INTRODUCING THE ORAL HEALTH ASSESSMENT TOOL (OHAT)

Explanation of Indicators

August 08

Halton Region Health Department Mission Statement

Together with the Halton community, the Health Department works to achieve the best possible health for all.

Purpose

To provide guidance in the use of the OHAT tool for long-term care staff.

Topics covered

- Background
- Categories
- Scoring
- Nursing interventions
- Follow up
- Questions

Background

- OHAT developed by Chalmers 2004
- Featured in RNAO Nursing Best Practice Guideline: *Oral Health: Nursing Assessment and Interventions (Fall 2007)*
- Modified with permission by HRHD and MOHLTC Regional Best Practice Coordinators
- Download from: www.rgpc.ca

ORAL HEALTH ASSESSMENT TOOL (OHAT) for LONG-TERM CARE

Resident:

Date:

Nursing Admission ○ Quarterly ○ 1 ○ 2 ○ 3

*NOTE: A Star * and underline indicates referral to an oral health professional (i.e. dentist, dental hygienist, denturist) is required.*

Category	0 = healthy	1 = changes	2 = unhealthy	Score	Action Required	Action Completed
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or lump, white/red/ulcerated patch; bleeding/ ulcerated at corners*		1=intervention 2 =refer	☐YES ☐ NO
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	Patch that is red and/or white, ulcerated, swollen*		1=intervention 2 =refer	☐YES ☐ NO
Gums and Tissues	Pink, moist, Smooth, no bleeding	Dry, shiny, rough, red, swollen around 1 to 6 teeth, one ulcer or sore spot under denture*	Swollen, bleeding around 7 teeth or more, loose teeth, ulcers and/or white patches, generalized redness and/or tenderness*		1 or 2 = refer	☐YES ☐ NO
Saliva	Moist tissues, watery and free flowing saliva	Dry, sticky tissues, little saliva present, resident thinks they have dry mouth	Tissues parched and red, very little or no saliva present; saliva is thick, ropey, resident complains of dry mouth*		1=intervention 2 =refer	☐YES ☐ NO
Natural Teeth ☐ Y ☐ N	No decayed or broken teeth/ roots	1 to 3 decayed or broken teeth/roots*	4 or more decayed or broken teeth/ roots, or very worn down teeth, or less than 4 teeth with no denture*		1 or 2 = refer	☐YES ☐ NO
Denture(s) ☐ Y ☐ N	No broken areas/teeth, dentures worn regularly and name is on	1 broken area/tooth, or dentures only worn for 1 to 2 hours daily, or no name on denture(s)	More than 1 broken area/tooth, denture missing or not worn due to poor fit, or worn only with denture adhesive*		1 = ID denture 2 = refer	☐YES ☐ NO
Oral Cleanliness	Clean and no food particles or tartar on teeth or dentures	Food particles/ tartar/ debris in 1 or 2 areas of the mouth or on small area of dentures; occasional bad breath	Food particles, tartar, debris in most areas of the mouth or on most areas of denture(s), or severe halitosis (bad breath)*		1=intervention 2 =refer	☐YES ☐ NO
Dental Pain	No behavioural, verbal or physical signs of pain	Verbal and/or behavioural signs of pain such as pulling of face, chewing lips, not eating, aggression*	Physical signs such as swelling of cheek or gum, broken teeth, ulcers, 'gum boil', as well as verbal and or behavioural signs*		1 or 2 = refer	☐YES ☐ NO
				Completed by:		

FOLLOW UP

☐ Oral Hygiene Care Plan - Date: ___________________ ☐ Oral Health Assessment to be repeated on - Date: ________________

☐ Person and/or family/guardian refuses: a) ☐ Referral - Date: _______________ b) ☐ Dental Treatment - Date: ________________

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Halton REGION

Categories

- Lips
- Tongue
- Gums & tissues
- Saliva
- Natural Teeth
- Denture(s)
- Oral cleanliness
- Dental Pain

