To develop competence in the appropriate use of plaque indices, enabling you to play a proactive role in patient oral care and education.

Understand plaque indices in relation to your role as a dental nurse

Describe the purpose of plaque indices in dental practice

Identify the most commonly used plaque disclosing solutions

Describe the materials and equipment required for plaque scoring

Demonstrate the plaque scoring process confidently

Prepare and manage patients when carrying out plaque scoring

Maintain accurate and appropriate clinical records

Course Learning Content

· Theory: Plaque indices, disclosing agents, communication, health & safety, patient management and record keeping

· Practical demonstration: Preparation of materials, equipment, patient and operator

· Clinical practice: Step-by-step plaque scoring, recording results and clinical notes

· Supervised practice

· Reflection: Patient management and plaque index recording

Theory -

- Introduction to plaque indices
- The role of plaque scoring in preventative dentistry
- Types of disclosing agents
- Communication skills for patient education
- Health and safety considerations
- Record keeping and documentation standards

Practical Demonstration

- Preparing materials and equipment
- Operator preparation
- Patient preparation and consent
- Demonstration of plaque scoring techniques

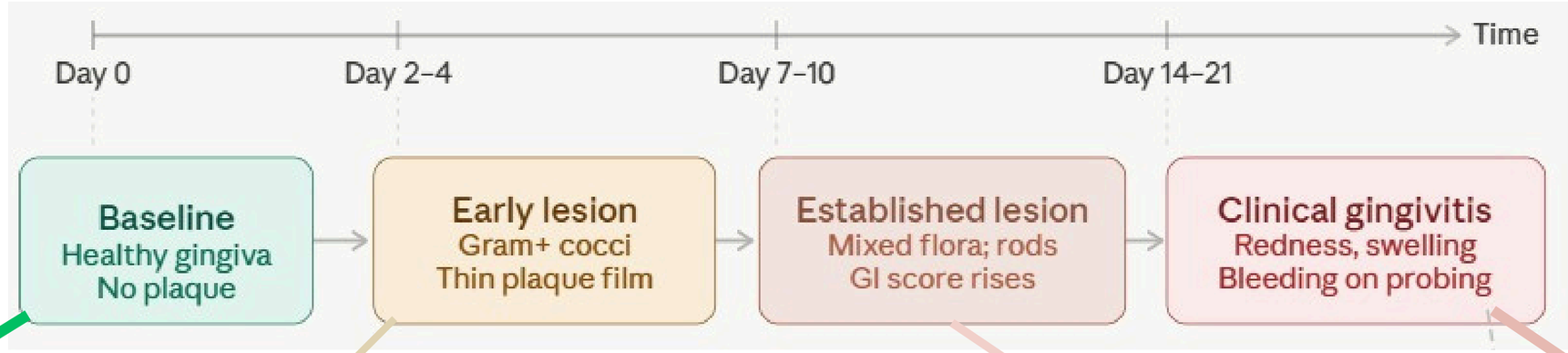
Clinical Practice

- Step-by-step plaque scoring
- Recording and interpreting results
- Clinical note documentation
- Delivering patient feedback

Supervised Practical Experience

- Complete 10 practical cases under supervision to build confidence and evidence competence.
- Reflection
- Reviewing patient management
- Reflecting on plaque index recording
- Identifying areas for professional development

Löe et al. (1965) Experimental gingivitis timeline



Day 0 — Baseline. Clinically healthy gingiva with no plaque. Oral hygiene was then completely withdrawn.

Days 2–4 — Early lesion. A thin supragingival biofilm forms. The gingiva may show mild changes histologically but not clinically obvious inflammation.

Days 7–10 — Established lesion. The gingival index begins to rise and early clinical signs emerge.

Days 14–21 — Clinical gingivitis. Full clinical inflammation is present — redness, oedema, and bleeding on probing

Gingivitis was reversible — restarting oral hygiene returned the gingiva to health within 7–10 days, confirming plaque as the primary cause of gingival inflammation.

Most significant conclusion: plaque induced gingivitis is reversibl

Dental plaque biofilm

How bacterial communities cause oral and systemic disease

Biofilm formation stages

Tooth surface (enamel / root)

1. **Pellicle** — Salivary proteins coat the tooth
2. **Early colonisers** — Streptococcus, Actinomyces attach
3. **Co-aggregation** — Late colonisers join; matrix forms
4. **Mature biofilm** — Multilayer, antibiotic resistant community

Whats the issue?

Acid microenvironment
Fermentation drops local pH to <5.5, dissolving enamel

Quorum sensing
Bacteria coordinate virulence signals across the community

Dentine/root surface?

Disease pathways

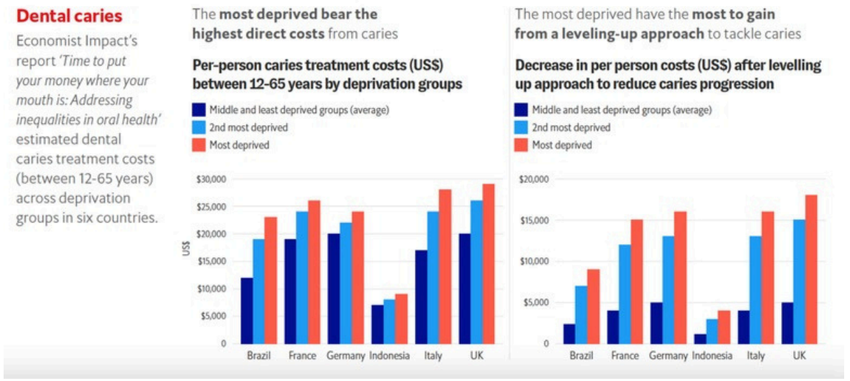
Mature plaque biofilm
Dysbiotic microbial community

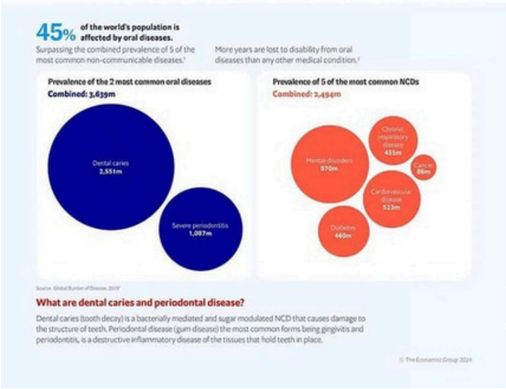
Dental caries
Strep. mutans ferments sugars → lactic acid demineralises enamel

Gingivitis
Supragingival plaque triggers gum inflammation; reversible at this stage

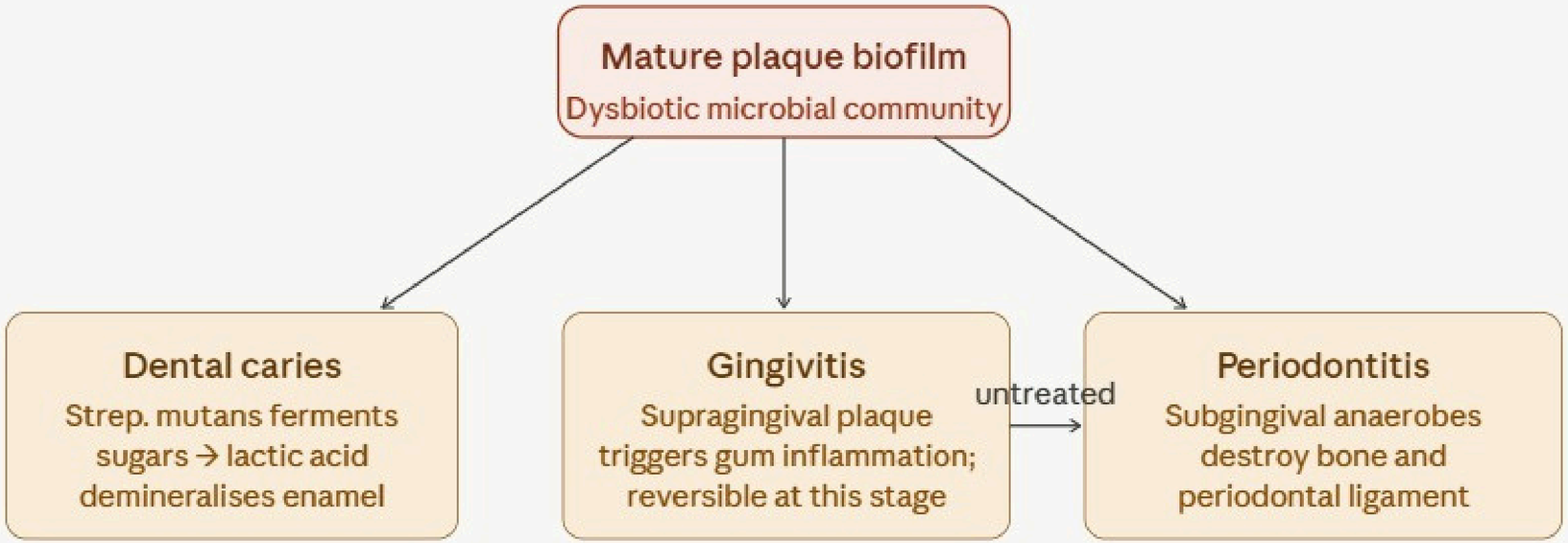
untreated →

Periodontitis
Subgingival anaerobes destroy bone and periodontal ligament





Disease pathways



Systemic health links

Periodontal bacteria and inflammatory mediators enter the bloodstream

Cardiovascular
Elevated atherosclerosis and stroke risk

Diabetes
Bidirectional: worsens glycaemic control

Preterm birth
Periodontal infection linked to low birth weight

Respiratory
Aspiration of oral bacteria → pneumonia

Breaking the biofilm cycle

Mechanical removal
Twice-daily brushing + daily flossing

Fluoride
Remineralises enamel; inhibits acid production

Antiseptics
Chlorhexidine, essential oils, CPC

Professional care
Scale & polish to disrupt mature biofilm

PMBR

Biofilm disruption every 24–48 hours prevents pathogenic succession and disease onset

