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| Patient Name |  |
| D.O.B |  |
| Hospital ID |  |
| NHS Number |  |

**Mouth Care Assessment**

To be completed for **every patient** admitted >24 hours. Reassess weekly on **MOUTHCARE MONDAYS**, or earlier if the patient’s condition changes.

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| **1. Risk Factors** | | | |
| **The following conditions may indicate that the patient requires additional mouth care** | | | |
|  Chemotherapy |  Frail |  Nil by mouth |  ITU / HDU |
|  Dysphagia |  Delirium |  Refusing food or drink |  Palliative Care |
|  Head & neck radiation |  Dementia |  Learning difficulties |  Unable to communicate |
|  Stroke |  Uncontrolled diabetes |  Severe mental health |  Dependent on oxygen |

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| **2. Patient has:** | | | | |
| All inpatients must have access to a toothbrush during inpatient stay  *Using risk factors, please assess whether patient requires standard or 360 toothbrush* | | | | |
| Standard toothbrush  360 toothbrush |  Y   Y |  N   N | If No ask NOK to bring in |  Provided   Date Provided …………………….   Date Provided ……………………. |
| *Prescription of Non foaming toothpaste should be considered for patients with reduced conscious level and / or dysphagia (note contains milk proteins)* | | | |
| Standard Toothpaste  Non foaming toothpaste |  Y   Y |  N   N | If No ask NOK to bring in   Prescribed |
| Upper denture |  Y |  N |  At home | *If at home ask NOK to bring in*  *Patients with dentures should have smiley face sign at  the bedside* |
| Lower denture |  Y |  N |  At home |
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| Denture pot |  Y |  N |  Provided |
| No teeth |  Y |  |  | *Patients with no teeth still require mouth care* |
| *For COVID-19 patients:*  Mouthwash |  Y |  N/A |  Provided | *Mouthwash should be used as per COVID 19 guidance for patients with COVID-19.* |

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| **3. Level of Support Required for Mouth Care** | |
| Patient is independent  *(Able to walk to sink and needs NO assistance with mouth care)* |  |
| Patient requires some assistance  *E.g. Unable to get to sink, needs reminders/assistance.*  *Please record the assistance the patient requires on their Mouth Care Plan* |  |
| Patient is fully dependent on others for mouth care |  |

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| **4. Patient Reported Mouth Problems** | | | |
| When did the patient last visit a dentist? ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On admission: does the patient have any pain / discomfort in the mouth?  Y  N | | | |
|  |  Severe dry mouth |  Painful teeth |  Ulcers |
|  |  Painful mouth |  Sore tongue |  Other |
| Note any other concerns patient has about their oral health / mouth care? | | | |

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**Initial & Weekly Re-Assessment of Mouth**

**Using Pen Torch**

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|  | **Findings**  *Tick relevant box* | On admission | Wk1  Date | Wk2  Date | Wk3  Date | Wk4  Date |  | Action  In addition to Standard Mouth care |
| **Lips** | Pink and moist |  |  |  |  |  | → |  None |
| Dry/cracked |  |  |  |  |  | → |  Additional Mouth Care |
| Swollen / ulcerated |  |  |  |  |  | → |  Refer to DOCTOR |
| **Tongue** | Pink and moist  Clean |  |  |  |  |  | → |  None |
| Dry  Fissured (cracked) / shiny |  |  |  |  |  | → |  Additional Mouth Care |
| Looks abnormal  White coating  Very sore / ulcerated |  |  |  |  |  | → |  Refer to DOCTOR |
| **Teeth & Gums** | Clean  Teeth not broken/loose  Gums not bleeding/inflamed |  |  |  |  |  | → |  None |
| Unclean  Broken teeth (no pain)  Inflamed gums |  |  |  |  |  | → |  Advise to see dentist on d/charge |
| Severe pain  Facial swelling  Severe inflammation / bleeding of gums |  |  |  |  |  | → |  Refer to DOCTOR / Dental Team |
| **Cheeks, palate & under tongue** | Clean  Saliva present  Looks healthy |  |  |  |  |  | → |  None |
| Mouth dry  Food debris / secretions  Ulcer (less than 10 days) |  |  |  |  |  | →  →  → |  Additional Mouth Care |
| Very dry/painful  Ulcer (more than 10 days)  Widespread ulceration  Looks abnormal |  |  |  |  |  | → |  Refer to DOCTOR |
| **Dentures** | Clean & Comfortable |  |  |  |  |  | → |  None |
| Unclean  Loose / uncomfortable  Patient will not remove |  |  |  |  |  | →  →  → |  Denture fixative   Advise to see dentist on d/charge   Encourage removal |
| Lost  Broken and unable to wear |  |  |  |  |  | → |  DATIX   Advise to see dentist on d/charge |

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**6. Mouth Care Plan**

To be completed following Mouth Care Assessment

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|  **Plan A - Standard Mouth Care**  Encourage and support patient to clean their mouth (teeth, tongue, palate and gums) twice daily with appropriate toothbrush and fluoride toothpaste. Avoid rinsing after brushing.   **Denture Care**: Support patient to wash dentures daily using liquid soap and toothbrush  Soak in named denture pot overnight and rinse well before refitting. |
|  **Plan B** - **Additional Mouth Care**  In *addition*to Plan A Standard Mouth Care: *(tick all that apply)*   If patient is safely able to drink, encourage regular sips of water to keep mouth moist   Clean mouth regularly of debris and secretions using appropriate toothbrush and water   Clean mouth regularly of debris and secretions using appropriate toothbrush and water   Hydrate the mouth regularly using appropriate toothbrush. *Single use foam swabs available if toothbrush alone ……….ineffective.*   Apply dry mouth gel to lips and oral mucosa as prescribed   Ulcer care: Saline rinses / anti-inflammatory spray as prescribed   Denture care: thrush treatment (leave denture out + chlorhexidine mouthwash to soak denture)   Patient prescribed low foaming toothpaste   Patient prescribed mouth/lip moisturiser   Patient requires suctioning – Yankers and tubing should be changed daily |

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| **Support required**   Patient is independent: (*Able to walk to sink and needs NO assistance with mouth care)*   Patient requires assistance *(state what support is required): ………………………………………………………………………………..*   Patient is fully dependent on others for mouth care | | |
| Minimum frequency of mouthcare: 1-2hrly  2-4 hrly  6 hrly  8 hrly  BD  | | |
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| Initial mouth care plan completed by:  *(Signature, name + role)* | Date: | |

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| **Mouth Care Re-Assessment** *To be filled in weekly on MOUTHCARE MONDAY for all patients (or earlier if condition changes)* | | | |
| ***Date*** | ***Time*** | ***Any changes to mouthcare plan above*** | ***Signature & Role*** |
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| **Mouth Care Daily Log** *For all patients who require additional mouthcare and / or assistance*   |  |  | | --- | --- | | Patient Name |  | | D.O.B |  | | Hospital ID |  |   Additional Mouth Care  *(see individualised Plan B)*  Assistance  (*see support required) Date: …… /…… /……….*  A pair of scissors  Description automatically generated with medium confidence  Minimum frequency of mouthcare: 1-2hrly  2-4 hrly  6 hrly  8 hrly  BD   This patient is : Dysphasic  NBM   | | | | | | | | | | | | | | |
| ***Time*** | ***Performed*** | | ***Application*** | | | | | | ***Observations Using Pen Torch*** | | | | ***Comments*** | ***Signature*** |
|  | Yes | No | *Teeth / Dentures cleaned*  *(tick)* | *Toothpaste*  *(Foaming / Non foaming)* | *Hydration to mouth with appropriate re-usable toothbrush* | *Hydration to mouth with single use foam swab (how many)* | *Mouth / lip moisturiser*  *(state which)* | *Suction required?*  *Y/N* | *Clean and Moist* | *Dry* | *Debris Secretion*  *Blood* | *Thrush or Ulcers* | *i.e “Mouthcare offered but patient declined” …* |  |
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