Scoring

0 = healthy

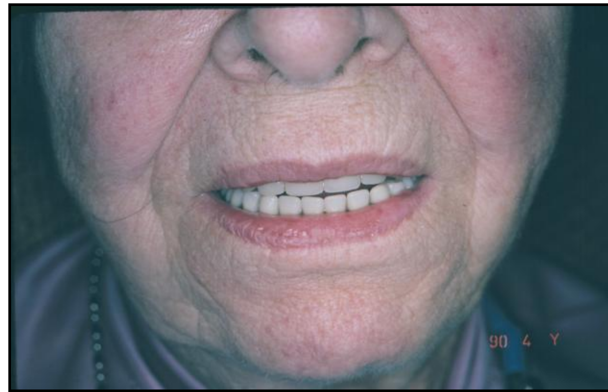
1 = changes

2 = unhealthy

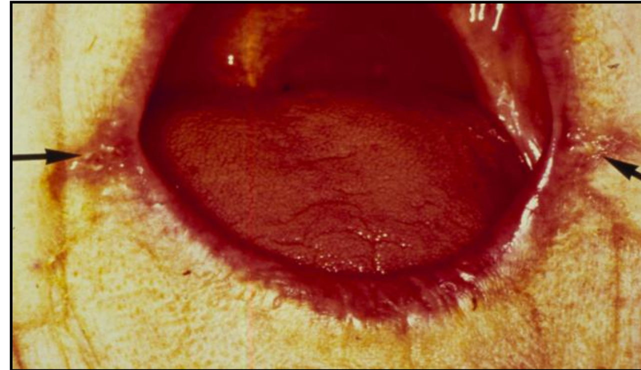
How do I decide?

Lips

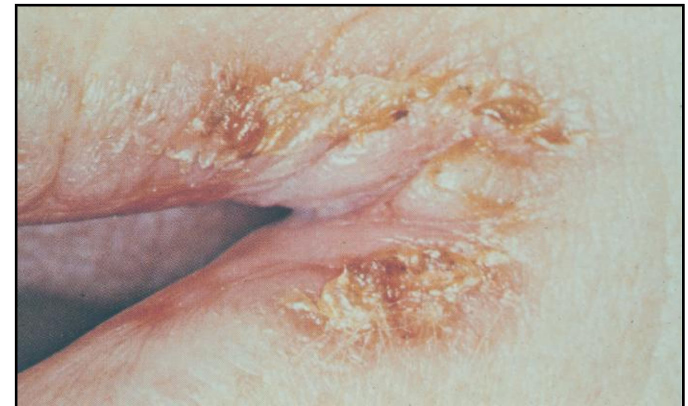
0 = healthy



1 = changes



2 = unhealthy

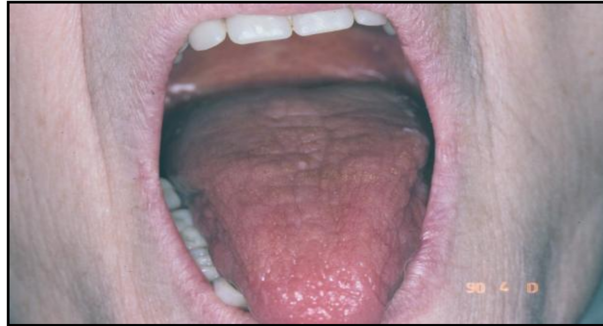


Nursing intervention

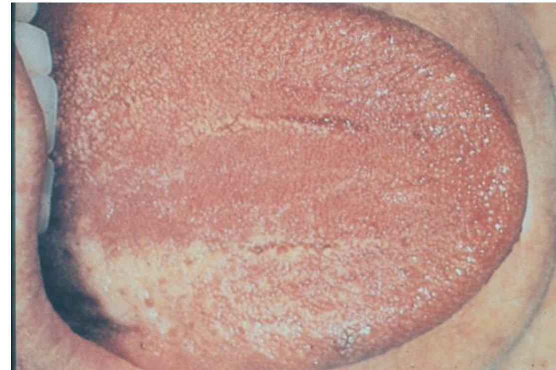
- Use lanolin, KY Jelly or other lip lubricant
- Do NOT use petroleum based products
- Consider possibility of vitamin B deficiency
- Monitor - if no change after 7 days refer