	0-2 years	3-6 years	7-17 years	18 - 65 years	Older / Vulnerable adults
Most common dental diseases & conditions	Dental caries	Dental caries Tooth wear	Dental caries Gingivitis Tooth wear	Dental caries Periodontitis Tooth wear Oral cancer	Dental caries Periodontitis Tooth wear Oral Cancer Dry Mouth
Major risk factors in this age group	Diet: sugar containing food/drinks Lack of fluoride	Diet: sugar containing food/drinks Lack of fluoride	Diet: sugar containing food/drinks Low/no fluoride Tobacco commencing Alcohol commencing	Diet: sugar containing food/drinks Low/no fluoride Tobacco Alcohol Polypharmacy Tooth loss Dentures	Diet: sugar containing food/drinks Low/no fluoride Tobacco Alcohol Polypharmacy Tooth loss Dentures
Promote for everyone in this age group	Healthy diet Fluoride toothpaste	Healthy diet Fluoride toothpaste Spit don't rinse after brushing	Healthy diet Fluoride toothpaste Spit don't rinse after brushing Avoid / stop tobacco Avoid alcohol	Healthy diet Fluoride toothpaste Spit don't rinse after brushing Avoid / stop tobacco Avoid / minimise alcohol	Healthy diet Fluoride toothpaste Spit don't rinse after brushing Avoid / stop tobacco Avoid / minimise alcohol Dry mouth care
Monitoring and recall period	3-12 months	3-12 months	3-12 months	3-24 months	3-24 months

Dental plaque as a biofilm and a microbial community

plaque

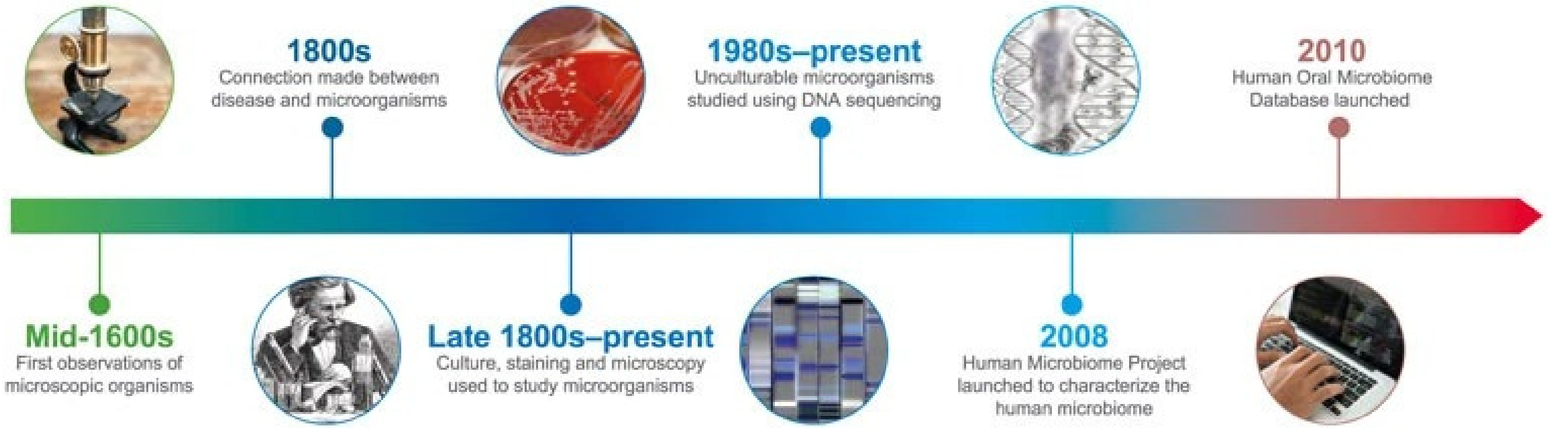
biofilm

plaque biofilm

dysbiotic plaque

oral microbiome

dysbiotic plaque biofilm



17th C

19th C

20th C

21st C

“Little animalcules”

plaque biofilm

Plaque matures undisturbed

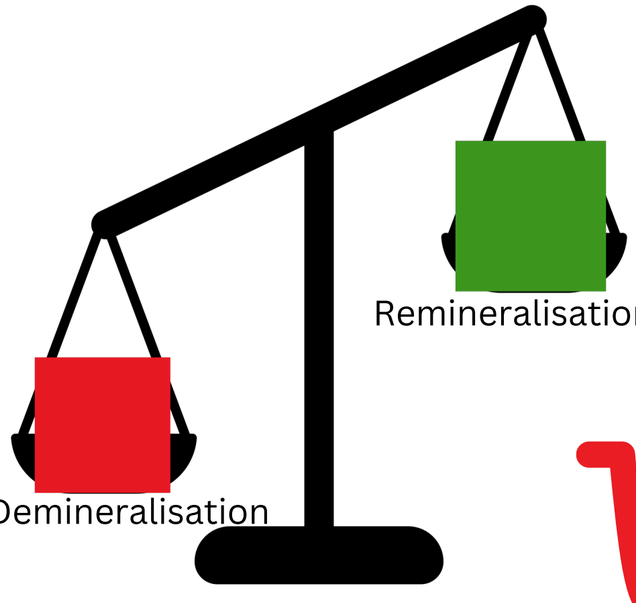
Plaque retention

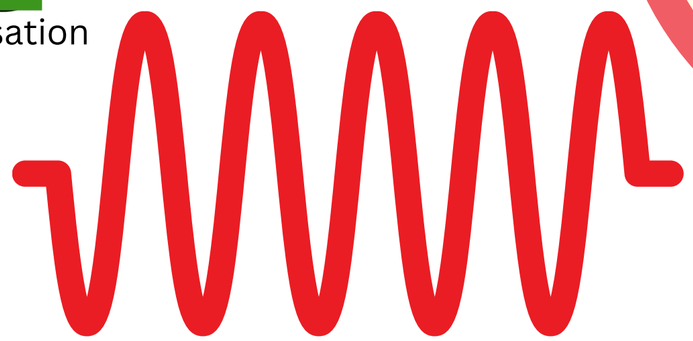
crooked teeth
lone standing
rough surfaces
implants
calculus

saliva flow
self cleansing
oral hygiene

https://www.bsperio.org.uk/assets/downloads/good_practitioners_guide_2016.pdf

Figure 1 Instanding LR1 showing localised plaque and calculus accumulation on the interproximal, buccal and lingual aspect.





The common denominator?

Plaque matures undisturbed

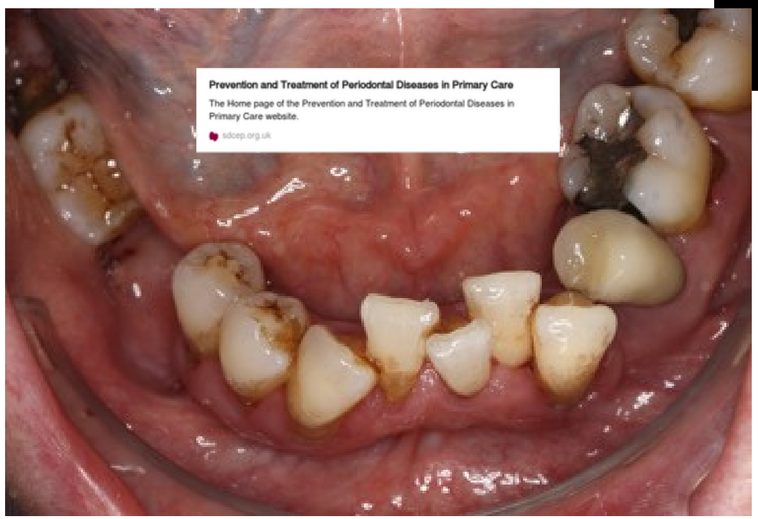
Plaque retention

https://www.bsperio.org.uk/assets/downloads/good_practitioners_guide_2016.pdf

Figure 1 Instanding LR1 showing localised plaque and calculus accumulation on the interproximal, buccal and lingual aspect.

