Mouth Care Matters

NHS Health Education England

Oral Health Needs Assessment

- Answers marked with ✱ ticked - Dental check-up required
- Answers marked with ⚡ ticked - **URGENT** dental check-up required

Resident's full name: **Resident's date of birth:**

1. Does the resident have dentures?	☐Yes	☐No		
If yes, please specify:	☐Upper - Full/Partial and Plastic/Plastic and Metal **Please delete as appropriate*			
	☐Lower - Full/Partial and Plastic/Plastic and Metal **Please delete as appropriate*			
If yes, are the dentures labelled?	☐Yes	☐No	☐Don't know	
If yes, how old are the dentures?	☐Less than 5 years		☐More than 5 years ✱	☐Don't know ✱

2. Is the resident experiencing any problems? *e.g. Pain, difficulty eating, decayed teeth, denture problems, dry mouth, ulcers, halitosis (bad breath), other?*	☐Yes ⚡	☐No	☐Don't know ⚡	
	☐Teeth	☐Gums	☐Denture	☐Other
If yes, please describe the problem:				

3. Does the resident need an urgent dental check-up?	☐Yes ⚡	☐No	☐Don't know ⚡

4. When did the resident last see a dentist?	☐Less than 1 year	☐More than 1 year ✱	☐Don't know ✱

5. Is the resident registered with a dentist?	☐Yes	☐No	☐Don't know
If yes, please record dentist name and address:			

Action:

Signed: **Job Title:** **Date:**

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Oral Care Plan/Chart

This Oral Care Plan should be kept with the resident's records and be updated daily.
The plan should be reviewed every three months, or sooner if changes are noted.

Resident's Full Name:

<table>
<tr><td>Please tick the categories which apply</td><td>Teeth:
☐Natural Teeth

☐Dentures

☐Natural Teeth and Dentures</td><td colspan="2">Dentures (if worn):
☐Upper – Full/Partial and Plastic/Plastic and Metal
*Please delete as appropriate

☐Lower - Full/Partial and Plastic/Plastic and Metal
*Please delete as appropriate</td></tr>
<tr><td>Level of assistance:</td><td>☐Independent</td><td>☐Some Assistance</td><td>☐Fully Dependent</td></tr>
<tr><td>If assistance is required, please give details:</td><td colspan="3"></td></tr>
<tr><td>Routine:
(Preferred time, location, routine for oral care and any particular preferences regarding equipment)</td><td colspan="3">Toothbrush Preference: ☐ Manual or ☐ Electric Toothpaste Preference:</td></tr>
<tr><td>Notes or comments for care of natural teeth:</td><td colspan="3"></td></tr>
<tr><td>Notes or comments for care of dentures:</td><td colspan="3"></td></tr>
<tr><td>Date for Review:</td><td></td><td colspan="2">Signed:</td></tr>
</table>

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Oral Care Plan/Chart

Insert initials when oral care has been completed OR insert ‘R’ if resident refuses and add comments.
Add comments / action required if changes are noted.

	Week Beginning	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Comments / Action Required
1	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
2	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
3	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
4	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
5	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
6	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
7	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
8	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
9	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
10	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
11	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	
12	/ /	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	Am: Pm:	