Oral Care Auditing Tool

User

HP

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**Oral health Audit Tables - Introduction**

**Purpose:** This tool provides suggestions about areas that homes can use to develop their own auditing protocols. Homes can use the audit tables that are provided, or they can adapt the audit tables to make it pertinent to their own oral care program.

**Disclaimer:** This document is not meant to be an all inclusive list. It is recommended that homes should audit components of their oral health program annually.

**Guidelines:** Auditing should be for the entire home as well as on a unit-by-unit basis (if they exist). This allows for units to be compared to one another. Homes do not need to audit every resident but should set a standard minimum percentage (for example at least 10% of residents) when conducting their audits.

**How to use the audit tables:**

1. Establish you homes targets in percentages for each of the audit tables you will be using, in order to set a benchmark to compare your results against
2. Decide which audit tables you will be using and/or adapt according to your needs
3. Decide on the number you residents you will audit
4. Use a method to randomly pick residents

**How to do the calculations when using these tables:** count all the checkmarks in each row and add the total to the column at the end. If using more than one page you will need to add the totals of all pages together. Divide each total by the total number of residents audited and place this number in the associated blank below. This will allow you assess the percentage of congruence with your goals for each area.

**Example of using an audit table:**

In this example, the toothbrushes were audited for four residents.

**Toothbrush Audit (√ for all that apply)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Variables** | **Resident room # 100** | **Resident room # 104** | **Resident room # 107-a** | **Resident room # 107-b** | **Resident room #** | **Resident room #** | **Total** |
| **Present** | **√** | **√** | **√** | **√** |  |  | 4 |
| **Labelled** | **√** |  |  | **√** |  |  | 2 |
| **Looks used but not dirty or too worn** | **√** | **√** | toothbrush was extremely worn and brown in colour | **√** |  |  | 3 |
| **Right colour \*** | **√** | **√** |  | **√** |  |  | 3 |

**\*if home is using a coloured toothbrush system to replace toothbrushes on a quarterly basis, this would be an indication of when the toothbrush was last changed.**

Present: 4/4 = 100%

Divide the rest by the total number of toothbrushes present:

Labelled: 2/4=50%

Satisfactory looking: ¾=75%

Right colour: ¾=75%

As you can see from this audit example, the home is doing a great job on providing toothbrushes. What you can see is that this home needs to address their process for labelling toothbrushes. The home might also consider reinforcing their practices in terms of when toothbrushes should be changed and their quarterly colour system.

1. **Equipment Audit Tools**

**Toothbrush Audit (√ for all that apply) - Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Variables** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Present** |  |  |  |  |  |  |  |
| **Labelled** |  |  |  |  |  |  |  |
| **Looks used but not dirty or too worn** |  |  |  |  |  |  |  |
| **Right colour \*** |  |  |  |  |  |  |  |

**\*if home is using a coloured system to replace toothbrushes on a quarterly basis**

Present: \_\_\_\_\_\_%

Divide the rest by total number of toothbrushes present

Labelled: \_\_\_\_\_\_%

Satisfactory looking: \_\_\_\_\_\_%

Right colour: \_\_\_\_\_\_%

**Denture and denture supplies audit (√ for all that apply) - Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Variables** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Dentures labelled** |  |  |  |  |  |  |  |
| **Dentures in good condition/clean (no warping)** |  |  |  |  |  |  |  |
| **Denture cup present** |  |  |  |  |  |  |  |
| **Denture cup labelled** |  |  |  |  |  |  |  |
| **Denture cup is clean** |  |  |  |  |  |  |  |
| **Denture brush present** |  |  |  |  |  |  |  |
| **Denture brush labelled** |  |  |  |  |  |  |  |
| **Denture brush is good condition** |  |  |  |  |  |  |  |

Dentures labelled: \_\_\_\_\_\_%

Dentures in good condition/clean: \_\_\_\_\_\_%

Denture cup present: \_\_\_\_\_\_%

Denture cup labelled: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Denture cup is clean: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Denture brush present: \_\_\_\_\_\_%

Denture brush labelled: \_\_\_\_\_\_%

Denture brush in good condition: \_\_\_\_\_\_% (divide number in total column with the number that are present)

**Other care supplies in residents’ care caddie audit (√ for all that apply) –** insert supplies as per your home policy

**Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Variables** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Oral health care card present** |  |  |  |  |  |  |  |
| **Toothpaste present** |  |  |  |  |  |  |  |
| **Toothpaste labelled** |  |  |  |  |  |  |  |
| **Mouth wash present** |  |  |  |  |  |  |  |
| **Mouth wash labelled** |  |  |  |  |  |  |  |
| **Cup for rinsing the mouth** |  |  |  |  |  |  |  |
| **Cup labelled** |  |  |  |  |  |  |  |
| **Cup is clean** |  |  |  |  |  |  |  |
| **Lip moisturizer** |  |  |  |  |  |  |  |
| **Lip moisturizer labelled** |  |  |  |  |  |  |  |

\*Use N/A if not applicable

Oral health care card present: \_\_\_\_\_\_%

Toothpaste present: \_\_\_\_\_\_%

Toothpaste labelled: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Mouth wash present: \_\_\_\_\_\_%

Mouth wash labelled: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Cup for rinsing present: \_\_\_\_\_\_%

Cup for rinsing labelled: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Cup for rinsing is clean: \_\_\_\_\_\_% (divide number in total column with the number that are present)

Lip moisturizer present: \_\_\_\_\_\_%

Lip moisturizer labelled: \_\_\_\_\_\_% (divide number in total column with the number that are present)

1. **Oral care practices**

**Forms Audit (√ for all that apply) Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Completed Oral Health Assessment tool** |  |  |  |  |  |  |  |
| **Consent for External Dental Services Provider signed** |  |  |  |  |  |  |  |
| **Oral care discussed at care conference** |  |  |  |  |  |  |  |
| **Oral hygiene section of POC/flow sheet completed for resident\*** |  |  |  |  |  |  |  |
| **Are there extended periods of time when oral care was not provided to resident as indicated on POC/ flow sheet? (2 or more days) \*** |  |  |  |  |  |  |  |
| **Referral form completed (if required)** |  |  |  |  |  |  |  |
| **Does resident refuse to remove dentures? (√ if yes)** |  |  |  |  |  |  |  |
| **Residents who refuse to wear dentures** |  |  |  |  |  |  |  |
| **Are dentures lost** |  |  |  |  |  |  |  |
| **Does resident require dentures due to not having teeth/many teeth** |  |  |  |  |  |  |  |

\*you might also consider developing an audit tool that looks at the oral care components of your PSW flow sheets (this will be individual for each home) – Example provided in the next table

Completed OHAT in chart: \_\_\_\_\_\_%

Annual assessment consent form in chart: \_\_\_\_\_\_%

Oral care discussed at care conference: \_\_\_\_\_\_%

Oral hygiene flow sheet is completed: \_\_\_\_\_\_%

Extended periods of no oral care: \_\_\_\_\_\_%

Referral form completed: \_\_\_\_\_\_%

Residents who refuse to remove dentures \_\_\_\_\_\_%

Residents who refuse to wear dentures \_\_\_\_\_\_%

Lost dentures \_\_\_\_\_\_%

Residents requiring dentures but don’t have \_\_\_\_\_\_%

**Example of a possible POC/Flowsheet Audit** (add home specific sections from your PSW flow sheets)

**Resident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Day** | **Evening** | **Night** | **Total** | **Comments** |
| **PSW flow sheet signed**  **(√ if signed)** |  |  |  |  |  |
| **What type of care was provided (TB = teeth brushed, M = mouth cleaned, D = denture care provided)** |  |  |  |  |  |
| **Was care done by staff or resident (ST = staff, R = resident, F = family)** |  |  |  |  |  |
| **Does resident refuse to remove dentures? (√ if yes)** |  |  |  |  |  |
| PSW Care audit | | | | | |
| What supplies were used? Toothbrush, toothpaste (how much toothpaste), mouth wash | | | | | |
| What parts of the mouth were cared for?   1. Outsides of teeth 2. Insides of teeth 3. Top teeth cleaned? N/A, Y or N 4. Bottom teeth cleaned? N/A, Y or N 5. Gums 6. tongue   Estimate amount of time care took:  If dentures, was mouth care done? Y/N (circle)  How was denture care done:   1. Was a denture brush used? Y/N (circle) 2. Were the dentures brushed? 3. Were they soaked? Y/N 4. Was a denture tab used? Y/N | | | | | |

\*NOTE: this is to be used for one resident at a time and audits the care being provided. There are no calculations to be done but you could compare these over time for the same resident.

Suggestion – if doing this audit, you may want to consider using the ‘Actual Resident Assessment’ table on the next page in conjunction with this audit. Therefore, you will not only capture the care that was recorded but you will also be able to audit the care that was provided.

**Actual Resident Assessment (√ if appears unhealthy, N/A if not applicable, please circle or describe any unusual findings) Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition of the oral cavity** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Lips –** cracked, blisters, other:\_\_\_\_\_ |  |  |  |  |  |  |  |
| **Tongue –** coated, dry, other:\_\_\_\_\_ |  |  |  |  |  |  |  |
| **Saliva –** ropey or absent, other:\_\_\_\_ |  |  |  |  |  |  |  |
| **Teeth –** cracked, cavity |  |  |  |  |  |  |  |
| **Dentures –** cracked, warped, poor fit, not labelled, other:\_\_\_\_\_ |  |  |  |  |  |  |  |
| **Debris in the oral cavity –** plaque, food |  |  |  |  |  |  |  |
| **Gums and mucous membranes –** inflamed, bleeding |  |  |  |  |  |  |  |
| **Bad breath** |  |  |  |  |  |  |  |
| **Oral pain** |  |  |  |  |  |  |  |
| **Resident requires dentures, are they in place (Yes or No)** |  |  |  |  |  |  |  |

**Unhealthy:**

Lips \_\_\_\_\_\_%

Tongue \_\_\_\_\_\_%

Saliva \_\_\_\_\_\_%

Problems with teeth \_\_\_\_\_\_%

Problems with dentures \_\_\_\_\_\_%

Debris in oral cavity \_\_\_\_\_\_%

Gums and mucous membranes \_\_\_\_\_\_%

Bad breath \_\_\_\_\_\_%

Oral pain: \_\_\_\_\_\_%

Dentures in mouth: \_\_\_\_\_\_%

**Admission Process (√ for all that apply) –** audit all new admission in the last quarter or a portion of new admissions **Date completed:\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Resident room #** | **Total** |
| **Oral health assessment completed** |  |  |  |  |  |  |  |
| **Oral health dental history completed** |  |  |  |  |  |  |  |
| **Oral health belief/preference/practices assessed** |  |  |  |  |  |  |  |
| **Care plan includes:**   1. **Oral health beliefs and practices** |  |  |  |  |  |  |  |
| 1. **Change to oral hygiene care plan, if at risk of aspiration** |  |  |  |  |  |  |  |
| 1. **Level of assistance that is required is specified** |  |  |  |  |  |  |  |
| 1. **If the resident has natural teeth, partial or complete dentures** |  |  |  |  |  |  |  |
| 1. **Type of oral care equipment to be used** |  |  |  |  |  |  |  |
| 1. **Frequency/timing of oral hygiene** |  |  |  |  |  |  |  |
| 1. **Techniques/strategies included if resident is resistive** |  |  |  |  |  |  |  |
| **Has the resident/SDM/POA signed (accepted or declined) the consent/agreement for annual dental assessment and other preventative dental services** |  |  |  |  |  |  |  |
| **Was information on dental supplies given (if applicable to your home)** |  |  |  |  |  |  |  |

OHAT completed \_\_\_\_\_\_%

Oral health history completed \_\_\_\_\_\_%

Oral health beliefs/preferences/practices assessed \_\_\_\_\_\_%

Care plan includes a) oral health beliefs and practices \_\_\_\_\_\_%

1. If at risk of aspirations this is included in oral health care plan \_\_\_\_\_\_%
2. Level of assistance: \_\_\_\_\_\_%
3. Information on teeth, partials and dentures \_\_\_\_\_\_%
4. Type of oral care equipment required \_\_\_\_\_\_%
5. Frequency/timing of oral hygiene \_\_\_\_\_\_%

Signed consent/agreement for dental maintenance and care \_\_\_\_\_\_%

Information on dental supplies given \_\_\_\_\_\_%

**Levels of assistance and behaviours Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Condition** | **# of residents** |
| **Residents who can perform their own oral care** |  |
| **Residents who require cueing** |  |
| **Residents who require assistance (including set-up)** |  |
| **Residents who are completely dependent for oral hygiene care** |  |
| **Residents who are refusing oral hygiene** |  |

Percentage of residents with the following levels of assistance requirements – take the number is each row and divide by total number of staff (should be able to run these reports from the software programs you are using for RAI-MDS).

