|  |  |  |
| --- | --- | --- |
|  | **Checkmark with solid fill** | **NOTES** |
| Does resident have and wear denture/s? | **\_**  **\_**  **\_**  **\_** | Yes has denture/s but does not wear them  Yes has denture/s and wears them  Removes them at night  Wears them at night |
| Does resident require assistance or prompting? | **\_\_** | **Reminding, prompting**  **Supervision, checking**  **Fully assisted** |
| Problems with toothbrushing  YES / NO | \_  \_  \_  \_  \_  \_  \_  \_ | Refuses toothbrushing  Won’t open  Pushes away  Is aggressive  Can’t spit  Has swallowing problems  Bites toothbrush  Head faces down – difficulty accessing the mouth |
| **Best time to brush** | \_  \_  \_  \_  \_  \_ | Morning before breakfast  After breakfast  Mid -morning  Afternoon  After dinner  Evening only |
| How often is toothbrushing able to take place |  | Once a day  Twice a day  Times a day |
| Is the denture/s named? | **\_\_** | **YES**  **NO** |
| **Soft tissue check** | **Y/N** | **comments** |
| Is the tongue coated? |  |  |
| Does the resident have a dry mouth? |  |  |
| Are there any ulcers, red or white patches present? |  |  |
|  |  |  |

Follow UP ASSESSMENT

DATE

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

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

Name of dental practice if 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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**  **Fewer than 10** |  | Encourage independence with cleaning morning and night with Small headed brush and fluoride toothpaste |
| Does the resident wear a denture/s? | * **Upper** * **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 |
| 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 for this service or purchase DIY denture marking kit kohc.co.uk/recommended-products |
| 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** |  |  | **Brushes independently. Remind. Prompt**  **Assist. Apply toothpaste on brush**  **Fully Assist with toothbrushing** |
| **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. |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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? | no a small amount ++ quite a lot +++ | | |
| How do the lips appear? | soft, moist dry, cracked or sore, redness ulcerated, bleeding,  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**

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| --- |
| **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  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |