NHS Ayrshire & Arran

Oral Health Risk Assessment

(Review 4-weekly and sign overleaf. Use new form if significant changes on review)

Write or attach label

HCR No: ……
CHI No: ……
Surname: ……
Forename: …… Sex: ……
Address: ……
……
Date of Birth: ……

Rapid Assessment Questions	Tick which is appropriate		Suggested outcome/actions if "Yes" ticked
	Yes	No	
Does the patient need assistance in carrying out their own basic oral care?	❒	❒	If you have answered yes to any of these questions please complete full oral health risk assessment below and review 4-weekly
Does the patient need assistance in caring for their denture?	❒	❒	
Is the patient suffering from mouth pain?	❒	❒	
What is your normal mouth care routine at home? (for initial assessment only)	Details		
Are you having any problems with your teeth or mouth?	Details		

Patient Assessment		Tick which is appropriate		Suggested outcome/actions if "Yes" ticked
		Yes	No	
Smoking habits	Smoker? (which may increase risk of gum disease and oral cancer)	❒	❒	Note amount per day on profile Consider smoking cessation
Dexterity problems	Having difficulty holding toothbrush?	❒	❒	May need supervision/help with mouth care Consider OT adaptation
Cognitive function	Evidence of short-term memory loss and/or confusion?	❒	❒	May need supervision/help with mouth care. Consider speaking with Next of Kin regarding OHRA.

Assessment – use tongue compressor and pen torch to examine oral cavity		Tick which is appropriate		Suggested nursing care if "Yes" ticked
		Yes	No	
Lips	Dry /cracked?	❒	❒	Apply an emollient e.g. lubricating gel
Tongue	Dry/coated?	❒	❒	Clean with MouthEze or soft toothbrush and toothpaste Offer frequent fluids if swallowing assessment allows
	Evidence of ulceration/soreness?	❒	❒	If yes, refer to Public Dental Services (PDS)* or advise patient to contact their dentist on discharge
Gums / soft tissue	Evidence of soreness, ulceration, bleeding gums or whiteness?	❒	❒	If yes, refer to PDS*
Saliva	Dry mouth? (xerostomia) could be side-effect of medication e.g. antidepressants, anticonvulsants etc.	❒	❒	Offer frequent fluids and/or iced water if swallowing assessment allows If symptoms persistent refer to dentist

Oral Assessment – use tongue compressor and pen torch to examine oral cavity		Tick which is appropriate		Suggested nursing care if "Yes" ticked
		Yes	No	
Teeth	Natural top teeth?	❒	❒	Encourage independence with cleaning teeth night and morning. Use toothbrush and fluoride toothpaste (see Basic Oral Care Guideline for concentration of fluoride) Supervise/help with oral care Use toothbrush and fluoride toothpaste
	Natural lower teeth?	❒	❒	
	Evidence of plaque / debris?	❒	❒	
Dentures	Top denture?	❒	❒	Supervise/help with cleaning dentures night and morning with mild soap and water; rinse dentures after meals. Clean teeth as above Remove dentures at night and leave to soak in water with Milton or metal based dentures in chlorhexidine gluconate 0.2% (see Basic Oral Care Guideline for more information)
	Lower denture?	❒	❒	
	Dentures and natural teeth?	❒	❒	
Pain	When eating/drinking?	❒	❒	If yes, refer to PDS* or advise patient to contact their dentist on discharge
	Caused by teeth/ dentures?	❒	❒	
Swallowing	Difficulty with swallowing?	❒	❒	Supervise/help with cleaning teeth and/or dentures and oral cavity after each meal
Nutrition	NBM / Fluid/dietary intake poor?	❒	❒	May require 2 hourly mouth care Consider use of MouthEze to remove build-up of secretions and keep soft tissues lubricated. Check whether oral problems contributing
	Dehydrated?	❒	❒	
	On energy-dense diet or prescribed supplements/snacks?	❒	❒	Consider high fluoride toothpaste if have natural teeth (2800ppm F)

1st assessment Signed: _____

Dated: _____

2nd assessment Signed: _____

Dated: _____

3rd assessment Signed: _____

Dated: _____

4th assessment Signed: _____

Dated: _____

*** Dental Services Helpline: 01292 616 990**

For urgent care or advice on weekdays

NHS 24: 111

For dental emergencies out-of-hours