

# **Oral health risk assessment & care plan**

Clients full name:

Known as:

Client’s date of birth:

Address/Room no:

**Please circle relevant answer**

|  |  |  |
| --- | --- | --- |
|   | **Assessment**  | **Suggested action for care plan**  |
| **1.** | Does the person have any natural teeth? Y/N Do they need help cleaning their teeth? Y/NType of support needed: | If yes get prescription for high fluoride toothpaste prescription from dentist Explore support needed to clean twice per day with soft toothbrush and pea sized amount of toothpaste  |
| **2.**  | Does the person have dentures? Y/NDo they need help cleaning their dentures? Y/NAre the dentures labelled? Y/N | If yes encourage cleaning morning and night. Clean mouth with moist gauze, rinse dentures after meals, Leave out at night & soak in water overnight. If no-label dentures  |
| **3.**  | Cleaning teethPreferred toothbrush & toothpaste: | Consider whether adapted toothbrush or specialist toothpaste is needed  |
| **4.**  | Routine: Preferred time:Location:Have previous mouth care routines been discussed with residents/ relatives? Y/N |   |
| **5.**  | Is the person experiencing any problems? e.g. **pain, difficulty eating, loose dentures#**, ***ulcers, bad breath\**** | **Circle any issues** * Dry mouth
* Saliva substitutes
* Fluorides
* Support with cleaning
 |
| **6.**  | Looking at the person’s mouth can you see any problems?**dry mouth#**, ***redness at corner of lips, dirty teeth, red gums or mouth, ulcers\****, **bleeding gums, poorly fitting dentures, broken teeth#**. Photo where possible | **Circle any issues** * Dry mouth
* Saliva substitutes
* Fluorides
* Support with cleaning
 |
| **7.**  | Cognitive/ behavioural issues |  |
| **8.**  | Relevant medical history***e.g. smoking, medication, alcohol, speech & language, dietetics\****  |  |
| **9.**  | Name and address of dentist: Next appointment due:Do they need to pay for treatment? Y/N | If unsure about payment help them to complete a HC1 form |

Signed:

Job title:

Date:

**Care Plan Key:**

**# Red Underlined issues**- contact dentist

***\* Blue Italics***- additional care needed

**NB: Assessment to be reviewed on a 3 monthly basis or sooner if any changes are noted.**



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