|  |  |  |
| --- | --- | --- |
| Does resident have and wear denture/s | Stop outlineStop outlineStop outlineStop outline | No  Yes has denture/s but does not wear them  Yes has denture/s and wears them  Yes and removes them at night  Yes and wears them at night |
| If resident requires assistance with toothbrushing | Stop outlineStop outlineStop outline | Reminding, prompting  Supervision, checking  Fully assisted |
| Problems with toothbrushing | Stop outlineStop outlineStop outlineStop outlineStop outlineStop outlineStop outlineStop outline | Refuses toothbrushing  Won’t open  Pushes away  Is aggressive  Can’t spit  Has swallowing problems  Bites toothbrush  Head faces down – difficulty accessing the mouth  OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Best time to brush** | Stop outlineStop outlineStop outlineStop outlineStop outline | Before breakfast  After breakfast  Mid -morning  Afternoon  After dinner  Evening only |
| How often is toothbrushing able to take place | Stop outlineStop outlineStop outlineStop outline | Twice a day  Once a day  **If once a day when indicate when \_\_\_\_\_\_**  --- times a week  Morning  Evening |
| **Soft tissue check** |  | **Circle** |
| Is the tongue coated? |  | Yes No |
| Does the resident have a dry mouth? |  | Yes No |
| Are there any ulcers, red or white patches present? |  | Yes No |
|  |  |  |

Follow UP ASSESSMENT

DATE

**Name of Resident**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Room\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of dental practice where registered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

**Name of Resident**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does resident have a registered dentist? Yes/No/Unsure Name of GDP if known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Details of registered dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the resident last attend a dentist visit (approx)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Dental status** | **Yes tick** | **No tick** | **Comments/ instructions for care home (manager/staff)** |
| Does the resident have any natural teeth? | **More than 10**  **Less than 10** |  | Encourage independence with Cleaning morning and night with Small headed brush and fluoride toothpaste |
| Does the resident wear a denture/s? | Stop outline**Upper**  Stop outline  **Lower** |  | Supervise /help with cleaning dentures morning and night with mild soap and water; rinse dentures after meals. Leave dentures out overnight if acceptable to resident |
| Does the resident complain of anything orally? |  |  | Discuss with resident/family and if in agreement, complete a referral or make an appointment for resident to see a dentist. |
| **Oral Hygiene ability** |  |  | **Independently**  **Assisted with brushing**  **Fully assisted** |
| If resident wears dentures check to see if broken or loose. |  |  | Check to see if denture needs denture adhesive. |
| Is the denture/s named? |  |  | If denture/s are not named ask the resident if he/she would like them to be marked. Contact your local dental laboratory or buy a denture marking kit. |
| **Soft tissue check** | **yes** | **No** | **Comment on advice to be given** |
| Is the tongue coated? |  |  | If the tongue is coated brush gently with a soft toothbrush and mild toothpaste or tongue cleaner. |
| Does the resident have a dry mouth? |  |  | Clean lips and oral soft tissues with water and apply water-based gel. Offer frequent fluids and/or iced water. |
| Are there any ulcers, red or white patches present? |  |  | Should you find any patches in the mouth, monitor. If is has not healed after 3 weeks seek a dentist. |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Findings** | **If Yes (circle below)** | | |
| Does the resident have broken teeth? | **0 1 2 3 +** | | |
| Does the resident appear to have food and debris in-between the teeth? | nothing 0 a small amount ++ quite a lot +++ | | |
| How do the lips appear? | soft, moist dry, cracked or sore, redness ulcerated, bleeding, lumps/s  At corners of the mouth | | |
| **Oral Care Plan**  **Please indicate what resident uses** | **Yes** | **No** | **Comments/ instructions for care home (manager/staff)** |
| Manual brush |  |  | To brush the along the gum margins and teeth 2 x daily |
| Adapted toothbrush |  |  | Indicate if resident needs the toothbrush to be adapted for better grip |
| Electric toothbrush |  |  | To place toothbrush along the gum margins . Brush 2 x daily |
| Interdental brushes (brushes for cleaning in-between the teeth) |  |  | Use interspace brushes in-between the teeth if resident requires assistance and discard after use. |
| Mouthwash |  |  | Fluoride mouthwash can be used daily. Corsodyl mouthwash should only be used if indicated by a dental professional. |
| Dentures |  |  | Encourage resident to leave denture/s out at night. Soak in water. Brush denture/s with a toothbrush, soap and water. |
| Denture pot |  |  | Plastic denture pot should be named |

**It is recommended that residents should have a review with a dentist at least once every 2 years.**

**This is organised by the care home and/or next of kin**

|  |
| --- |
| **NOTES:**  **Write any preferences the resident has with oral care such as products eg. Preferred toothpaste/mouthwash, type of toothbrush, fixative etc..**  I am concerned and would like this person to see a dental professional  This person has expressed that he/she would like to see a dentist Review residents’ oral health again on  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |