Oral Hygiene Audit

Section 1 – Demographics

Audit number ☐☐☐ ☐ Male ☐ Female

Date of Birth ☐☐/☐☐/☐☐ Adm. date ☐☐/☐☐/☐☐

Section 2 – Assessment

	Yes	No	N/A
Have the patient's oral hygiene needs been assessed	☐	☐	☐
Is there any evidence that the patient was given advice on oral hygeine *(in the casenotes/nursing notes)*	☐	☐	☐
Has oral care been discussed with patient	☐	☐	☐
Has oral care been discussed with carer	☐	☐	☐
Has this discussion been documented *(in the casenotes/nursing notes)*	☐	☐	☐
Is there any evidence that care was required *(in the casenotes/nursing notes)*	☐	☐	☐

please specify required care……
……

Who will be responsible for the patient's oral hygiene:

	Yes	No	N/A
patient	☐	☐	☐
carer	☐	☐	☐
nursing staff	☐	☐	☐
HCSW	☐	☐	☐

Is assistance available if required	☐	☐	☐
Does the patient require assistance	☐	☐	☐
Is the bathroom environment acceptable to patient	☐	☐	☐
Is the bathroom environment acceptable to carer	☐	☐	☐
Was this help at the appropriate level	☐	☐	☐

If no, please give details ……
……

Is the patient using his/her own toiletries	☐	☐	☐
Were 'single use' toiletries available	☐	☐	

Section 3 – Information on oral hygiene

	Yes	No	N/A
Was the patient given verbal information regarding their own oral hygeine needs	☐	☐	☐
Was the patient made aware of sources of further information regarding oral hygeine	☐	☐	☐
Was the carer given verbal information regarding the oral hygeine needs of the patient	☐	☐	☐
Was the carer made aware of sources of further information regarding oral hygeine	☐	☐	☐

Section 4 – Condition of mouth

	Yes	No	N/A
Was the condition of the patient's mouth assessed, at least once, by qualified staff	☐	☐	☐

if yes, by whom

staff nurse	☐
sister	☐
doctor	☐
dietition	☐
Other	☐

	Yes	No
If yes, was the condition of the mouth clean and moist	☐	☐

If no, was the mouth

dry	☐	☐
evidence of oral thrush	☐	☐
coated tongue/debris	☐	☐
ulcers	☐	☐
other, *please specify* ……..		

	Yes	No	N/A
Did the patient report a problem with their mouth	☐	☐	☐

If yes, what was the reported problem …….
……

Was this problem confirmed by a health care professional	☐	☐	☐

If yes, please give designation

HCSW	☐
Qualified Nurse	☐
Doctor	☐

Dietition ☐
Other ☐

	Yes	No	N/A
Did the carer report a problem with the mouth of the patient	☐	☐	☐

If yes, what was the reported problem …….
……

Was this problem confirmed by a health care professional	☐	☐	☐

If yes, please give designation

HCSW ☐
Qualified Nurse ☐
Doctor ☐
Dietition ☐
Other ☐

If an oral problem was noted, was this treated

If yes, please specify treatment ……
……...

Section 5 – Repeat assessment

	Yes	No	N/A
Was oral care discussed again with the patient	☐	☐	☐
If yes, was this documented *(in the casenotes/nursing notes)*	☐	☐	☐
Was oral care discussed again with the carer	☐	☐	☐
If yes, was this documented *(in the casenotes/nursing notes)*	☐	☐	☐
Was a further assessment of the mouth necessary	☐	☐	☐

If no, why not (eg. patient has good oral health) ……...

If yes, please complete the following:

How many times during I/P stay was oral hygiene assessed by a health care professional

daily ☐
once a week ☐
twice weekly ☐
three times a week ☐
other (please specify) …….

	Yes	No
Is each occasion documented (in the casenotes/nursing notes)	☐	☐

Section 6 – Discharge information

	Yes	No
Is the patient still on the ward	☐	☐

If no, discharge date ☐☐/☐☐/☐☐

Section 7 – Any other information

Please enter any other relevant information relating to the oral hygeine of this patient