Residents who perform own oral care: \_\_\_\_\_\_\_\_%

Residents who require cueing: \_\_\_\_\_\_\_\_%

Residents who require assistance: \_\_\_\_\_\_\_\_%

Residents who are completely dependent in oral hygiene to be performed by staff: \_\_\_\_\_\_\_\_%

Residents who are refusing oral hygiene \_\_\_\_\_\_\_\_%

1. **Annual Assessment Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residents who have been seen by a dental professional this past year \_\_\_\_\_% (# residents seen/total # of residents)**

1. **Quarterly Assessment –** you will need to work with your RAI Coordinator to get an individualized report on each of these indicators (\*there might be other RAI-MDS indicators that you could include based on your homes needs)

**RAI-MDS Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Coding** | **# of residents** |
| **Residents with chewing problems (K1a)** |  |
| **Residents with mouth pain (K1c)** |  |
| **Residents with debris present in mouth prior to going to bed at night (L1a)** |  |
| **Residents who has dentures and/or removable bridge (L1b)** |  |
| **Residents with some or all natural teeth lost – does not have or does not use dentures (L1c)** |  |
| **Residents with broken, loose, or carious teeth (L1d)** |  |
| **Residents with inflamed gums; swollen or bleeding gums; oral abscesses, ulcers or rashes (L1e)** |  |
| **Residents with daily cleaning of teeth or dentures, or daily mouth care – by resident or staff (L1f ) \*** |  |
| **E2 – resistive** |  |
| **Residents with a Dental care RAP being triggered** |  |

**\*** this one should almost always be 100% and if not the care plan for that/those resident(s) should explicitly state why not

Percentage of residents that have the following oral health issues on RAI-MDS coding – take the number is each row and divide by total number of staff (should be able to run these reports from the software programs you are using for RAI-MDS).

Chewing problems: \_\_\_\_\_\_\_\_%

Mouth pain: \_\_\_\_\_\_\_\_%

Debris present in mouth prior to going to bed: \_\_\_\_\_\_\_\_%

Has denture or removable bridge: \_\_\_\_\_\_\_\_%

Some or all natural teeth lost: \_\_\_\_\_\_\_\_%

Broken, loose, or carious teeth: \_\_\_\_\_\_\_\_%

Inflamed gums; swollen or bleeding gums; oral abscesses, ulcer or rash: \_\_\_\_\_\_\_\_%

Daily cleaning of teeth or dentures, or daily mouth care (by resident or staff): \_\_\_\_\_\_\_\_%

Resistive during oral care \_\_\_\_\_\_\_\_%

Dental RAP triggered: \_\_\_\_\_\_\_\_%

1. **Annual evaluation of oral care education Date completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Education topics**

|  |  |  |
| --- | --- | --- |
| **Type of education** | **# of Registered staff who have completed training** | **# of personal support workers who have completed training** |
| **~~Oral health~~ How to do an oral health status exam** |  |  |
| **Denture Care** |  |  |
| **How to brush teeth** |  |  |
| **Techniques and strategies for behaviour management (ex. Hand-over-hand, two toothbrush technique)** |  |  |
| **Special needs: example palliative, Other:\_\_\_\_\_\_** |  |  |

\*Add other rows to include home specific education

Percentage of staff who have been trained – take the number is each row and divide by total number of staff

(Know total numbers)

How to do an oral health assessment status exam Reg staff\_\_\_\_\_\_\_\_% PSWs\_\_\_\_\_\_\_\_%

Denture care Reg staff\_\_\_\_\_\_\_\_% PSWs\_\_\_\_\_\_\_\_%

How to brush teeth Reg staff\_\_\_\_\_\_\_\_% PSWs\_\_\_\_\_\_\_\_%

Techniques and strategies for behaviour management Reg Staff\_\_\_\_\_\_\_\_% PSWs\_\_\_\_\_\_\_\_%

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reg Staff\_\_\_\_\_\_\_\_% PSWs\_\_\_\_\_\_\_\_%

**Resident and Family Information**

|  |  |
| --- | --- |
| **Councils** | **# who received education** |
| **Education provided to family council** |  |
| **Education provided to residents council** |  |
| **Information on oral health included in Newsletter/Display** |  |
| **Individually – for residents/families: such as during care conference, as problems arise, or brochure on admission** |  |

Percentage of residents and family who received education – take the number is each row and divide by total number of residents