

Disinfect dentures (weekly). Specify day: _____

Oral Hygiene Aids

◯ Soft toothbrush ◯ Modified toothbrush ◯ Toothbrush grip ◯ Denture brush ◯ Spray bottle (labelled)

Oral Health Care Products

◯ Mild soap (denture)
◯ Antibacterial product
◯ Saliva substitute
◯ Lip moisturiser
◯ High fluoride (5000 ppm) toothpaste

Additional Oral Care Instruction

◯ Antifungal gel
◯ Denture adhesive
◯ Interproximal brush
◯ Tongue scraper
◯ Normal saline mouth toilet

Check daily, document and report to RN if:

bad breath	bleeding gums	lip blisters/sores/cracks	tongue for any coating/ change in colour	sore mouth or gums
mouth ulcer	swelling of face/mouth	broken/lost denture	difficulty eating	refusal of oral care
denture not named	excessive food left in mouth	broken teeth		

Signed: _____ **(RN)** Date: ____/____/_____