ORAL HEALTH RISK ASSESSMENT AND CARE PLAN – to be completed on admission

Patient Name: **D.O.B.**
Name of person completing oral health risk assessment and care plan:
Job title:
Date: **Review date (every 6 months):**
Resident ethnicity:

Choose any one of the following:							Resident declined
White Asian	White Irish	Other White background	White and Black Caribbean	White and Black African	White and Asian	Other mixed background	Asian or Asian British Indian
Asian or Asian British Pakistani	Asian or Asian British Bangladeshi	Other Asian background	Black or Black British Caribbean	Back or Black British African	Other Black background	Chinese	Any other ethnic group

1.	**Current Dentist Details**		**ACTION FOR CARE PLAN**
a)	Does resident have a regular dentist?	Y	ADD NAME AND CONTACT DETAILS
		N	REFER TO APPROPRIATE DENTAL SERVICE
		REFUSES	REFER TO ORAL HEALTH CHAMPION +/- DENTAL CHAMPION
b)	Is date of last appointment known?	Y/N	ADD TO CARE PLAN
c)	Is date of next appointment known?	Y	ADD TO CARE PLAN
		N	ARRANGE IF INDICATED
2.	**Access and dependency**		
a)	Does resident have capacity to agree to OH risk assessment?	Y/N/not sure	ADD FURTHER COMMENTS
b)	Are there any behavioural issues which would impact on a dental visit?	Y/N/not sure	ADD FURTHER COMMENTS
c)	Can resident mobilise independently (or need additional support e.g. Wheelchair access/carer support/arrange transport/domiciliary care/ other?	Y	
		N	ADD REQUIRED SUPPORT TO CARE PLAN
d)	Does resident pay for dental treatment?	Y	
		N	ADD EXEMPTION DETAILS
		Don't know	VERIFY PAYMENT STATUS
3.	**General Health**		
a)	Relevant medical history? e.g. smoking, medication, alcohol, speech and language, swallowing difficulties, dietetics, learning disabilities, dementia	Y	ADD DETAILS AND MEDS LIST TO CARE PLAN
		N	
4.	**Immediate Oral Health**		
a)	Is the resident experiencing any urgent dental issues? e.g. pain, difficulty eating, loose dentures, ulcers	Y	ADD DETAILS TO CARE PLAN

		N	
b)	Does resident have an oral care plan updated within last 6 months?	Y	
		N	ADD TO CARE PLAN
c)	Does resident have a daily oral care log?	Y	
		N	ADD TO CARE PLAN
d)	If 'YES' to last question, are there any outstanding actions on this?	Y	ADD COMMENTS TO CARE PLAN
		N	
5.	**Dentures - only if applicable. If not applicable, please cross here and continue to section 6** ☐		
a)	Does the resident have dentures?	Y / N	ADD TO CARE PLAN IF THEY NEED HELP WITH DENTURES
b)	Are dentures marked?	Y	
		N	MARK DENTURES
c)	Is a denture pot available?	Y	
		N	PROVIDE DENTURE POT
6.	**Mouth care**		
a)	Does the resident have any natural teeth?	Y/N	
b)	Does resident use manual toothbrush/ electric toothbrush/ special toothbrush/ soft tissue cleaning aid?	Y	COMMENT ON TOOTHBRUSH TYPE USED
		N	PROVIDE TOOTHBRUSH
	Date toothbrush was last replaced:		REPACE IF OVER 3 MONTHS OLD
c)	Does resident have a usual toothpaste brand they use?	Y	BRAND NAME
		N	
d)	Does resident use a high fluoride prescription toothpaste (Duraphat toothpaste)?	Y	
		N	IF CONCERNED DISCUSS WITH OHC/DC
e)	Does resident use other OH cleaning methods? Mouthwash / floss / interdental brushes/other?	Y	ADD COMMENTS
		N	
f)	Does resident have a preferred time and place to brush teeth	Y	ADD COMMENTS
		N	
g)	Who provides the resident their toothbrush/tooth paste and additional oral health items: patient/family/care home	KNOWN	ADD FURTHER COMMENTS
		UNKNOWN	VERIFY
h)	Type of support needed for tooth brushing/mouth care/denture care	NO SUPPORT (GREEN)	ADD TEMPLATE TO CARE PLAN
		SOME ASSISTANCE (AMBER)	ADD TEMPLATE TO CARE PLAN

		FULL ASSISTANCE (RED)	ADD TEMPLATE TO CARE PLAN
7.	**Diet**		
a)	Does resident take food orally?	Y	
		N	ADD COMMENTS e.g. PEG fed
b)	Does resident use supplements to thicken oral liquids?	Y	ADD COMMENTS ON FREQUENCY OF USE
		N	
c)	Does resident drink sugary drinks between meals during the day e.g. juice, squash, milkshakes, tea/coffee with sugar?	Y	ADD DIET ADVICE
		N	
d)	Does resident have snacks between meals?	Y	ADD DIET ADVICE
		N	
e)	Does resident snack after main evening meal?	Y	ADD DIET ADVICE
		N	

8. EVALUATION QUESTION – add answer to care plan

a) I feel my daily oral care routine is supported by the care home (mark below picture)

Strongly Disagree	Disagree	Neither agree/disagree	Agree	Strongly Agree	Don't Know
					?

9. FURTHER COMMENTS

Are there any further comments you would like to add relevant to this resident's oral health needs?