




| MONTHLY MOUTHCARE ASSESSMENT | | | | | | | | |
|---|--|---------------------------|--|------|------|------|------|------|
| Name: | | | | | | | | |
| Date of Birth: | | | | Date | Date | Date | Date | Date |
| Date of moving to home: | | Date of first assessment: | | | | | | |
| Assessment: Accepted (A) or Refused (R) (If assessment is refused, try again later in the day or the next day) | | | | | | | | |

| Part 1: Pre-assessment information | Low risk | Medium risk | High risk | Record the highest risk (L, M or H) to inform the mouthcare plan | | | | |
|---------------------------------------|--------------------------------|--|---|--|--|--|--|--|
| Consent | Has capacity to consent | Capacity fluctuates | No capacity to consent | | | | | |
| Part 2: Level of support | Low risk | Medium risk | High risk | Record the highest risk (L, M or H) to inform the mouthcare plan | | | | |
| Level of Support needed for Mouthcare | No help required for mouthcare | Needs some help with mouthcare e.g. help to put toothpaste on toothbrush | Fully dependent on others for mouthcare | | | | | |

Care Home staff must look in the mouth to do this part of the assessment

| Part 3: Oral hygiene and prevention need | Low risk | Medium risk | High risk | Record the highest risk (L, M or H) to inform the mouthcare plan | | | | |
|--|---------------------------------|---|--|--|---------|---------|---------|---------|
| Daily Diet | Balanced diet | | Has a high sugar diet or prescribed nutritional supplements | | | | | |
| Risk of Choking | Low choking risk | Some swallow problems or uses thickeners | High choking risk or PEG / tube fed | | | | | |
| Saliva | Mouth moist, no problems | | Dry mouth | | | | | |
| Mouth Cleanliness | Teeth and mouth clean | Some areas of the mouth not clean | Teeth and mouth not clean | | | | | |
| Gum Health | Gums do not bleed on brushing | Gums sometimes bleed on brushing | Gums bleed all the time on brushing | | | | | |
| Part 4: Dental need | Low risk | Medium risk | High risk | Record the highest risk (L, M or H) to inform the mouthcare plan | | | | |
| Dentures <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> No dentures | Dentures clean | Dentures not clean or resident complains of loose dentures. Seek routine advice from the dental team | Dentures broken, painful or recently lost. Seek urgent advice from the dental team | | | | | |
| Natural Teeth <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> No natural teeth | No problems. All appear healthy | Broken or decayed teeth but no pain. Seek routine advice from the dental team | Behaviour indicates dental pain. Very loose teeth. Seek urgent advice from the dental team | | | | | |
| Lips, Tongue and Soft Tissues | All appears healthy | Lips dry or tongue 'coated' | Very sore mouth – white or red patches, ulcers, swelling or thrush. Seek urgent advice from the dental team | | | | | |
|  | | | | Date | | | | |
| | | | | Date | | | | |
| If dental advice is required, record the date advice was requested: _____ | | | | Date | Date | Date | Date | Date |
| Completed by _____ | | | | Initial | Initial | Initial | Initial | Initial |