Tongue

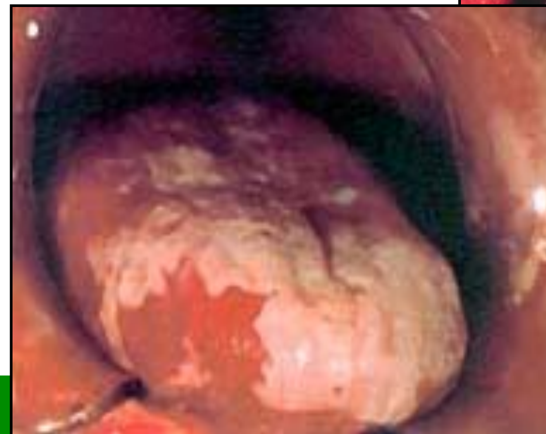
0 = healthy

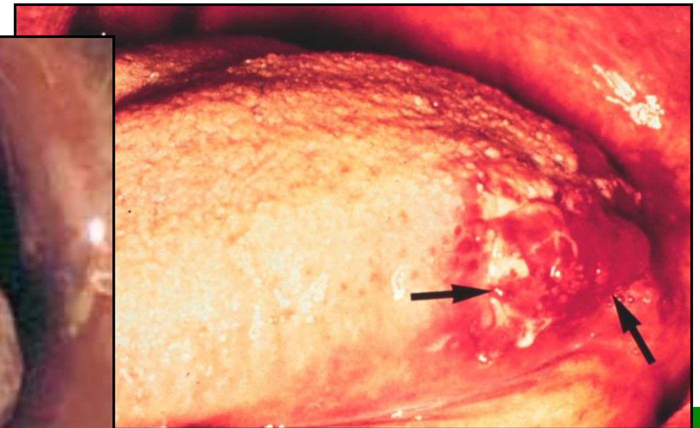


1 = change



2 = unhealthy

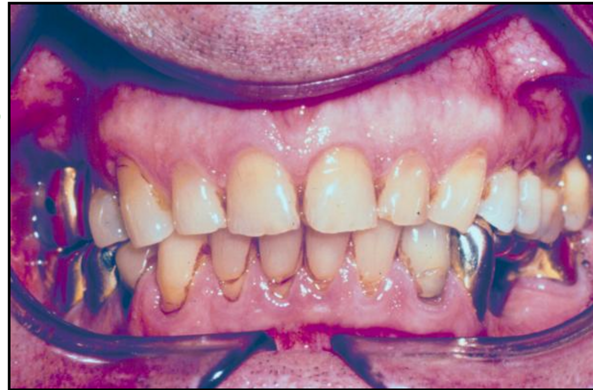




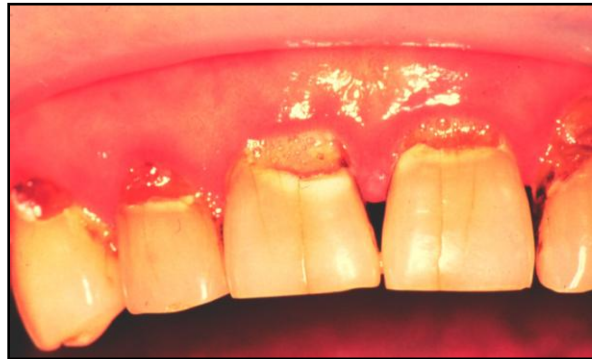
Nursing intervention

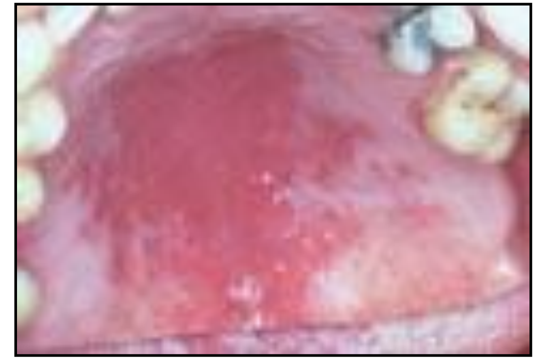
- Clean tongue twice daily with soft toothbrush or tongue scraper
- Monitor for changes

