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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 toothbrush360 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 ToothpasteNon 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 |
|  |  |  |  |
| 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  | Wk1Date | Wk2Date | Wk3Date | Wk4Date |  | ActionIn 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 |
| UncleanLoose / uncomfortablePatient will not remove |  |  |  |  |  | →→→ |  Denture fixative  Advise to see dentist on d/charge Encourage removal |
| LostBroken 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*

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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” …*  |  |
| 00:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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