Brushing Up on Mouth Care

An oral health resource for those who provide care to older adults

DALHOUSIE UNIVERSITY
Inspiring Minds
Faculty of Dentistry

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Capital Health

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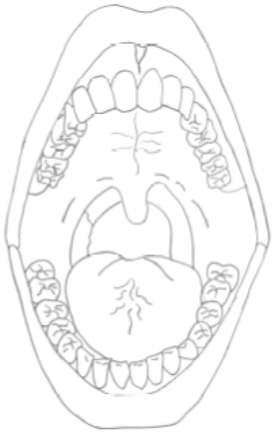
Please note that these educational resources were developed for use in Long Term Care and therefore the term 'resident' is used throughout to describe the recipient of care. This information is also valuable to those providing care in other settings such as home care and acute care. In these instances, please take the term 'resident' to mean client, patient, loved one, or whatever term best describes the person you are caring for.

DAILY ORAL HEALTH ASSESSMENT

Providing daily oral care to residents also presents an important opportunity to check the mouth for any abnormalities.



Before providing daily oral care, we ask that you take 60 seconds to do a quick 'check' of the resident, patient, or client's mouth. Use the following principles to guide you:

LOOK: *Look in the mouth for any abnormalities. Look at the teeth, the roof of the mouth, the floor of the mouth, all sides of the tongue, inside the cheeks and lips, and along the gumline. If the resident has dentures or partials, remove them from the mouth and inspect them for any loose or broken pieces.*

FEEL: *Feel along the gum line and in the cheeks. DO NOT put your fingers between the teeth.*

TELL: ***If you notice something abnormal:***

1) *fill out the Daily Oral Health Assessment Form,*
2) *put it in the resident's file,*
3) *TELL your supervisor.*

An abnormality would be considered anything new, or that wasn't there before. It may present as red or white patches, swelling/lumps, loose teeth, etc. Using the legend provided, simply mark on the mouth-diagram **what you've noticed and where**. Place your name and date on the card. This will provide a recorded timeline of any changes occurring in the resident's mouth.

Legend	
R	Red Patches
W	White Patches
^v^	Lumps, Bumps or Swelling
S	Sores
B	Bleeding
☆	Loose/Broken Tooth

Any abnormalities that do not resolve themselves within 14 days should be looked at by a dental professional.

Daily assessment forms only need to be completed when something abnormal is found. Completed cards are then to be placed in the resident's file. Since there are many tasks that must be completed while in the washroom with the resident, we recommend completing this form as soon as possible once you have completed care for that resident.

SEE EDUCATIONAL VIDEO #5 FOR MORE INFORMATION ON HOW TO COMPLETE THIS ASSESSMENT

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Daily Oral Health Assessment Sheet

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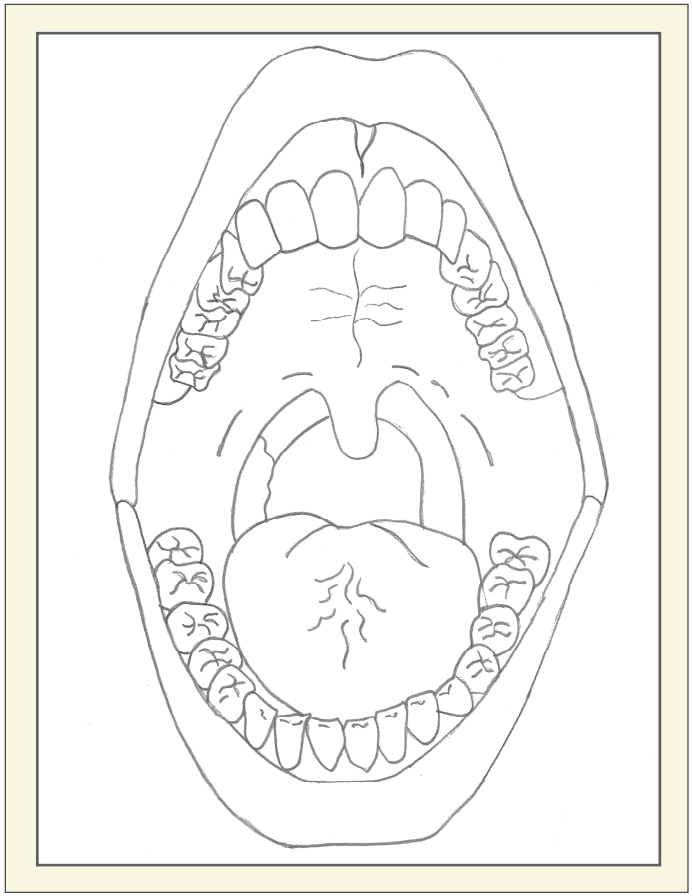
Please use the illustration below to record any problems observed when performing the resident's daily oral care routine