Gums & tissues



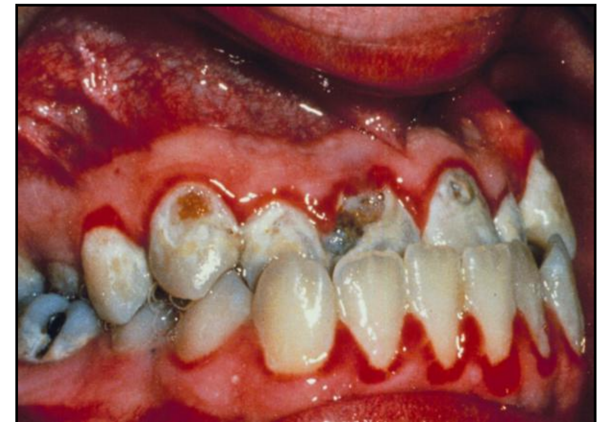
0 = healthy





1 = changes

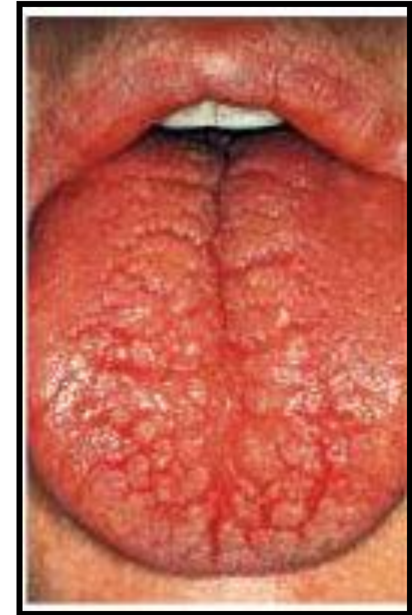
2 = unhealthy



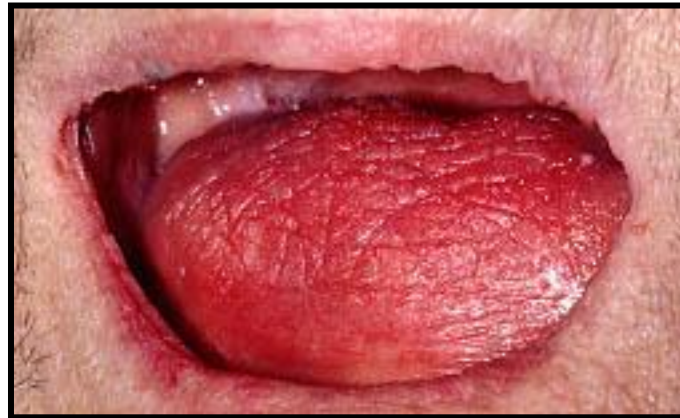
Saliva

0 = healthy

1 = changes



2 = unhealthy

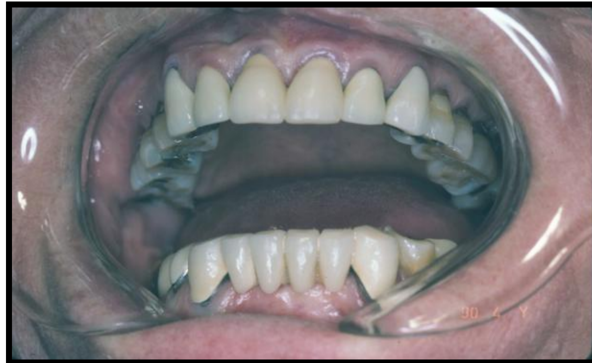


Nursing intervention

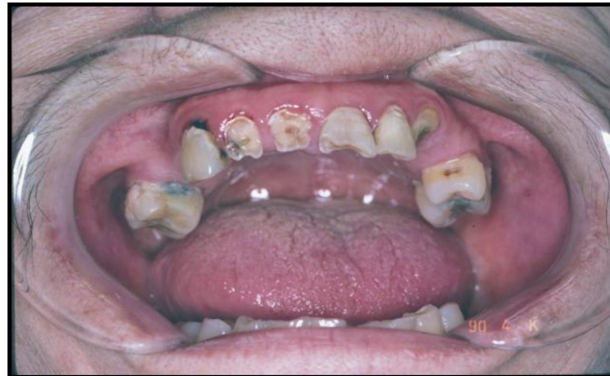
