Basic Oral Care
Keep it Simple
Halton Region Health Department
Mission Statement

Together with the Halton community, the Health Department works to achieve the best possible health for all.
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Note

All patient care plans must be approved by the resident’s/patient’s appropriate health care provider.
Caregiver Reluctance to Provide Oral Care

- Shortage of time
- Not the right supplies
- Fear of being bitten
- Challenges with behaviours
- Lack of confidence that the oral care is being done correctly
- Health and safety/ergonomics
Timing Daily Oral Care

In order to achieve two or more oral care sessions each day:

• May change time of day
• May require two caregivers
The Hand Hold
The Hug
Daily Oral Hygiene Care Planning for Natural Teeth and Dentures

- Location for Care
- Customized Supplies
- Care Provider’s Role
Basic Supplies

- Wash cloth
- Gauze / J-cloth
- 2 toothbrushes/denture brush
- Perivex gel
Toothbrush Type

Note:

• the size of the handle
• the length of the handle
• the size of the brush head
Flossing

• Not realistic for many caregivers or for residents/patients with dexterity problems
• Easier to use inter-dental brushes, proxi-brushes and stimudents
Why You Should **NOT** Use Toothpaste for Everyone

- Regular toothpaste causes:
  - Foaming
  - Increased saliva flow and need to spit
  - Reduced caregiving visibility
  - Increased risk for choking (swallowing problems)

- Strong flavour may not appeal to older adults

- Perivex
  - For residents/patients at risk of choking
  - Does not contain fluoride
  - If resident/patient can rinse and spit, use fluoridated toothpaste
Positioning and Prepping for Oral Care

• Drape resident/patient with hand towel
• Dampen disposable cloth or 4X4 gauze with warm water
• Place small amount of gel on cloth/gauze
“Mop and Go” Technique

- Does not require the resident/patient to have to spit or swallow
- Debris and saliva is mopped up throughout the brushing procedure
  - 4X4 gauze
  - Disposable J-cloth

Reminder:
Oral care can be performed anywhere
- Bathroom, bedroom, sitting area, etc.
Safety and Ergonomics for Resident / Patient and Caregiver
Wheel Chair Method

Large wheelchairs often recline making it easy to do the oral care and the “mop and go” oral care technique.
Reducing the Potential of Being Bitten or Grabbed
Using Toothbrush Handle to Hold Back Cheek
Bed Method

- Never awaken a resident/patient to provide oral care

- Resident/patient in safe and proper positioning
  - Bed rails up if necessary

- Use 2 toothbrushes, hand holding, etc
Denture Considerations

• Always remove dentures before brushing natural teeth
  – Clean plaque off gums and check for sores

• Place cloth in bottom of sink before filling with water
  – Provides a cushion in case the denture slips into the sink

• Brush denture with denture brush with a professional denture cleaner
  – Vinegar and water if hard deposits need to be removed

• Remove dentures at night and place in denture cup with room temperature water
Oral Care Approaches for Persons with Dementia

- Use dementia care techniques you may have learned in your approach for other aspects of care (e.g., GPA)
- Try to do oral care in the bathroom where familiar personal (oral care) items are stored
- Give the resident / patient a rolled up washcloth or soft ball if their hands start grabbing or tugging
- Consider using the 2-person approach and have only one person speaking during the oral care
- Distract with soft music, preferred item to hold, etc
Difficulty Providing Oral Care
Other Considerations

• Record oral care challenges on an oral care plan and in the progress notes

• Review the oral care plan regularly
  – Reassess oral care needs as the resident’s/ patient’s health worsens

• Contact family and determine if a family member will assist with oral care

• Onsite visit or off-site appointment with dentist for poor oral health status
  – Arrange for dental treatment to be provided
Implants

- Stabilize dentures
- Can replace missing teeth
Angular Cheilosis

Red inflamed sores at the corners of the mouth

Caused by:
• A fungal or bacterial infection
• Vitamin B deficiency

Treatment:
• Use an antifungal agent or antibacterial agent
• Have dentures that are clean and fit well
Candida Infection (Thrush/Yeast)

Caused by:
• A weak immune system
• Taking antibiotics for a long time
• Leaving dentures in the mouth for a long time
• Certain medications / Dry mouth

Treatment
• Antifungal agent prescribed by doctor or dentist
NOTE:

• Use a new toothbrush and denture brush

• Disinfect denture box and brush or replace.
Tools for Oral Health Program Management