Date:_____

Resident Name:_____

Staff Name:_____

Legend

R	Red Patches
W	White Patches
^v^	Lumps, Bumps or Swelling
S	Sores
B	Bleeding
☆	Loose/Broken Tooth

BE SURE TO REMOVE DENTURES/PARTIALS BEFORE COMPLETING ASSESSMENT

Where to look

- **Tongue** (sides and front)
  - *Have resident stick out tongue*
- **Floor of the mouth** (underneath the tongue)
  - *Have resident lift tongue OR move with toothbrush*
- **Roof of the mouth** (hard & soft palate)
  - *Tilt resident's head back slightly*
- **Cheeks**
  - *Pull cheek away from teeth*
- **Gums & Teeth**
  - *Fold top lip up and bottom lip down to assess gums*
- **Lips**

PLEASE REPORT ANY PROBLEMS TO THE RN ON DUTY

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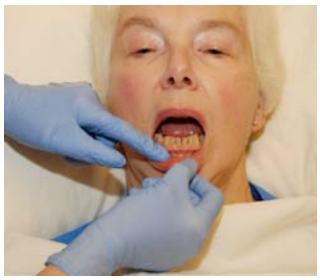
ANNUAL ORAL HEALTH ASSESSMENT

A resident's oral status should be assessed on a regular basis, and in a routine and methodical manner

Each new resident entering a care facility should have an assessment completed prior to the development of their initial care plan. **All residents should have their oral health assessed annually by a member of the nursing staff.** Ideally annual assessments will be completed to coincide with annual care conferences.

The Oral Health Assessment Tool (OHAT) is a widely accepted validated tool for assessing various aspects of oral health status. This quick and easy one page document is used to identify common healthy and unhealthy conditions associated with the mouth tissues and dentures.



The 8 categories we will examine are:

- LIPS NATURAL
- TONGUE -
- GUM & TISSUES
- ORAL CLEANLINESS
- TEETH
- DENTURE(S)
- SALIVA
- DENTAL PAIN

At the top of the page write the date, resident's name, and indicate if this assessment is:
1) an ADMISSION assessment,
2) an ANNUAL assessment
3) a FOLLOW-UP assessment being completed on a resident who requires more attention to their oral health

The OHAT is divided into columns:
Category: the areas and conditions to be examined
Assessment columns: Any section in these columns that is underlined with a star indicates that a dental professional should be consulted to assess the issue.
0 = HEALTHY: *the resident has good oral health; no intervention required*
1 = CHANGES*: some changes are apparent; an intervention or referral is required*
2 = UNHEALTHY: *the oral cavity is unhealthy; referral is required.*
Score: add up the score from the assessment columns
Action Required: based on the score, indicate if referral and/or intervention is required
Action Completed: indicate if the referral or intervention been completed

At the bottom of the page there is space for follow-up and referral. The Oral Hygiene Care Plan should be updated based on the results of the OHAT. A resident with abnormal findings may need to have a follow-up assessment completed within the year. If referral to an oral health professional was recommended and the resident or a family member refuses the referral, there is a space for them to indicate why they refused and to sign.

