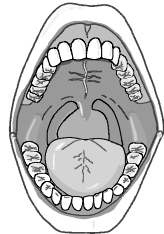


# ORAL HYGIENE CARE PLAN for LONG-TERM CARE

Resident: \_\_\_\_\_

Level of Assistance Required     Independent     Some assistance     Fully dependent

Date: \_\_\_\_\_

<b>Assessment of Natural Teeth &amp; Tissues:</b>  <i>(please circle)</i>	<b>Upper</b>	Yes	No	Root tips present	<b>Interventions for oral hygiene care:</b> <i>(check <u>all</u> that apply and indicate frequency as needed)</i>
	<b>Lower</b>	Yes	No	Root tips present	
	<b>General</b>	<i>Indicate any other findings on chart below:</i>  			

<b>Assessment of Dentures:</b> <i>(please circle)</i>	<b>Upper</b>	Full	Partial	Not worn	No denture	<input type="checkbox"/> Brush mouth tissues & tongue <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Scrub denture(s) with denture brush <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Soak denture(s) over night in 1 part water/1 part vinegar solution <input type="checkbox"/> Scrub denture cup & lid weekly with detergent & water <input type="checkbox"/> Dry mouth products as needed <input type="checkbox"/> Identify denture(s) <input type="checkbox"/> Other: _____
	<b>Lower</b>	Full	Partial	Not worn	No denture	

<b>Regular Barriers to Oral Care or Dental Treatment</b> <i>(check <u>all</u> that apply)</i>	<input type="checkbox"/> Forgets to do oral hygiene care <input type="checkbox"/> Can't remember how to do oral care <input type="checkbox"/> Refuses oral hygiene care <input type="checkbox"/> Won't open mouth <input type="checkbox"/> Bites toothbrush <input type="checkbox"/> Can't or doesn't follow directions <input type="checkbox"/> Can't swallow properly (dysphagia) <input type="checkbox"/> Can't rinse or spit <input type="checkbox"/> Swallows all toothpastes or liquids	<input type="checkbox"/> Responsive behaviours: <input type="checkbox"/> Pushes away <input type="checkbox"/> Hits <input type="checkbox"/> Turns head away <input type="checkbox"/> Bites <input type="checkbox"/> Spits <input type="checkbox"/> Swears <input type="checkbox"/> Other _____  <input type="checkbox"/> Constantly grinding / chewing  <input type="checkbox"/> Won't take dentures out at night <input type="checkbox"/> Difficulty getting dentures in or out	<input type="checkbox"/> Head faces downwards <input type="checkbox"/> Head is constantly moving <input type="checkbox"/> Dexterity or hand problems / arthritis <input type="checkbox"/> Can do some oral care but not all <input type="checkbox"/> Tired, sleepy or poor attention <input type="checkbox"/> Requires financial assistance for dental treatment <input type="checkbox"/> Other: _____
	<b>Completed by:</b> _____		