dacs
DEMENTIA & AGED CARE SERVICES

| ORAL HYGIENE MANAGEMENT PLAN | | | |
|---|---|---|---|
| **Client Name:** | | | **Client Date of Birth:** |
| Dentist Details | | | |
| Dental Practice Name | | Phone number | |
| | | Type of Practice | Public/Private |
| List all dental appointments:<br>Date of next OHCP review: | | | |
| Does the client wish staff to assist with oral hygiene care problems | | ☐Yes ☐No | |
| IS this assessment | Baseline | 3 month | 6 month |

| Dentures | | |
|---|---|---|
| Upper | ☐Full ☐Partial ☐Not worn ☐No denture ☐Named | |
| Lower | ☐Full ☐Partial ☐Not worn ☐No denture ☐Named | |
| Denture cleaning | ☐Daily ☐When possible | |
| Best time to clean dentures | | |
| **Natural teeth** | | |
| Upper | ☐Yes ☐No ☐Roots present | |
| Lower | ☐Yes ☐No ☐Roots present ☐Attempt denture | |
| Cleaning | ☐Daily ☐When possible | |
| Best time to clean teeth | | |

| Interventions for oral hygiene care Please tick all that apply | | | |
|---|---|---|---|
| ☐ | Is independent – no assistance needed | ☐ | Forgets to do oral hygiene care |
| ☐ | Needs reminding/prompting/task breakdown | ☐ | Won't open mouth |
| ☐ | Needs supervision/checking of oral hygiene | ☐ | Refuses oral hygiene care |
| ☐ | Needs full assistance from staff | ☐ | Does not understand |
| ☐ | Uses bridging/chaining/distraction techniques | ☐ | Is aggressive/kicks/hits |
| ☐ | Use electric/suction toothbrush | ☐ | Can't swallow properly |
| ☐ | Use backward bent toothbrush for access | ☐ | Can't rinse and spit |
| ☐ | Use bite block | ☐ | Bites toothbrush and/or staff |
| ☐ | Use chlorhexidine spray bottle/gel daily weekly | ☐ | Constantly grinding/chewing |
| ☐ | Use fluoride | ☐ | Head faces downwards |
| ☐ | Use Neutraflour 5000 toothpaste | ☐ | Other |
| ☐ | Use oral balance gel for dry mouth | | |

| Assessment Completion | |
|---|---|
| Name of person completing the assessment: | Designation: |
| Date and time assessment completed: | Signature: |
| Date uploaded to iCare: | |