- Check for medications causing dry mouth
- Use dry mouth products
- Increase fluid intake
- Monitor for changes

Natural teeth

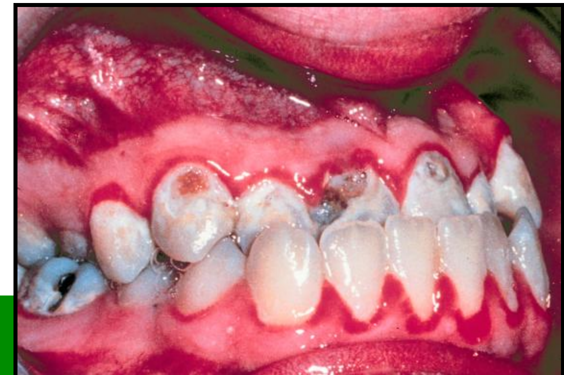
0 = healthy



1 = changes



2 = unhealthy



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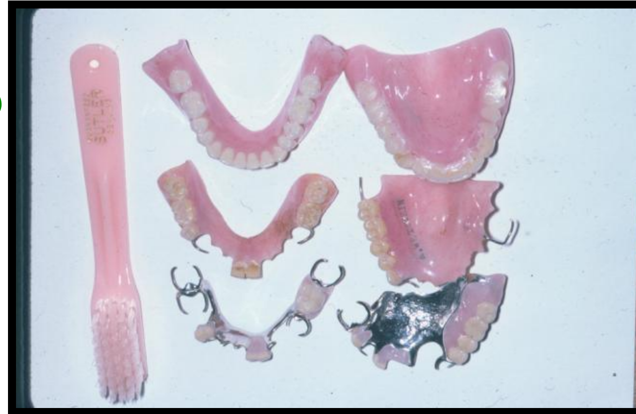
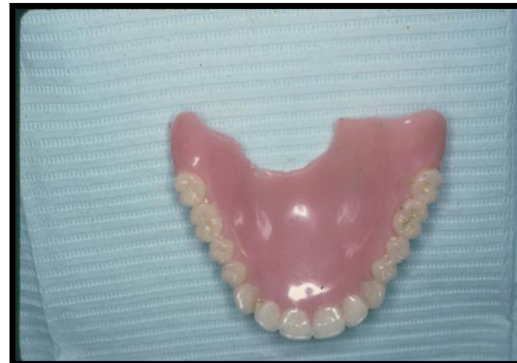
Dentures

