Oral Health Care Plan

Oral Health Assessment (OHA) Date: ____________________ (OHA) Review 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

<table>
<thead>
<tr>
<th>Natural Teeth</th>
<th>Morning</th>
<th>After Lunch</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>clean teeth, gums, tongue</td>
<td>rinse mouth with water</td>
</tr>
</tbody>
</table>

Cleaned by:  
- Self  
- Supervise  
- Assist

Replace toothbrush (3 monthly)

Date: ____________________

Denture

<table>
<thead>
<tr>
<th>Full</th>
<th>Partial</th>
<th>Morning</th>
<th>After Lunch</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper</td>
<td>Lower</td>
<td>clean teeth, gums, tongue</td>
<td>rinse mouth with water</td>
<td>clean teeth, gums, tongue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>brush denture</td>
<td>rinse denture</td>
<td>brush denture with mild soap</td>
</tr>
</tbody>
</table>

Inserted / removed by:  
- Self  
- Staff

Cleaned by:  
- Self  
- Supervise  
- Assist

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  
- 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: ____________________