crooked teeth
lone standing
rough surfaces
implants
calculus

saliva flow
self cleansing
oral hygiene



Dental plaque biofilm

Factors that Influence the Composition of the Oral Microbiome

Life stage

Oral microbial diversity

High

Low

Factors

Maternal transmission

Genetics

Oral hygiene practice

Dietary habits

Smoking

Stress

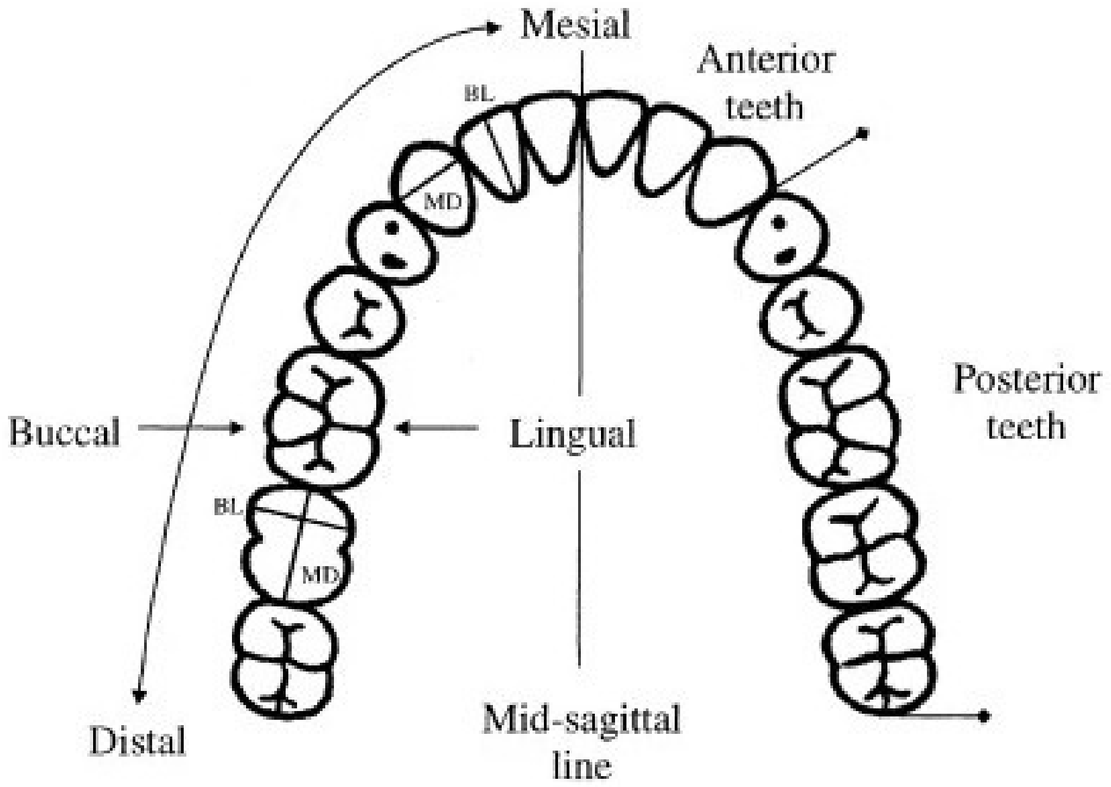
Medications

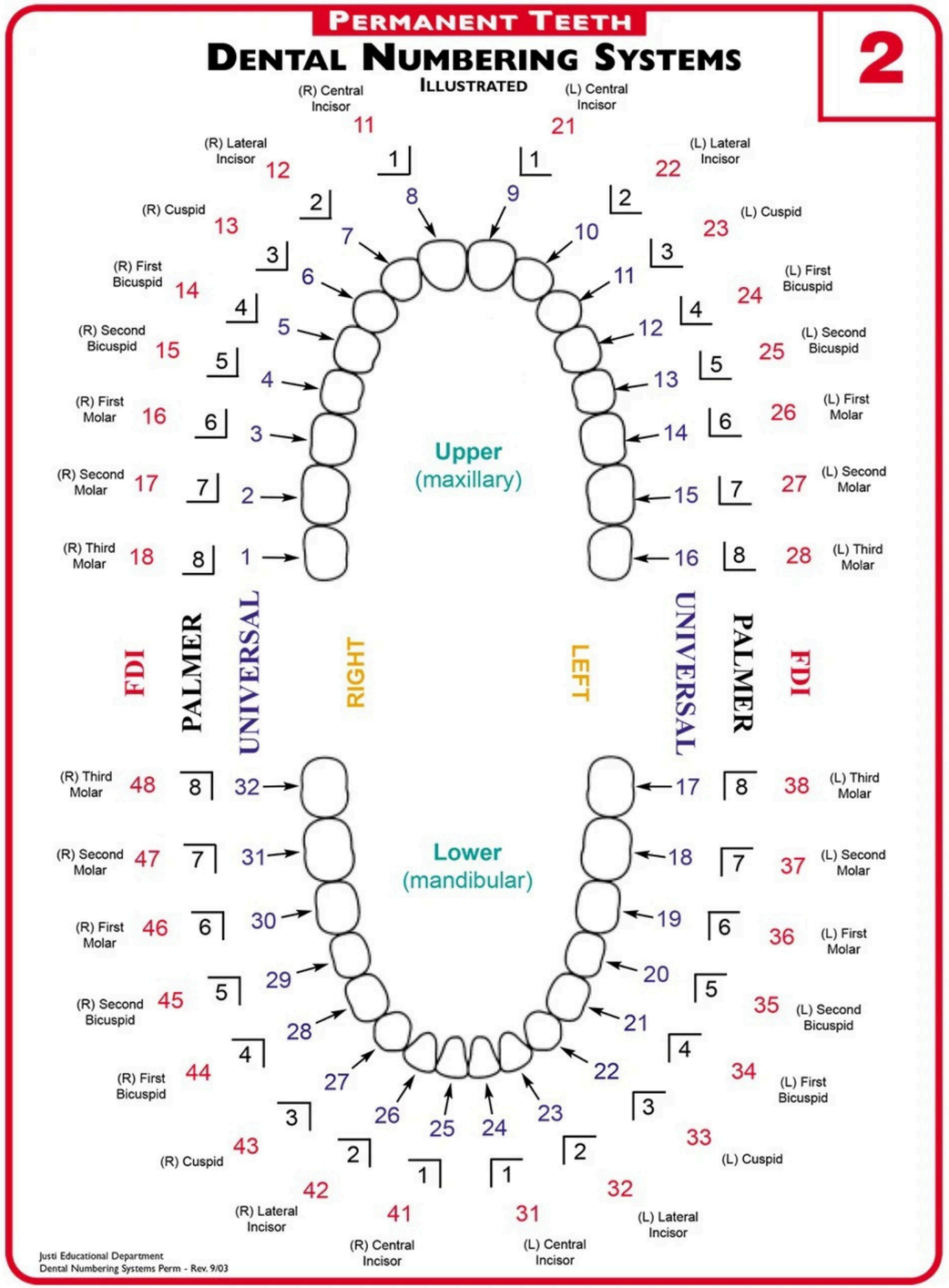
Environmental Factors

Systemic diseases/ conditions

The Oral Microbiome: From First Encounters to Lifelong Encounters

Speaking the same language?
Nomenclature





A way of expressing a clinical observation by numbers

Indices

Simple - presence/absence

Cumulative - measures all evidence of a condition

Irreversible

Reversible index

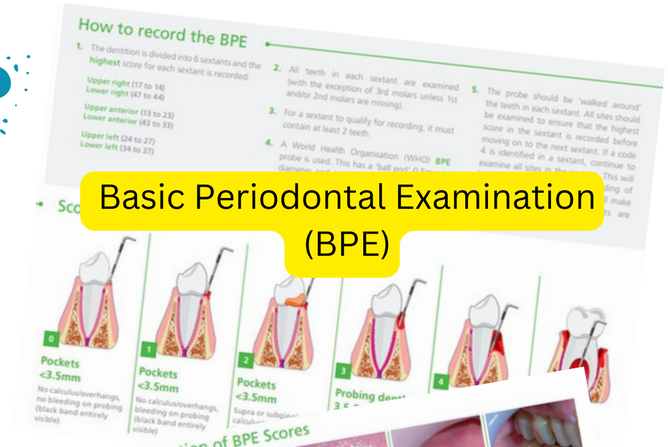
Useful and effective index:

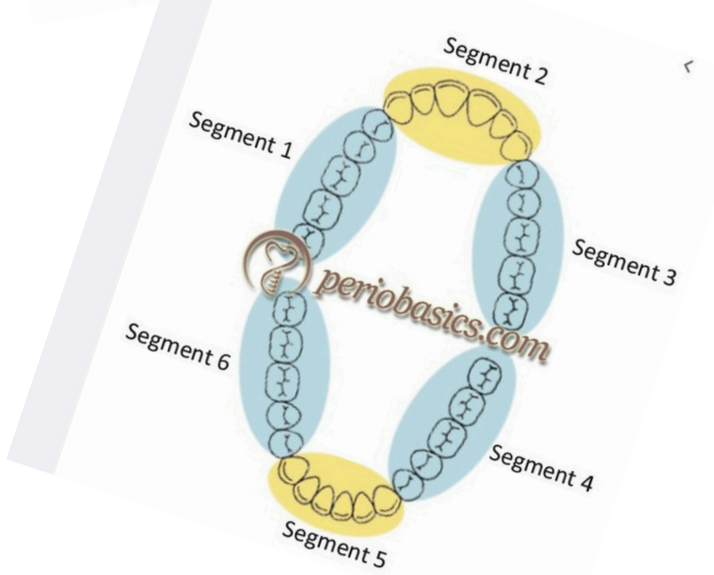
- simpleto use and calculate.
- minimal equipment, expense, and time to complete.
- acceptable to the patient - no discomfort
- easy to understand and use
- is objective

