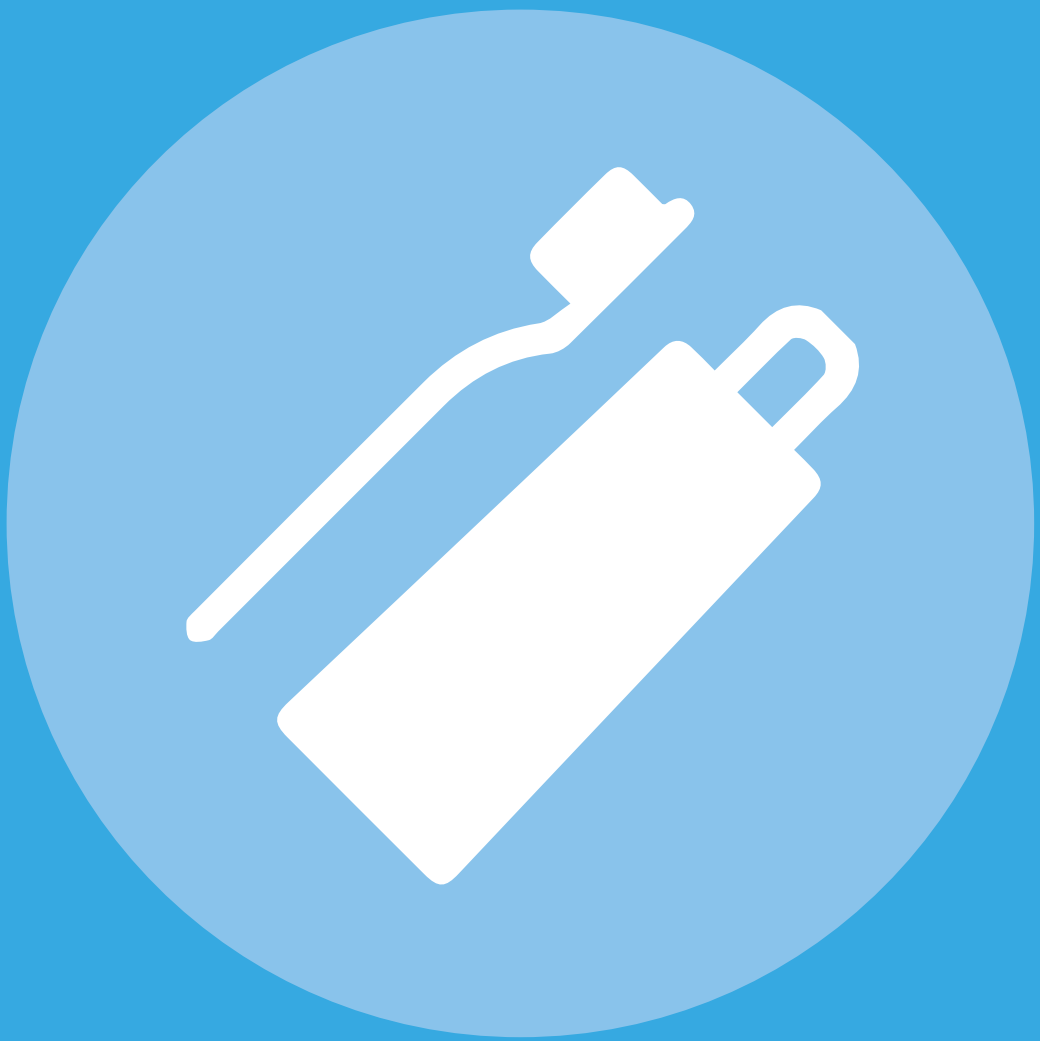
Section 11
Mouth



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?	☐Yes ↯	☐No	☐Don't know ↯	
e.g. Pain, difficulty eating, decayed teeth, denture problems, dry mouth, ulcers, halitosis (bad breath), other?	☐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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Mouth Care Matters

NHS Health Education England

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:

Please tick the categories which apply	**Teeth:** ☐Natural Teeth ☐Dentures ☐Natural Teeth and Dentures	**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*	
Level of assistance:	☐Independent	☐Some Assistance	☐Fully Dependent
If assistance is required, please give details:			
Routine: *(Preferred time, location, routine for oral care and any particular preferences regarding equipment)*	Toothbrush Preference: ☐ Manual or ☐ Electric	Toothpaste Preference:	
Notes or comments for care of natural teeth:			
Notes or comments for care of dentures:			
Date for Review:		**Signed:**	

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Mouth Care Matters

NHS Health Education England

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:	

Caring for Older Peoples' Teeth

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- Don't wear your dentures 24 hours a day. This gives your mouth a chance to "rest" and prevents fungal infections.
- Soak your dentures in a specialist cleaner, following manufacturers instructions.
- Remove your dentures when playing contact sports.
- If you get an ulcer/sore in your mouth and it has not healed after two weeks you should see your dentist.
- If you are wearing dentures, or have no teeth of your own, you should visit your dentist regularly to ensure that your mouth stays healthy.

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Oral Health Matters

Denture Care
Cúram Fiacla Bréige

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Caring for your dentures and mouth are very important.

To keep your mouth healthy and your dentures in good condition it is important that you follow a simple daily routine.

Care of Full Dentures/Mouth

- Dentures should be cleaned daily.
- Take your dentures out of your mouth to clean them.
- Clean your denture over a basin /sink of cold water or over a folded towel to avoid damage if they are dropped.
- Soap/denture cleaning paste can be used to clean dentures with a toothbrush or a soft nailbrush.
- Clean your tongue and roof of your mouth with a soft toothbrush.
- Always put your dentures in cold water when they are out of your mouth to prevent warping.

Care of Partial dentures

- Partial dentures should be removed after eating and rinsed under cold water.

- If your partial denture has a metal clasp, do not use any cleaning agents which contain bleach.
- When cleaning partial dentures, remember also to clean and floss your own teeth and gums using a toothbrush with soft/medium bristles and fluoride toothpaste.
- Don't forget to floss your remaining teeth daily.

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