

# **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/N  Type 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/N  Do they need help cleaning their dentures? Y/N  Are 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 teeth  Preferred 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:

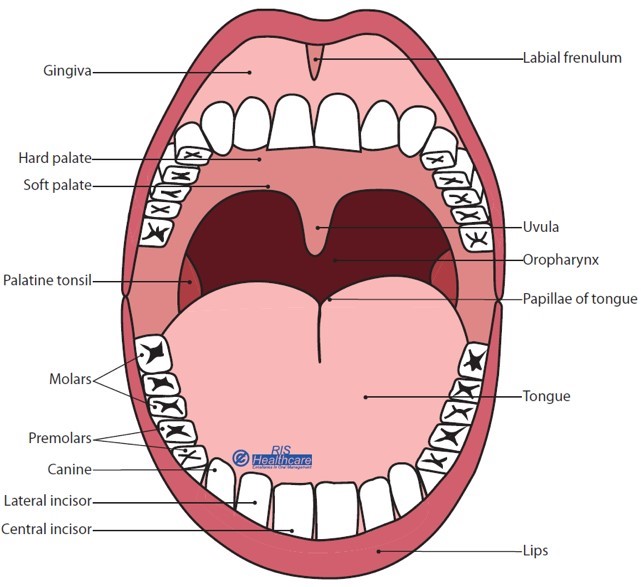
Date:

**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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