SEE EDUCATIONAL VIDEO #5 FOR MORE INFORMATION ON HOW TO COMPLETE THIS ASSESSMENT

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ORAL HEALTH ASSESSMENT TOOL (OHAT) for LONG TERM CARE

Admission Assessment ○ Annual Assessment ○ Follow-up Assessment 1○ 2○ 3○	Resident:
	Date:

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 & 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 labeled	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:

1) Oral Hygiene Care Plan **updated** – ☐ Y ☐ N
   Date:_____
2) OHAT to be **repeated** - ☐ in one year
   ☐ on date _____

REFERRAL:

a) REFERRAL to an oral health professional **required** ☐ Y ☐ N
b) REFERRAL **made** ☐ Y (appointment date: _____) ☐ N (*see below*)
c) REFERRAL **refused** by resident/family/guardian ☐ Y
Reason for refusal: _____Signature:_____

(OHAT Tool, Chalmers 2004)
This version is based on modifications from the Halton Region's Health Department (2007)

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ORAL HYGIENE CARE PLAN

The care planning tool can be used to outline what is required to ensure that each resident is receiving adequate and appropriate oral care on a daily basis

This care plan should be reviewed and updated each time the Oral Health Assessment Tool is completed: *It provides a way for staff to communicate about the oral care of individual residents and can also provide a record of whether or not progress is being made over time.*

It is important to fill in the patient's name, who completed the chart, the date it was completed, and, if they have one, the name and phone number of the resident's dentist for easy referral. The date of the resident's last dental appointment and the date for their next oral hygiene assessment and treatment can also be recorded here.

Assessment of dentures:
Circle whether the resident has upper or lower dentures or both. Indicate whether they are full or partial dentures. If the resident does not have any dentures, this should also be noted here. Record if the dentures are labeled or not.

Assessment of natural teeth:
Here we indicate whether the resident has any natural teeth in either the upper or lower arch. There is also an opportunity to record whether there are "root tips" present in either arch. When the crown of a tooth breaks off at the gum-line, the part of the tooth that remains in the arch is a root or root-tip. These are often stable in older adults and not a cause for concern. However, they can become infected so need to be monitored carefully.

Level of Assistance:
Record whether or not the resident is able to look after his or her own teeth or denture care or what level of assistance they may require.

Interventions for Oral Hygiene Care:
A variety of common oral hygiene interventions are itemized to cue the care-provider about best approaches for a particular resident. For example, it may be observed that an electronic toothbrush is indicated at least once a day.

Regular Barriers to Oral Care:
The itemized list helps to identify behaviors that might be expected of a particular resident such as "won't open mouth" or "aggressive". These are noted in order to better prepare the care-provider to deliver oral hygiene care.

SEE EDUCATIONAL VIDEO #5 FOR MORE INFORMATION ON HOW TO COMPLETE THIS ARE PLAN

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ORAL HYGIENE CARE PLAN for LONG TERM CARE

Resident:	
Completed by:	**Date:**
Dentist:	**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 ***Name on denture:*** Yes No	**Level of Assistance** *(please circle)* **Denture Cleaning:** Independent some assistance fully dependant
	LOWER	FULL PARTIAL NOT WORN NO DENTURE ***Name on denture:*** Yes No	
Assessment of Natural Teeth: *(please circle)*	UPPER	YES NO Root tips present	**Teeth Cleaning:** Independent some assistance fully dependant
	LOWER	YES NO Root tips present	

Interventions for oral hygiene care *(check all that apply and indicate frequency as needed)*	□ Mouth swab…… □ a.m. □ p.m. □ Electric toothbrush……. □ a.m. □ p.m. □ Suction toothbrush……. □ a.m. □ p.m. □ Regular toothbrush ……... □ a.m. □ p.m. □ Use 2 toothbrushes……. □ a.m. □ p.m. □ Interproximal toothbrush / floss…. □ a.m. □ p.m. □ Regular fluoride toothpaste…… □ a.m. □ p.m. □ Do not use toothpaste □ Scrub denture/s with denture brush…….. □ a.m. □ p.m. □ Soak denture/s over night in water with denture tablet □ Scrub denture bath weekly □ Dry mouth products as needed _____ □ Fluoride varnish or other fluoride products (Rx by dentist or physician) □ Chlorhexidine mouth rinse (Rx by dentist or physician) □ Other:	**Regular barriers to oral care** *(check all that apply)*	□ Forgets to do oral hygiene care □ Refuses oral hygiene care □ Won't open mouth □ No compliance with directions □ Aggressive / kicks / hits □ Bites toothbrush and/or staff □ Can't swallow properly □ Can't rinse / spit □ Constantly grinding / chewing □ Head faces downwards / moves □ Won't take dentures out at night □ Dexterity or hand problems / arthritis □ Requires financial assistance □ Other:

(Modified from Chalmers, 2004)

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