MONTHLY MOUTHCARE ASSESSMENT

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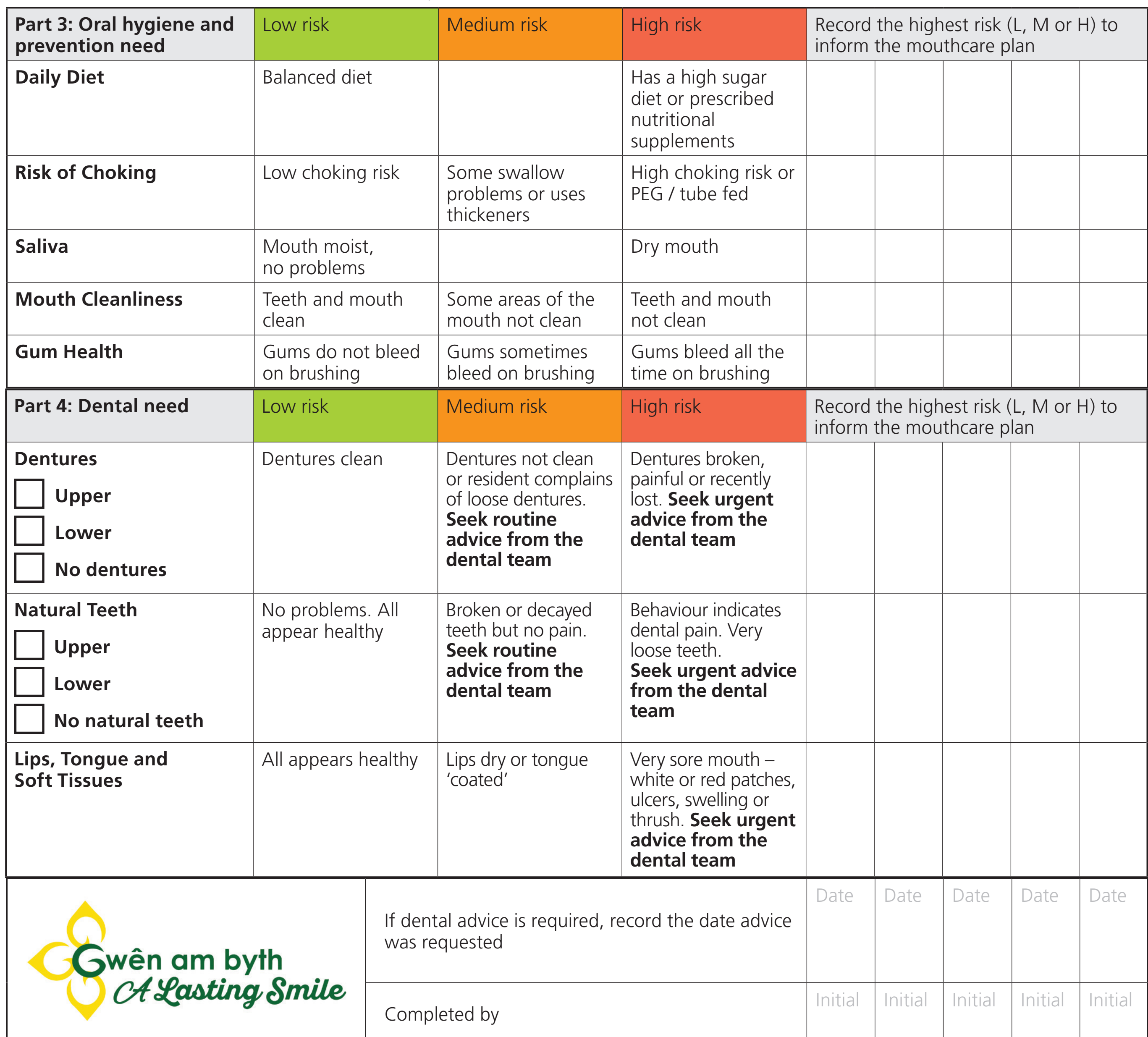
Name:						
Date of Birth:		Date	Date	Date	Date	Date
Date of moving to home:	Date of first assessment:					
Assessment: Accepted (A) or Refused (R) (If assessment is refused, try again later in the day or the next day)						