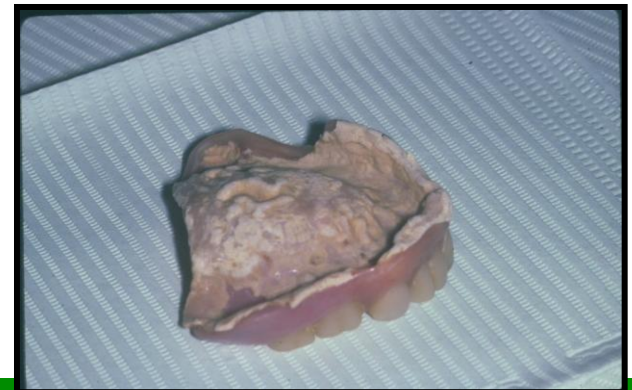
0 = healthy



1 = changes



2 = unhealthy

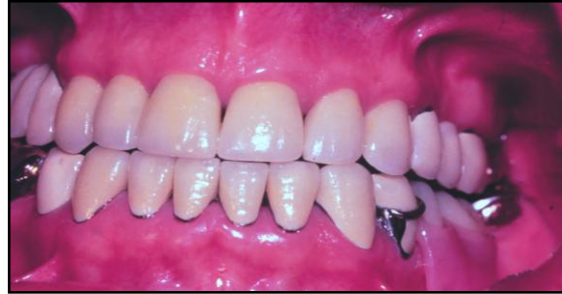


Nursing intervention

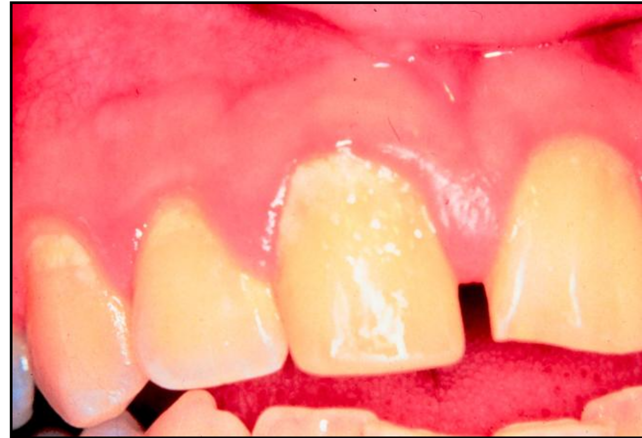
- Identification of dentures

Oral cleanliness

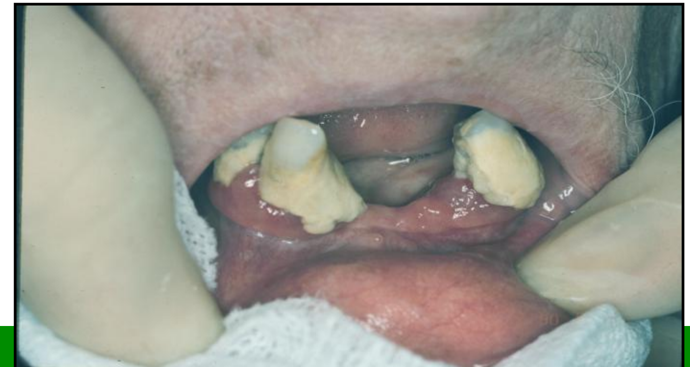
0 = healthy



1 = changes

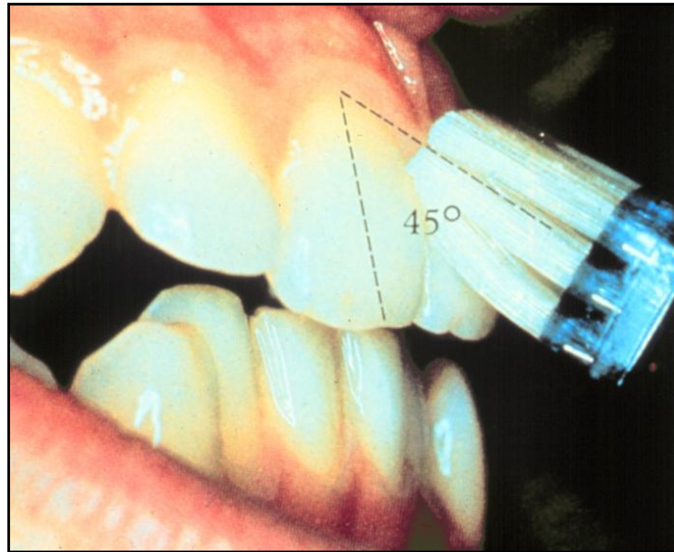


2 = unhealthy



Nursing intervention

- Brush teeth and oral tissues 2 X daily