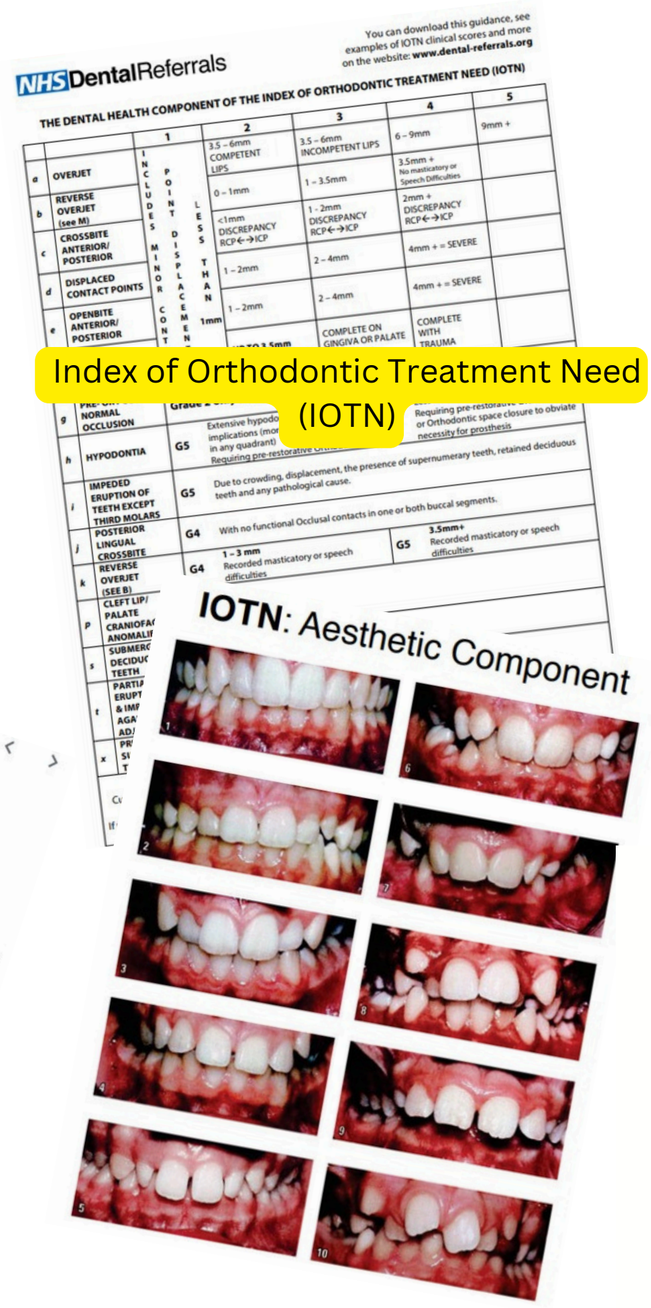
Valid

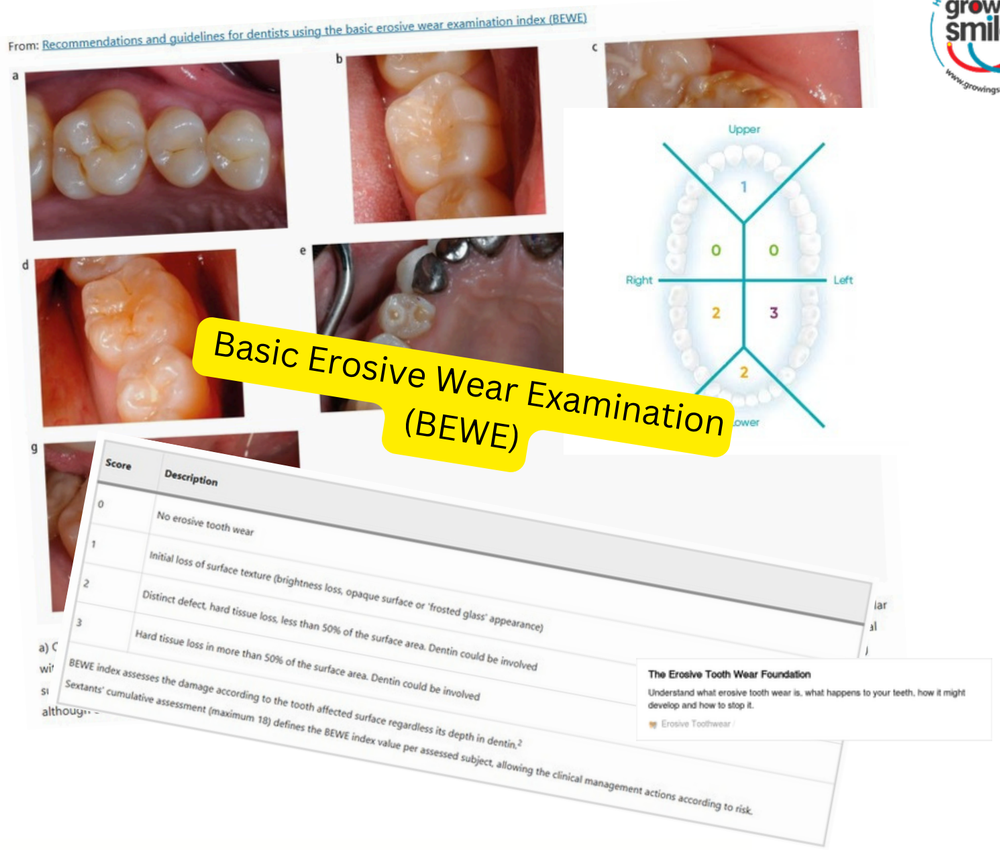
Reliable

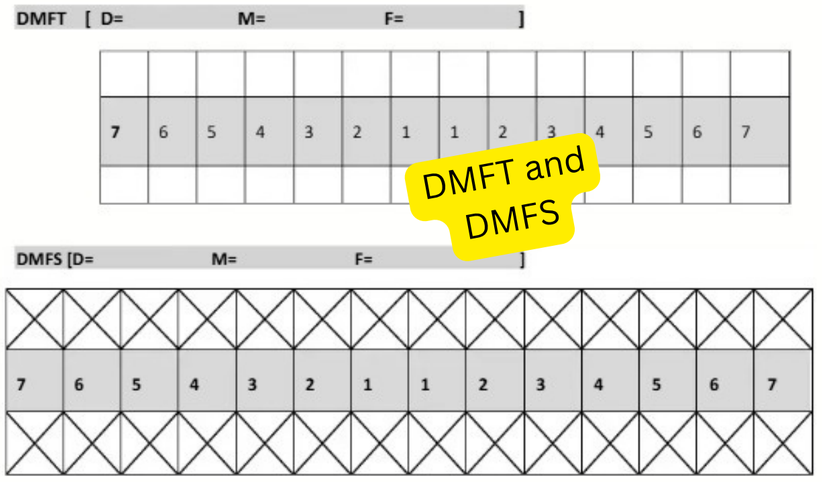
Quantifiable


How to record the BPE
Basic Periodontal Examination (BPE)
Pockets <3.5mm
Pockets <3.5mm
Pockets <3.5mm
Probing
Guidance on Interpretation of BPE Scores
Periobasics


Segment 1
Segment 2
Segment 3
Segment 4
Segment 5
Segment 6
periobasics.com


NHS DentalReferrals
You can download this guidance, see examples of IOTN clinical scores and more on the website: www.dental-referrals.org
THE DENTAL HEALTH COMPONENT OF THE INDEX OF ORTHODONTIC TREATMENT NEED (IOTN)
Index of Orthodontic Treatment Need (IOTN)
IOTN: Aesthetic Component


From: Recommendations and guidelines for dentists using the basic erosive wear examination index (BEWE)
Basic Erosive Wear Examination (BEWE)
Upper
Right
Left
Lower
Score
Description
The Erosive Tooth Wear Foundation


DMFT [D= M= F=]
DMFS [D= M= F=]
DMFT and DMFS

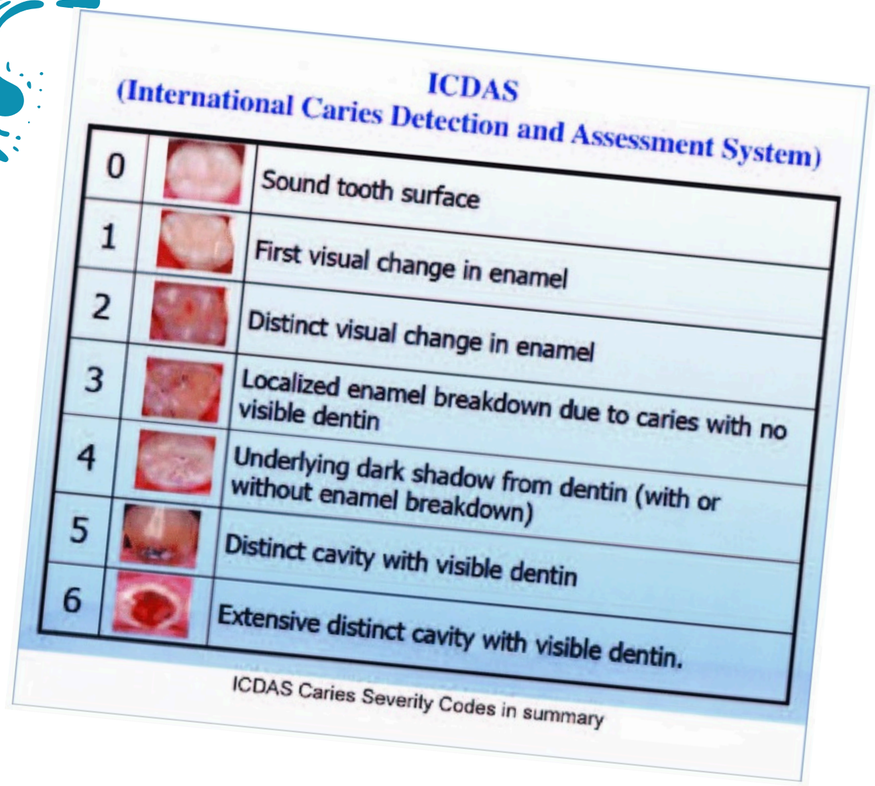
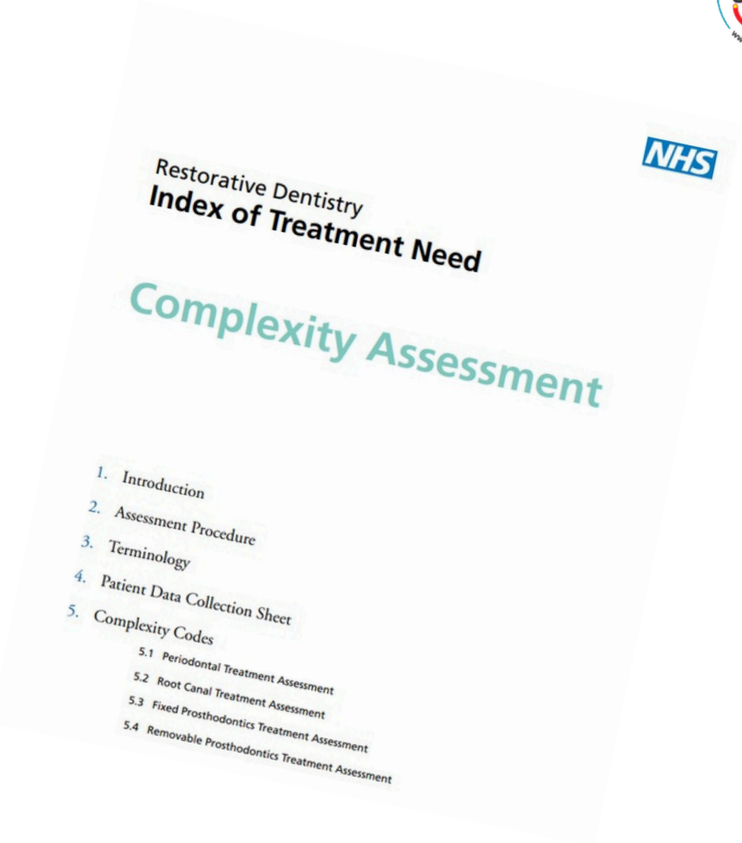
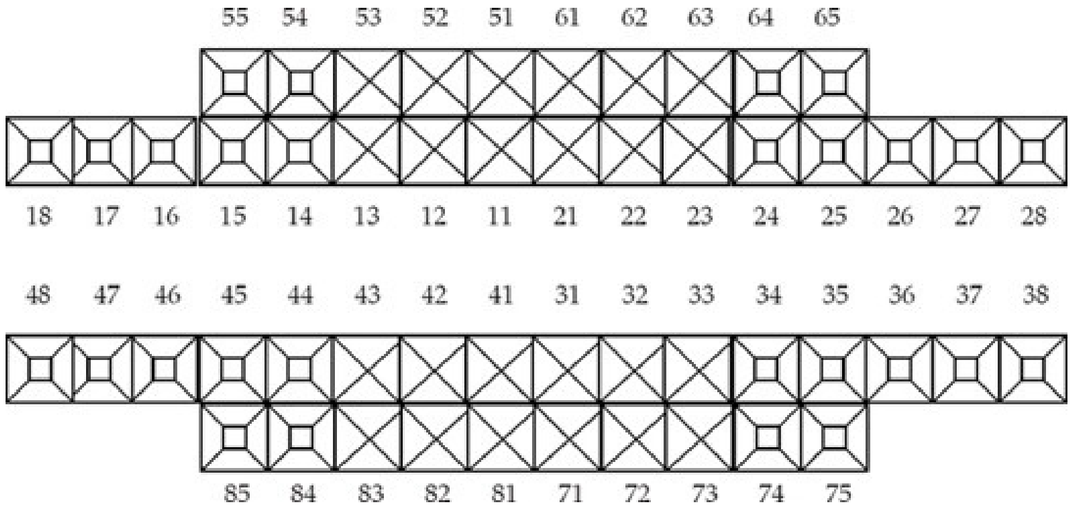


Table 2. Formula for computing RCI.

$$\frac{\text{Root surfaces decayed + filled} \times 100}{\text{Root surfaces with loss of periodontal attachment}} = \text{Decayed + Filled + Sound}$$





Modified Smartphone Camera Can Detect Dental Plaque Biofilm

Selfies take on new meaning in oral healthcare with the advent of this technology.

Understanding Plaque Indices

O’Leary Plaque Index

Best for patient motivation

Biofilm Index (BI) [Plaque Index]

Measures plaque thickness

Modified Quigley-Hein Index

Useful for research and comparative scoring

Approximal Plaque Index

Specifically for interdental plaque assessment

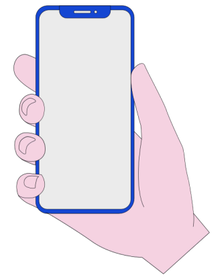
INDEX	SCORING	METHOD	SURFACES RECORDED	CLINICAL USE
O'Leary Plaque Control Record O'Leary et al., 1972 Dichotomous	0 = absent 1 = present % surfaces with plaque	Disclosing solution applied; presence or absence of plaque recorded at each surface. Score expressed as a percentage.	4 surfaces per tooth: mesial, distal, buccal, lingual/palatal. All teeth included.	Patient motivation and oral hygiene instruction. Simple, quick, and easy to explain to patients. Target ≤10%.
Plaque Index (PII) Silness & Löe, 1964 Ordinal 0–3	0 = none 1 = thin film 2 = moderate 3 = abundant	Visual and tactile assessment with a probe; no disclosing agent required. Score averaged per tooth or per mouth.	4 gingival areas: mesial, distal, buccal, lingual. Focus on plaque at the gingival margin.	Epidemiological research and clinical trials. Sensitive to plaque at the gingival margin; correlates with gingival inflammation.
Modified Quigley-Hein Index (Turesky) Turesky et al., 1970 Ordinal 0–5	0 = none 1 = flecks 2 = thin band ≤1mm 3 = >1mm, <⅓ 4 = ⅓–⅔ 5 = >⅔	Disclosing solution required. Plaque extent scored on facial and lingual surfaces from the gingival margin coronally.	Facial and lingual surfaces of all teeth. Does not include proximal surfaces separately.	Widely used in clinical trials of oral hygiene products (toothpastes, mouthrinses). Sensitive to small changes in plaque extent.
Approximal Plaque Index (API) Lange et al., 1977 Dichotomous	0 = absent 1 = present % approximal spaces	Disclosing agent used; plaque presence recorded in interproximal spaces only, alternating between buccal and oral aspects across quadrants.	Approximal (interproximal) spaces only. Recorded buccally in Q1 & Q3; orally in Q2 & Q4.	Periodontal supportive therapy; monitors interproximal hygiene. Guides: <25% = optimal, 25–39% = adequate, 40–70% = inadequate, >70% = poor.

The *Purpose* of plaque indices in dental practice

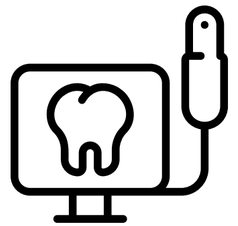
Objectively **measure, record, and monitor the amount of dental plaque on a patient's teeth**

Evaluate personal oral hygiene efficacy

Identify areas for improvement



Motivate patients



Identify the most commonly used plaque disclosing solutions

Disclosing Tablets

Disclosing Solutions

Two-Tone / Multi-Tone Disclosing Agents

Fluorescent Plaque Detection Systems

Digital & Fluorescence-Based Imaging Systems

Materials and equipment required for plaque scoring

Disclosing agents

Disclosing tablets
Disclosing solution
Single-use disclosing swabs

Personal protective equipment (PPE)

Disposable gloves (nitrile)
Face mask
Protective eyewear/visor
Clinical uniform/apron

Instruments & materials

Mouth mirror
Good light source (dental chair light or portable)
Cotton buds or microbrush applicators (if using solution)
Gauze/tissue
Dental chair with suction (desirable)
(Dental probe - to identify stained deposits)

Patient education materials

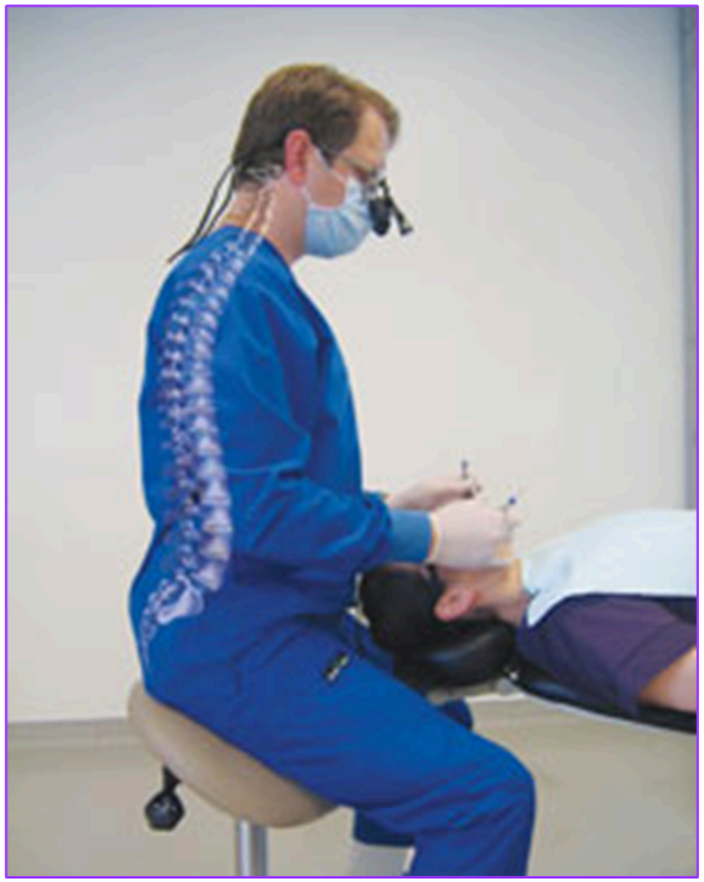
Hand mirror
Plaque score recording chart
Toothbrush and interdental aids for demonstration
Patient information
(Camera/patient phone)

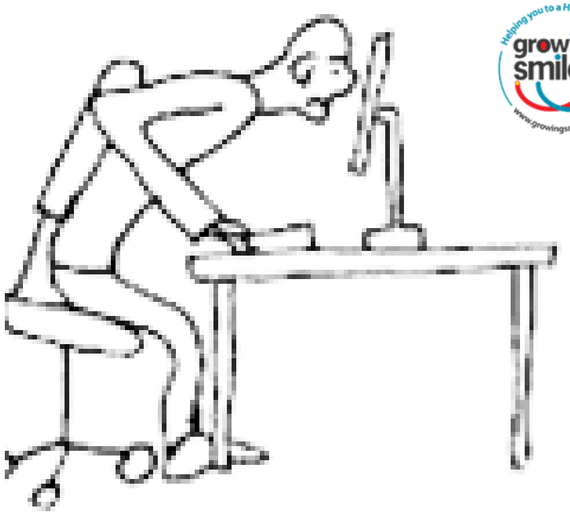
Waste disposal

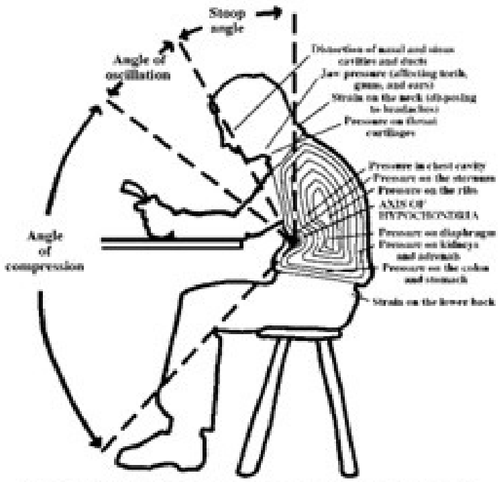
Clinicalwaste
Non-clinical waste

Documentation

Patientrecords/notesfor recording plaque scores/patient education given
Software records - logged in under your own name
Consent







The Posture Theory Diagram

Stool is only ergonomic if it adjusts to fit your body size and shape.

Over a 30-year career, dental clinicians spend over 60,000 hours chairside = >1800 days!

Adjust operator stool first

Sit comfortably

Adjust the backrest height so the most convex portion (the lumbar support) nestles in your low-back curve

Ajust the height -feet flat on floor until thighs slope slightly downward. Weight should be evenly distributed in a tripod through each foot on the floor and through buttocks

Thumbs up!!

Thighs angled forward. Angle of thighs to torso > 90º

Patient position

Patient positioning techniques will vary slightly depending upon the quadrant being treated, the patient's tolerance to reclining, and patient chair shape and width.

Patient head at end of headrest.

Adjust the height of the patient chair so forearms are parallel to the floor or sloping 10 degrees upward

Supine

Semi - supine

Ask patient to turn their head slightly during treatment

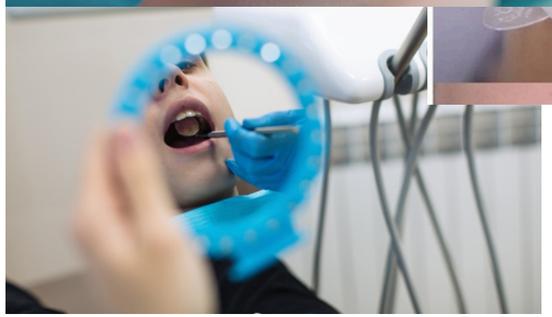
Handpieces/ instruments about elbow height.

Finger fulcrums increase stability and reduce compression in the carpal tunnel.

Repositioned light to prevent shadowing – or use a headlight

Mastering indirect vision

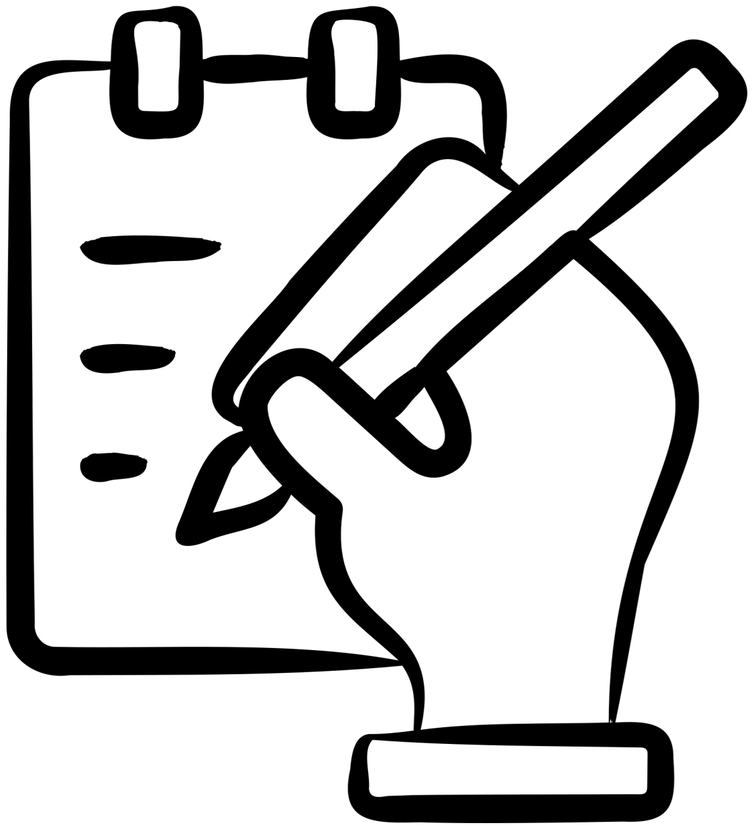
"mirror image"



Practice makes PROGRESS

Use of Mouth Mirror / Mirror Image	Purpose in Clinical Practice	Benefits to the Dental Clinician
Indirect Vision (Mirror Image)	Viewing areas of the mouth that cannot be seen directly, such as lingual/palatal surfaces and	Improves access and visibility while maintaining ergonomic posture
Retraction	Moving cheeks, lips and tongue away from the working area	Enhances access, visibility and patient safety
Illumination	Reflecting light into darker areas of the oral cavity	Improves visualisation of teeth and soft tissues
Magnification	Slight enlargement of structures viewed in the mirror	Supports more detailed examination and precision
Transillumination	Reflecting light through tooth structure	Assists in identifying cracks, caries or calculus deposits
Moisture Control Assistance	Helping manage saliva and soft tissue positioning	Maintains a clearer working field
Patient Education	Allowing patients to view plaque, restorations or oral conditions	Improves communication and patient understanding
Assessment of Oral Structures	Examination of teeth, gingivae and soft tissues	Supports diagnosis and monitoring
Ergonomic Working	Facilitating indirect working positions	Reduces operator strain and musculoskeletal risk
Support During Procedures	Assisting with instrument positioning and orientation	Enhances clinical accuracy and efficiency

Record



PATIENT NAME — | DATE 17/05/2026 | CLINICIAN —

RAMFJORD INDEX TEETH — PLAQUE PRESENCE/ABSENCE

16 JR6	N/A	21 UL1	N/A	24 UL4	N/A
Interproximal	0 1	Interproximal	0 1	Interproximal	0 1
Buccal	0 1	Buccal	0 1	Buccal	0 1
Palatal	0 1	Palatal	0 1	Palatal	0 1

36 LL6	N/A	41 LR1	N/A	44 LR4	N/A
Interproximal	0 1	Interproximal	0 1	Interproximal	0 1
Buccal	0 1	Buccal	0 1	Buccal	0 1
Lingual	0 1	Lingual	0 1	Lingual	0 1

SCORE

SURFACES SCORED	PLAQUE PRESENT	MAX POSSIBLE	PLAQUE SCORE
0	0	18	—

0% — 100%

BSP-S3 targets (Step 1 therapy): plaque ≤ 20%, or ≥ 50% reduction from baseline · marginal bleeding ≤ 30%, or ≥ 50% reduction from baseline

NOTES

Clinical notes, baseline comparison, hygiene instruction given…

Reset scores | Interpret result ↗

Step-by-Step Calculation

Identify tooth surfaces: Typically, four (6) surfaces are assessed per tooth

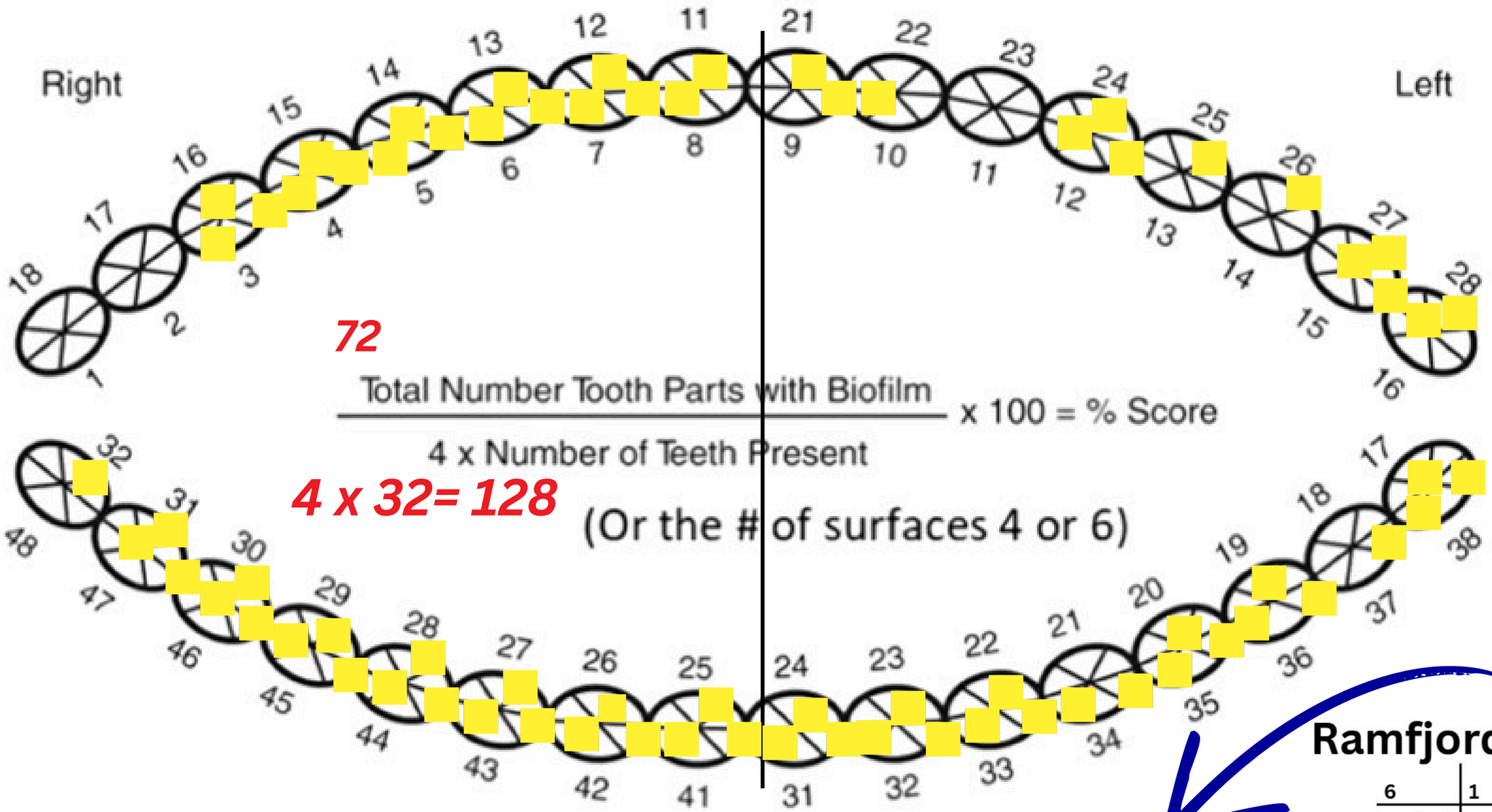
Scores: Mark each surface as \(1\) (plaque present) or \(0\) (plaque absent).

Calculate Percentage

$$\text{Plaque Score (\%)} = \left(\frac{\text{Number of surfaces with plaque}}{\text{Total number of surfaces examined}} \right) \times 100$$

O’Leary Plaque Control Record

72/128 = 0.56 x 100 =56%



Visible plaque = 2

Ramfjord Teeth

6	1 4
4 1	6

Modified palque index 17 x 2 = 34 /6 =5.6 x 100 =56%

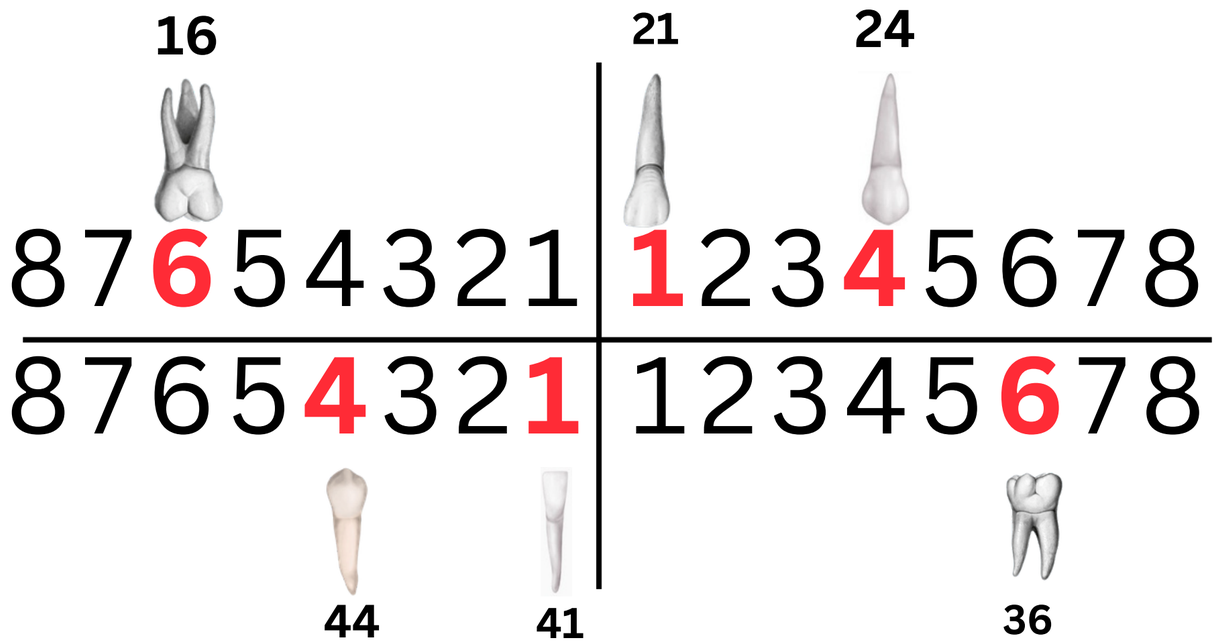
Prevention and Treatment of Periodontal Diseases in Primary Care