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 ☐ **Upper** ☐ **Lower** ☐ **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 ☐ **Upper** ☐ **Lower** ☐ **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**					

Gwên am byth A Lasting Smile	If dental advice is required, record the date advice was requested	Date	Date	Date	Date	Date
	Completed by	Initial	Initial	Initial	Initial	Initial

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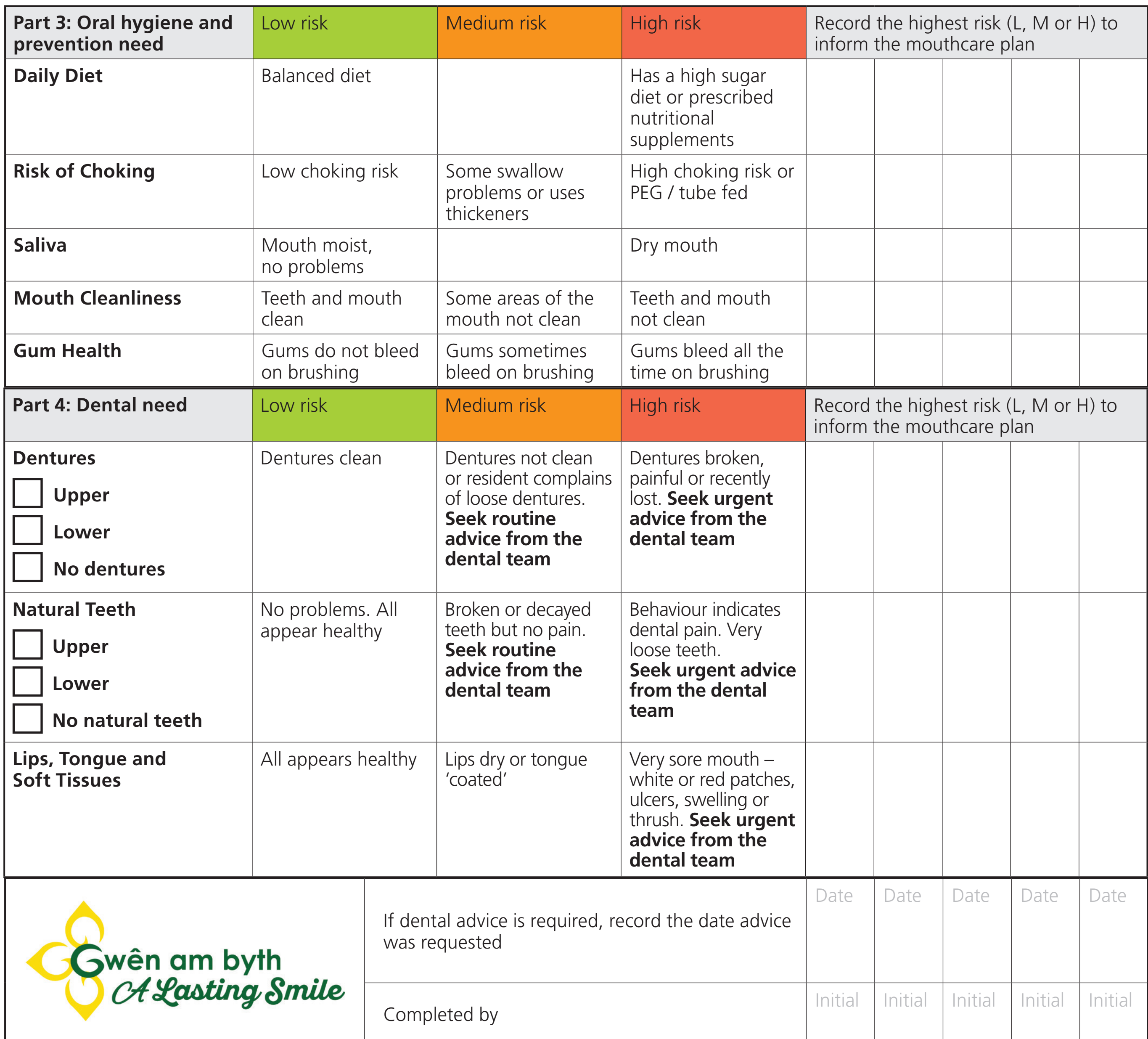

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