- Monitor levels of plaque and debris



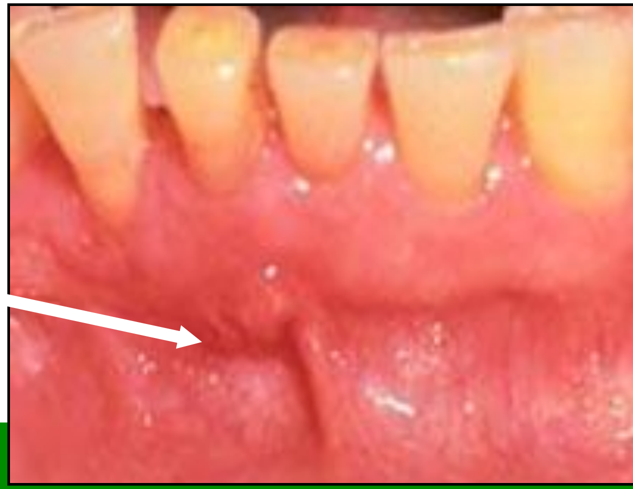
Dental pain

0 = healthy

1 = changes

2 = unhealthy

draining abscess



Action Completed

This section serves as a reminder to ensure either the nursing intervention took place or the referral was made.

Action Completed

YES NO

Follow Up

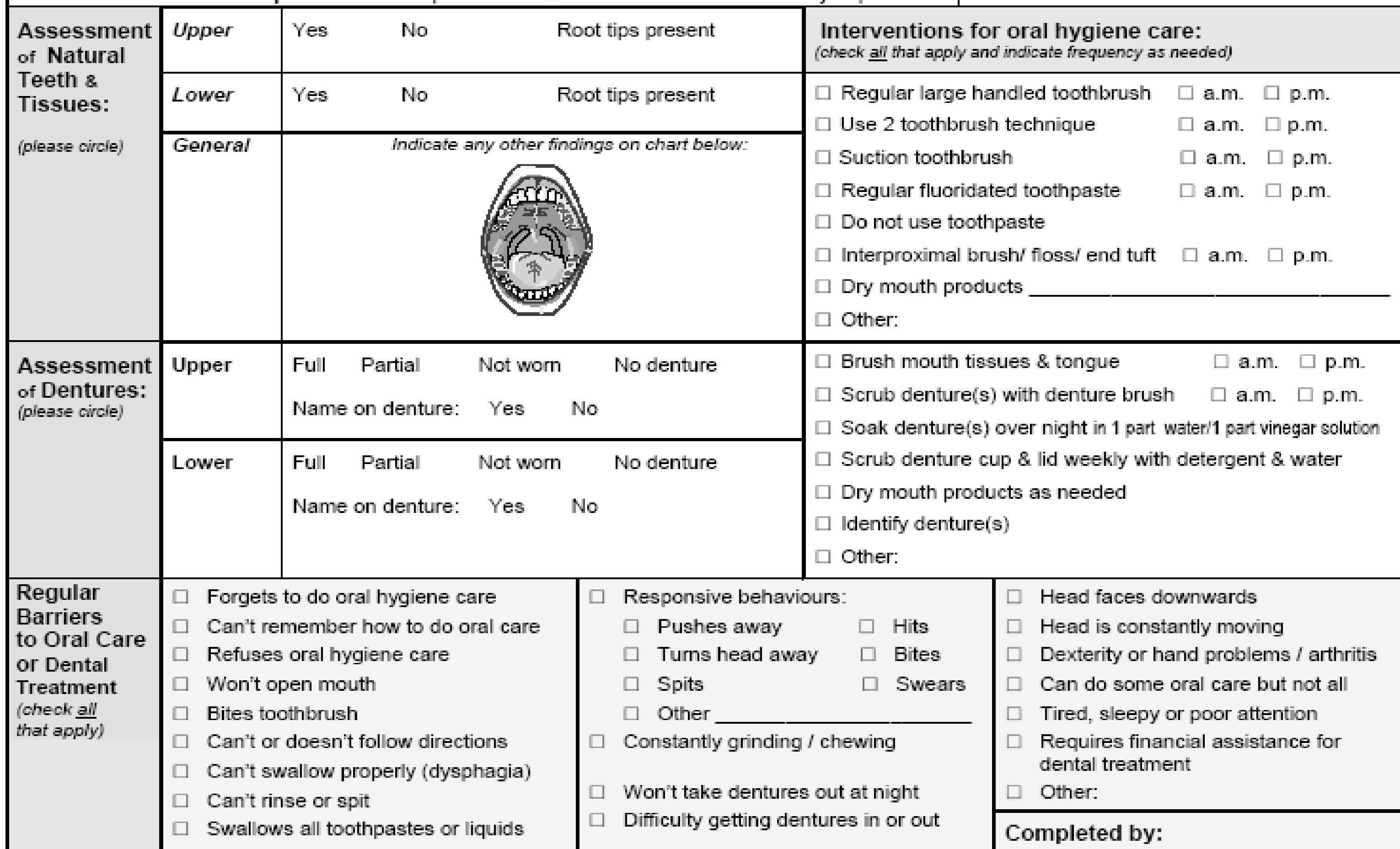
An Oral Hygiene Care Plan must be completed