Dental Clinical Guidance, 2nd Edition - February 2024

Scottish Dental Clinical Effectiveness Programme

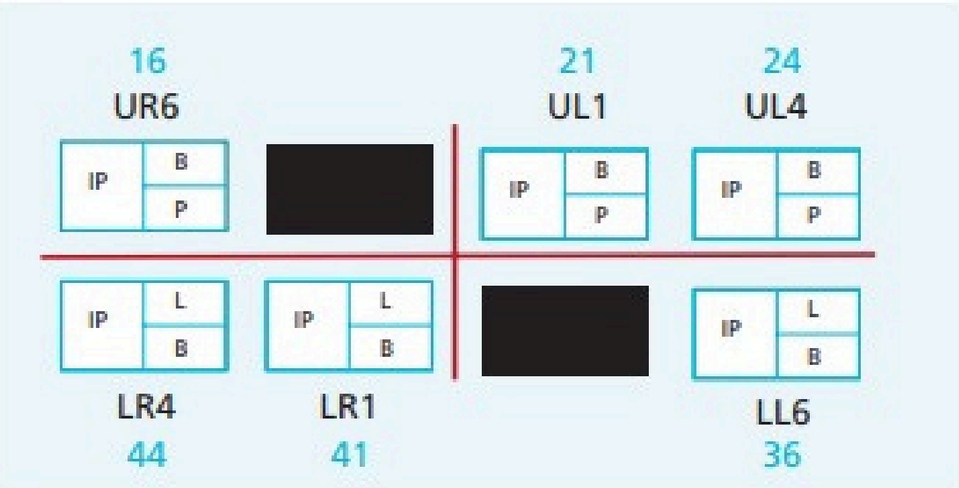
Ramfjord Teeth

6	1 4
4 1	6

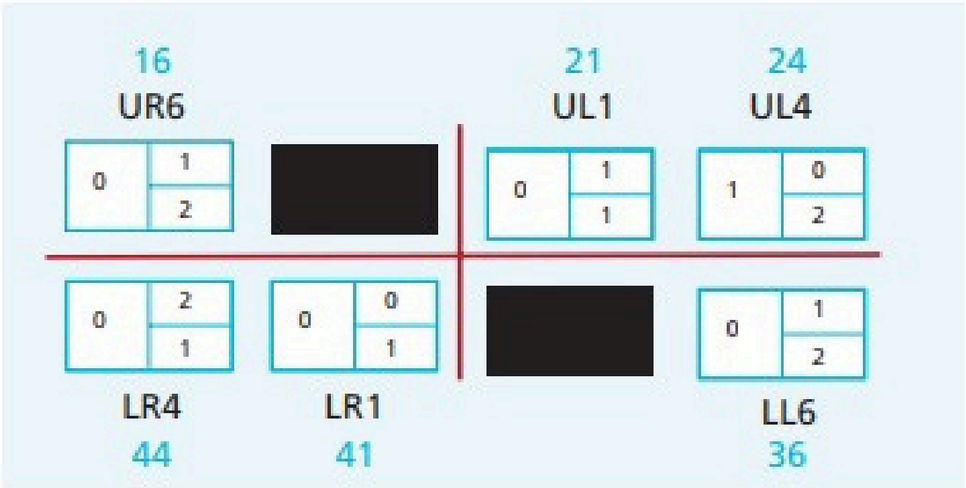


Modified Plaque Score

Ramfjord's Teeth



An Example of a Modified Plaque Score



Code	Description
0	No plaque visible, even when a probe is used
1	Some plaque visible only when a probe was used to skim the tooth surface
2	Visible amount of plaque which can be seen without use of a probe
N	No measurement could be made for this surface/tooth

Total Score = 15

Plaque Score:

$\frac{15}{36} \times 100 = \mathbf{41.66 = 42\%}$

Modified Plaque Score = 42%

https://www.bsperio.org.uk/assets/downloads/NHS_HGdM_Quick_Ref_(Mar19).pdf

Prepare and manage patients when carrying out plaque scoring

BE PREPARED

Confirm patient identity

Medical history

Consent

What Why

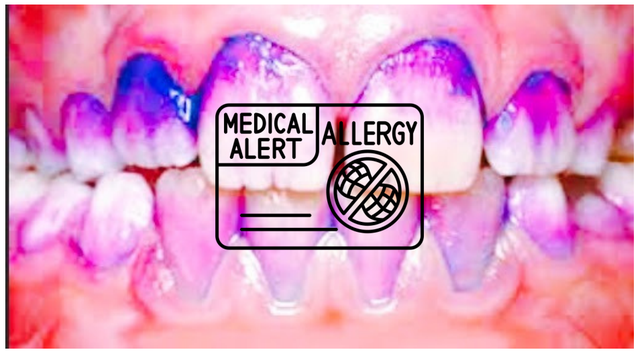
Stain is temporary
BUT

up to 30–60 minutes on soft tissues

Explain procedure

Patient/operator position

Medical history



cosmetic or educational

GOV·UK

2 or more ingredients (including any additives) must be listed in order of weight, with the main ingredient first.

Erythrosine

(Red / CI 45410 / D&C Red No. 28)

Brilliant Blue

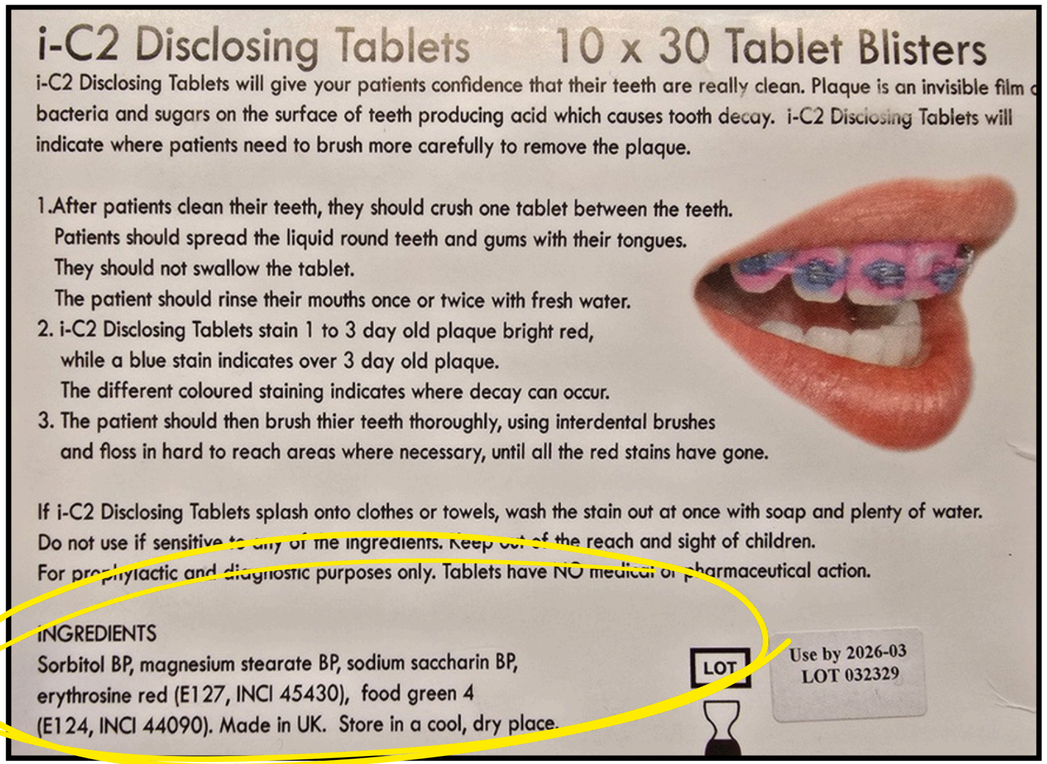
(Blue / CI 42090 / FD&C Blue No. 1)

Allergens

You must highlight allergens on the label using a different font, style or background colour. You must also list them in the ingredients.

The allergens you need to highlight and list are:

- celery
- cereals containing gluten - including wheat, rye, barley and oats
- crustaceans - including prawns, crab and lobster
- eggs
- fish
- lupin
- milk
- molluscs - including squid, mussels, cockles, whelks and snails
- mustard
- nuts
- peanuts
- sesame seeds
- soya beans
- sulphur dioxide or sulphites at levels above 10mg per kilogram or per litre



Binders & Bulking Agents

Dextrates or Sorbitol

Magnesium Stearate

Texture & Flavour

Sodium Starch Glycolate

Aroma (Fruit, Mint, or Menthol)

Dye Sensitivities

Gluten / Celiac Disease

Prepare patient - position, light etc

Apply petroleum jelly

Disclose - chew, swish, tongue spread

Rinse & spit

Examine and assess plaque present

Record

Score

Interpret

Utilise - ACT

What to do if disclosing solution is spilled?

