

ORAL CARE PLAN (MONTHLY REVIEW)

This document can be used to establish an oral care plan for the persons(s) you care for. Following the initial assessment, please complete the plan at the beginning of each month using tick boxes and noting any further information in the space below. After each monthly review, the individual's daily care plan should be adjusted accordingly.

Date/task	Teeth	Dentures	Dry mouth	Lips	Tongue and soft tissues	Other problems, e.g. swallowing	Other problems, e.g. nutrition	Signature
	Brush twice a day	Clean twice a day, rinse after meals, soak in sodium hypochlorite	Offer frequent fluids	Apply water-based gel	Clean with moist gauze	Clean teeth and oral cavity after each meal	May require two-hourly mouth care	
Initial assessment __/__/__								
Any other information: (e.g. smoking, medication, dexterity or cognitive function; ulcer, pain or referral to dentist)								
Monthly review assessment __/__/__								
Review notes: (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist)								
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