Oral Hygiene Care Plan (Chalmers, 2004 for use by the Iowa Geriatric Education Center)

Client: _____ **Completed by:** _____ **Date:** __/__/__

Dentist: _____ **Phone**: _____

Date of last dental appointment: _____ **Date for next oral hygiene care plan review:** ___/___/___

Assessment of Dentures: *(please circle)*	Upper	Full / Partial / Not worn/ No denture Named/ Not named Does/doesn't wear at night	Denture cleaning: independent needs assistance
	Lower	Full / Partial / Not worn/ No denture Named/ Not named Does/doesn't wear at night	Clean dentures: daily twice daily _____
Assessment of Natural teeth: *(please circle)*	Upper	Yes / No / Roots present	Teeth cleaning: independent needs assistance
	Lower	Yes / No / Roots present	Clean teeth: daily twice daily _____

Interventions for oral hygiene care ***(check all that apply and circle frequency needed)***

- use mouthswab
- use electric toothbrush
- use suction toothbrush
- use regular toothbrush
- use toothbrush *backward bent/ 2 toothbrushes*
- use interproximal toothbrush or floss
- use regular fluoride toothpaste *morning/night*
- scrub denture/s with soap and water *morning/night*
- soak denture/s at night in *water/denture tablet*
- use saliva substitute for dry mouth
- use fluoride varnish or other fluoride products (as prescribed by dentist or medical director)
- use chlorhexidine mouthrinse (as prescribed by dentist or medical director)
- other _____
- other _____

Regular barriers to oral hygiene care : ***(check all that apply)***

- forgets to do oral hygiene care
- refuses oral hygiene care
- won't open mouth
- no compliance with directions
- is aggressive / kicks / hits
- bites toothbrush and/or staff
- can't swallow properly
- can't rinse and spit
- constantly grinding/chewing
- head faces downwards / moves
- won't take dentures out at night
- dexterity or hand problems/arthritis
- refuses assistance from carer
- other _____