Oral Hygiene Care Plan – Date:___________

and a follow up date for a repeat assessment decided upon.

Oral Health Assessment to be repeated on -Date:___________

Remember to review/update the OHCP after each assessment.



ORAL HYGIENE CARE PLAN for LONG-TERM CARE

Resident:

Date:

Level of Assistance Required ☐ Independent ☐ Some assistance ☐ Fully dependent

Assessment of Natural Teeth & Tissues: *(please circle)*		
Upper	Yes No Root tips present	
Lower	Yes No Root tips present	
General	*Indicate any other findings on chart below:*	

Interventions for oral hygiene care:
(check all that apply and indicate frequency as needed)

- ☐ Regular large handled toothbrush ☐ a.m. ☐ p.m.
- ☐ Use 2 toothbrush technique ☐ a.m. ☐ p.m.
- ☐ Suction toothbrush ☐ a.m. ☐ p.m.
- ☐ Regular fluoridated toothpaste ☐ a.m. ☐ p.m.
- ☐ Do not use toothpaste
- ☐ Interproximal brush/ floss/ end tuft ☐ a.m. ☐ p.m.
- ☐ Dry mouth products ______________________________
- ☐ Other:

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

- ☐ Brush mouth tissues & tongue ☐ a.m. ☐ p.m.
- ☐ Scrub denture(s) with denture brush ☐ a.m. ☐ p.m.
- ☐ Soak denture(s) over night in 1 part water/1 part vinegar solution
- ☐ Scrub denture cup & lid weekly with detergent & water
- ☐ Dry mouth products as needed
- ☐ Identify denture(s)
- ☐ Other:

Regular Barriers to Oral Care or Dental Treatment *(check all that apply)*

- ☐ Forgets to do oral hygiene care
- ☐ Can't remember how to do oral care
- ☐ Refuses oral hygiene care
- ☐ Won't open mouth
- ☐ Bites toothbrush
- ☐ Can't or doesn't follow directions
- ☐ Can't swallow properly (dysphagia)
- ☐ Can't rinse or spit
- ☐ Swallows all toothpastes or liquids

- ☐ Responsive behaviours:
  - ☐ Pushes away ☐ Hits
  - ☐ Turns head away ☐ Bites
  - ☐ Spits ☐ Swears
  - ☐ Other ______________________
- ☐ Constantly grinding / chewing
- ☐ Won't take dentures out at night
- ☐ Difficulty getting dentures in or out

- ☐ Head faces downwards
- ☐ Head is constantly moving
- ☐ Dexterity or hand problems / arthritis
- ☐ Can do some oral care but not all
- ☐ Tired, sleepy or poor attention
- ☐ Requires financial assistance for dental treatment
- ☐ Other:

Completed by:

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Follow Up

If the resident or the family/guardian refuses referral and/or dental treatment this must be recorded.

Person and/or family refuses: a) Referral - Date:____________ b) Dental Treatment – Date:____________

Questions?

For more information call
Halton Region's Health Department

Dental Health

905-825-6000
Toll free: 1-866- 4HALTON (1-866-442-5866)
TTY 905-827-9833

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