**Oral health risk assessment & care plan**

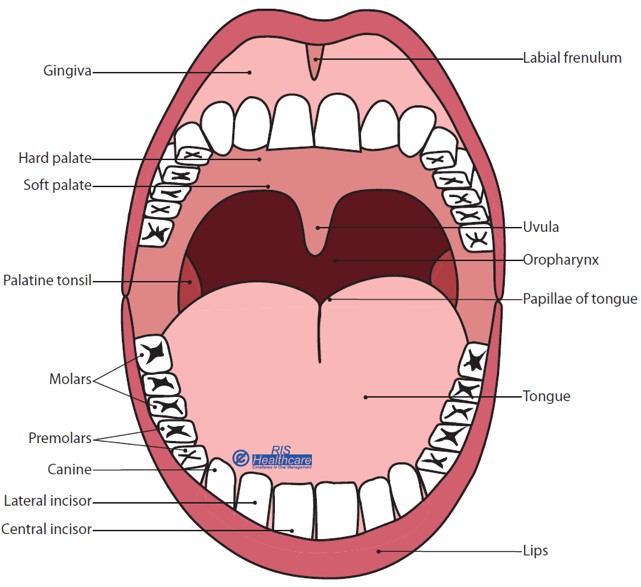
Clients full name:  *Known as:*

*Clients date of birth: Address/Room no:*

**Please circle relevant answer**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Assessment** |  | | **Suggested action for care plan** |
| **1.** | Does the person have any natural teeth?  Do they need help cleaning their teeth?  Type of support needed... | Yes No  ***Yes\**** No  Yes No | | 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?  Do they need help cleaning their dentures?  Are the dentures labelled | Yes No  ***Yes\**** No  Yes ***No\**** | | 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? | |  | |
| **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 | |
| **7.** | Cognitive/ behavioural issues | ***Yes\**** No | |  |
| **8.** | Relevant medical history  ***e.g. smoking, medication, alcohol, speech & language, dietetics\**** | ***Yes\**** No | |  |
| **9.** | Name and address of dentist  Next appointment due….  Do they need to pay for treatment |  | | If unsure about payment help them to complete a HC1 form |
| **Care Plan: # Red Underlined issues** - contact dentist ***\* Blue Italics*** - additional care needed  Signed: Job title: Date: | | | | | | |

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



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