Resource Materials

Assessment tools
Oral Care Plans
Educational Materials
Service Pamphlets

**ORAL HEALTH ASSESSMENT TOOL (OHAT)**

<table>
<thead>
<tr>
<th>Category</th>
<th>0 = healthy</th>
<th>1 = changes</th>
<th>2 = unhealthy</th>
<th>Category scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lips</strong></td>
<td>Smooth, pink, moist</td>
<td>Dry, chapped, or red at corners</td>
<td>Breathing or labial, white/brown/red splotches</td>
<td>Breathing or labial, white/brown/red splotches at corners</td>
</tr>
<tr>
<td><strong>Tongue</strong></td>
<td>Normal, moist roughness, pink</td>
<td>Patchy, fissured, red, coated</td>
<td>Patch that is red, dry, white, ulcerated, papillae</td>
<td>Patch that is red, dry, white, ulcerated, papillae</td>
</tr>
<tr>
<td><strong>Gums and tissues</strong></td>
<td>Pink, moist, smooth, no bleeding</td>
<td>Dry, erythema, red, ulcers around 1 to 3 teeth, one suspicious site under dentures</td>
<td>Swollen, bleeding around 7 teeth or more, loose teeth, ulcers, whitish patches, generalized reddening under dentures</td>
<td>Swollen, bleeding around 7 teeth or more, loose teeth, ulcers, whitish patches, generalized reddening under dentures</td>
</tr>
<tr>
<td><strong>Saliva</strong></td>
<td>Moist, viscosity and need for flowing saliva</td>
<td>Dry, sticky, few saliva present, resident thinks they have a dry mouth</td>
<td>Tissue pasted and red, very thin, no saliva present, saliva in sticky mass, resident thinks they have a dry mouth</td>
<td>Tissue pasted and red, very thin, no saliva present, saliva in sticky mass, resident thinks they have a dry mouth</td>
</tr>
<tr>
<td><strong>Natural teeth</strong></td>
<td>No decayed or broken tooth roots</td>
<td>1 to 3 decayed or broken teeth, roots, or very worn down teeth</td>
<td>4 to 6 decayed or broken tooth roots, or very worn down teeth, or less than 4 teeth</td>
<td>More than 1 broken tooth root, broken single tooth, fractured or not worn, so large area needs dental attention</td>
</tr>
<tr>
<td><strong>Dentures</strong></td>
<td>No broken areas or teeth, dentures regularly worn, and clean</td>
<td>1 broken area/teeth, or dentures only worn for 1 or 2 hrs daily, or dentures not named</td>
<td>More than 1 broken area/teeth, broken single tooth, fractured or not worn, so large area needs dental attention</td>
<td></td>
</tr>
<tr>
<td><strong>Oral cleanliness</strong></td>
<td>Clean or no food particles in mouth or mouth</td>
<td>Food particles/particles in 1-2 areas of mouth or on small area of dentures or occasional halitosis (bad breath)</td>
<td>Food particles/particles in most areas of mouth or on small area of dentures or severe halitosis (bad breath)</td>
<td>Food particles/particles in most areas of mouth or on small area of dentures or severe halitosis (bad breath)</td>
</tr>
<tr>
<td><strong>Dental pain</strong></td>
<td>No behavioral, verbal, or physical signs of dental pain</td>
<td>Any verbal or behavioral signs of pain such as pulling at face, chewing/teething, or inability to eat</td>
<td>Any physical pain signs (jawing of teeth or gum, broken teeth, ulcers), as well as verbal or behavioral signs (pulling at face, not eating, aggression)</td>
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</tr>
</tbody>
</table>

**Notes**
- A star * and underlining means: Refer person to have a dental examination by a dentist
- Person and/or family/guardian refuses dental treatment
- Review Oral Hygiene Care Plan and start oral hygiene care interventions
- Review this person’s oral health again on Date:

**ORAL HYGIENE CARE PLAN**

Client: __________________________
Completed by: ______________________
Date: ____________________________

**Dental:**
- 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 dentures: ______________________
- Name on denture: __________________
- Yes: ____________________________
- No: _____________________________
- Denture cleaning: independent some assistance fully dependent

**Assessment of Natural Teeth (please circle):**
- Upper: __________________________
- Yes: ____________________________
- No: _____________________________
- Root tips present: __________________
- Teeth cleaning: independent some assistance fully dependent

**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 / kids / 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: __________________________

For more information contact Halton Region

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