To minimise spills: BE PREPARED!
Use small amounts of solution
Use dappen dishes
Keep lids closed when not in use
Prepare trays carefully
Use disposable bibs etc
Apply solution slowly and carefully

Patient Question	Suggested Evidence-Based Response
What is the dye for?	The disclosing solution highlights plaque biofilm on the teeth so we can see areas that may be missed during brushing.
What exactly is plaque?	Plaque is a sticky layer of bacteria that constantly forms on teeth and gums. If not removed, it can contribute to tooth decay and gum disease.
Will it hurt?	No. Plaque disclosing is painless and non-invasive.
Will it stain my teeth permanently?	No. The colour is temporary and usually brushes away within a few hours.
Will it stain my lips or tongue?	It can temporarily colour soft tissues, but this fades quickly. Protective measures help minimise staining.
Why are some areas darker than others?	Darker areas often show older or more established plaque that has not been cleaned away effectively.
Does this mean my teeth are dirty?	Not necessarily. Most people miss certain areas when brushing. The aim is to identify where cleaning can be improved.
Why do I need plaque scoring?	Plaque scoring helps assess oral hygiene effectiveness and supports personalised oral health advice.
How often should plaque scoring be done?	This depends on individual oral health needs, but it can be useful during preventive visits, orthodontic care or gum disease monitoring.
Can children use disclosing tablets?	Yes, under supervision. They can be very helpful for teaching brushing skills to children.
Can I buy these products myself?	Yes. Many disclosing tablets are available from pharmacies, dental practices and online retailers in the UK.
Why do braces make plaque harder to remove?	Brackets and wires create more plaque-retentive areas that are harder to clean effectively.
Can mouthwash remove plaque?	NO!! Plaque is removed by mechanical means - toothbrush IDC
What colour should healthy teeth look after disclosure?	Ideally, there should be very little or no staining visible after cleaning.
Why are my back teeth showing more plaque?	Back teeth are often more difficult to reach and clean thoroughly.
Can plaque cause bad breath?	Yes. Plaque bacteria can contribute to oral malodour. Tongue cleaning can help
What happens if plaque is left on teeth?	Over time, plaque can harden into calculus (tartar) and increase the risk of gum disease and tooth decay.
Can plaque be removed without brushing?	Effective plaque removal requires mechanical cleaning with brushing and interdental aids.

PMBR

Personal mechanical biofilm removal

- Have hand mirror ready
- Explain disclosed areas to the patient - mature, new plaque
  - Explain goals - lower score, reduce mature plaque, improved OH, reduced inflammation etc

Feel the clean

- Assess oral hygiene techniques -modify/amend tools etc

Plaque biofilm

KEY RECOMMENDATIONS

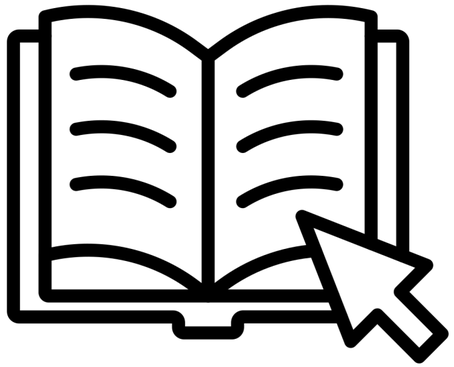
Advise patients (and their carers, where appropriate) to regularly remove plaque biofilm using a toothbrush, and interdental aids where required, as an effective regime to prevent and facilitate management of plaque-induced gingivitis and periodontitis.

(Strong recommendation; moderate certainty evidence)

Use behaviour change methods when providing oral hygiene instruction for patients who have sub-optimal oral hygiene.

(Conditional recommendation; low certainty evidence)

https://www.periodontalcare.sdcep.org.uk/supporting-tools/monitoring-plaque-and-bleeding/



Prevention and Treatment of Periodontal Diseases in Primary Care

The Home page of the Prevention and Treatment of Periodontal Diseases in Primary Care website.

sdcep.org.uk

Prevention and Treatment of Periodontal Diseases in Primary Care

Scottish Dental
Clinical Effectiveness Programme

Home | Published guidance | In development

Home / Published guidance

Published guidance

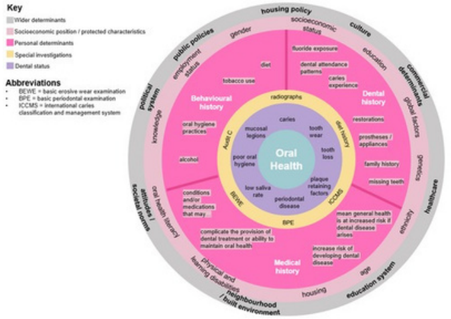
https://www.sdcep.org.uk/published-guidance/caries-in-children/

GOV.UK

Delivering better oral health: an evidence-based toolkit for prevention

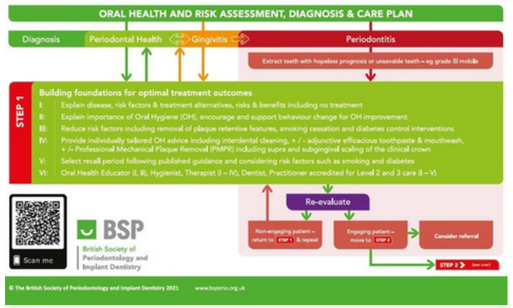
This is an evidence-based toolkit to support dental teams in improving their patients' oral and general health.

GOV.UK / Sep 10, 2025



BSP UK CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF PERIODONTAL DISEASES

HALEON



GDC publishes revised Scope of Practice guidance

16 September, 2025

Share

Core Scope of Practice

The fundamental daily responsibilities that all registered dental nurses carry out include:

- **Chair-side Support:** Assisting the dentist or hygienist by preparing and maintaining instruments, materials, and medicaments.
- **Infection Control:** Decontaminating and sterilising equipment, maintaining surgery hygiene, and implementing strict cross-infection procedures.
- **Record-keeping:** Noting clinical dictation, charting, and keeping accurate, contemporaneous patient records.
- **Patient Care:** Monitoring patient wellbeing, providing pre- and post-operative advice, and comforting anxious patients.
- **Radiography:** Processing radiographs and managing stock controls. Dental Nurse Network +1

Additional Post-Registration Skills

With additional certified training and competency, dental nurses can legally perform extended duties such as:

- Taking dental impressions.
- Applying topical fluoride.
- Clinical photography.
- Dental radiography (taking X-rays).
- Plaque scoring and oral health education. General Dental Council +1

BSP
British Society of Periodontology and Implant Dentistry

Healthy gums DO matter!

BSP Clinical Guidelines

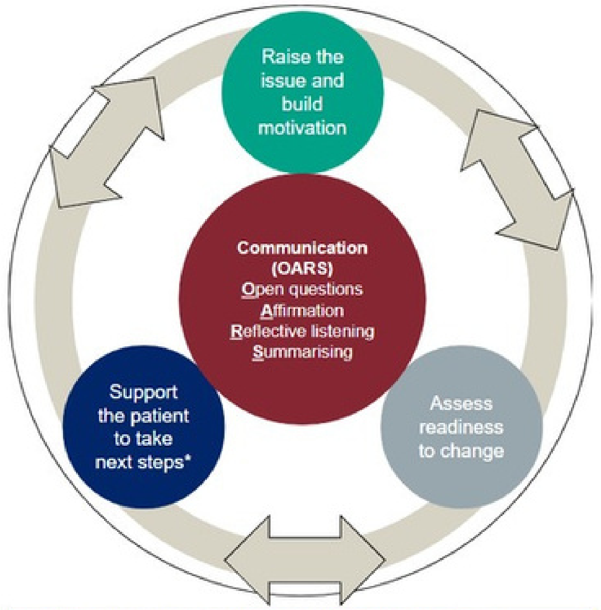
- NHS Avoidance of doubt: Provision of phased treatments
- Delivering phased care for periodontitis patients under UDA banding in England: Road map to prevention and stabilisation
- BSP Flowchart Implementing the 2018 Classification
- Good Practitioner's Guide to Periodontology 2016 (PDF) PLEASE NOTE: this document is currently being updated to link with BSP and EFP recommendations. The GPG is presently overruled by current guidance from DoH and UK CDOs due to COVID-19.
- BPE Guidelines 2019
- S3 Flowchart: UK Clinical Practice Guidelines for the Treatment of Periodontal Diseases
- Parameters of Care
- BSP Guidelines for Periodontal Patient Referral
- Guidelines for Periodontal Screening and Management of Children and Adolescents Under 18 Years of Age - Executive Summary
- Guidelines for Periodontal Screening and Management of Children and Adolescents Under 18 Years of Age

Dental plaque biofilm is the primary cause of the most common oral diseases, including gingivitis and dental caries — effective plaque control is fundamental to oral health.

.Plaque that patients cannot see is often difficult for them to understand or remove effectively. Making plaque visible creates powerful learning opportunities.

Not just a scoring exercise. It's a patient education and behaviour change tool. How scores are communicated matters - supportive, non judgemental build confidence and motivation

Small daily improvements can lead to significant long-term oral hea.lth benefits. DBOH Behaviour change TIPS



*Provide person-centred support and tailored instruction.
1. Help set SMART (specific, measurable, achievable, relevant, timely) goals
2. Help identify barriers
3. Discuss relapse prevention
4. Provide reassurance
5. Plan rewards
6. Signpost or refer

Consistency, accuracy and clear record keeping are essential parts of safe clinical practice

Dental nurses play an important role in prevention, patient engagement and improving oral health outcomes.

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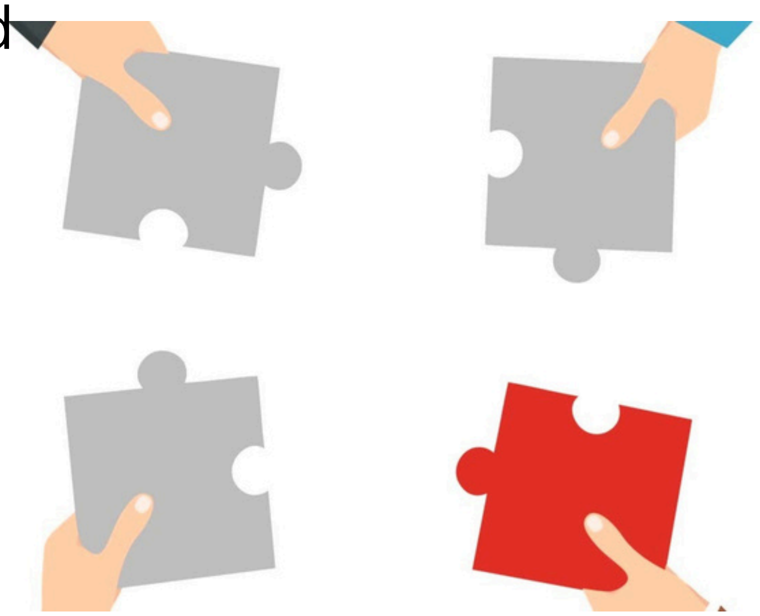

Aim is not simply to record plaque scores — it is to help patients achieve healthier mouths for life.