

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

**Mouth Care Assessment**

To be completed for **every patient** within **24 hours of admission**.

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Risk Factors** | | | |
| **The following conditions may indicate that the patient requires additional mouth care** | | | |
|  Chemotherapy |  Frail |  Nil by mouth |  ITU / HDU |
|  Swallow disorder |  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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 toothbrushes* | | | | |
| Standard toothbrush  360 toothbrushes |  Y   Y |  N   N | If No, ask NOK to bring in |  Date 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 |
| 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.* |

|  |  |
| --- | --- |
| **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 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **4. Patient Reported Mouth Problems** | | | |
| On admission: does the patient have any pain / discomfort in the mouth?  Y  N | | | |
|  |  Severe dry mouth |  Painful teeth |  Ulcers  Oral Thrush |
|  |  Painful mouth |  Sore tongue |  Other |
| Note any other concerns patient has about their oral health / mouth care? | | | |

|  |  |
| --- | --- |
| **Initial mouth care plan completed by:**  *(Signature, name + role)* | **Date:** |

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

**6. Mouth Care Plan**

To be completed following Mouth Care Assessment on Admission

|  |  |  |
| --- | --- | --- |
| **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 toothpaste and toothbrush.   * Soak in named denture pot overnight and rinse well before refitting. | | |
| **Plan B** – **Enhanced Mouth Care**  In *addition*to Plan A Standard Mouth Care: *(tick all that apply)*   * Patient prescribed low foaming toothpaste and mouth/lip moisturiser * Clean mouth regularly of debris and secretions using appropriate toothbrush and water   Hydrate the mouth regularly using appropriate toothbrush.   * Apply dry mouth gel to lips and oral mucosa as prescribed * Patient requires suctioning – Yankers and tubing should be changed daily * Ulcer care: Saline rinses / anti-inflammatory spray as prescribed * **Denture care:** * thrush treatment (leave denture out + chlorhexidine mouthwash to soak denture) * denture fixative * (loose/uncomfortable or broken and unable to wear): advise to see dentist on discharge * Encourage removal if patient will not remove * If lost since an Inpatient, complete | | |
| **Plan C – Radnor Intensive Mouth Care**   * Brush twice a day (6am&6pm) using normal or low foaming toothpaste (indications apply) – **Plan A** * Provide mouth care at least every 4 hours single use sage mouth swab and Dentyl mouthwash. * Moisten lips and oral cavity with water based Toothette mouth moisturiser. * Aspirate pharyngeal secretions and subglottic port at least every 4 hours for patients those need assistance. * Check ETT / Tracheotomy cuff pressure minimum every 4 hours. * For level 3 patients and those who have complex oral health needs use reusable Oralieve 360 toothbrush. * Low-foaming toothpaste is recommended for level 3 patients as well as people with dysphagia, dry mouth, nil by mouth and unable to follow directions due to cognitive issues. However, the use of low-foaming toothpaste is not suitable for vegans or patients with lactose intolerance. * The Use of chlorhexidine is only recommended in cardiac surgery patients. * Refer to Doctor | | |
| |  | | --- | | **Mouth Care Re-Assessment** *To be filled in daily or earlier if condition changes* |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | ***Date*** | ***Time*** | ***Support required*** | ***Follow Care Plan*** | ***Comments*** | ***Signature & Role*** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | | |
|  |  |  |

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

**5. Initial & Daily Re-Assessment of Mouth *(Using Pen Torch) –* Radnor only**

***On completing this assessment, please tick the box correspondent to the action required the day the re-assessment is occurring.***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Findings**  Tick relevant box | **Date**  **.../.../...** | **Date**  **.../.../...** | **Date**  **.../.../...** | **Date**  **.../.../...** | **Date**  **.../.../...** | **Date**  **.../.../...** | **Date**  **.../.../...** | **Action** |
|  | Pink and moist |  |  |  |  |  |  |  | 🞎 Plan A |
| **Lips** | Dry/ cracked |  |  |  |  |  |  |  | 🞎 Plan B |
|  | Swollen/ ulcerated |  |  |  |  |  |  |  | 🞎 Plan C |
|  | Pink, moist and clean |  |  |  |  |  |  |  | 🞎 Plan A |
| **Tongue** | Dry,  Fissured (cracked) -/ shiny |  |  |  |  |  |  |  | 🞎 Plan B |
|  | Looks abnormal,  White coating,  Very sore -/ ulcerated |  |  |  |  |  |  |  | 🞎 Plan C |
|  | Clean,  Teeth not broken -/ loose,  Gums not bleeding -/ inflamed |  |  |  |  |  |  |  | 🞎 Plan A |
| **Teeth & Gums** | Unclean,  Broken teeth (no pain),  Inflamed gums |  |  |  |  |  |  |  | 🞎 Plan B |
|  | Severe pain,  Facial swelling  Severe inflammation - bleeding gums |  |  |  |  |  |  |  | 🞎 Plan C |
|  | Clean,  Saliva present and  Looks healthy |  |  |  |  |  |  |  | 🞎 Plan A |
| **Cheeks, palate & under** | Mouth dry,  Food debris / secretions,  Ulcer (less than 10 days) |  |  |  |  |  |  |  | 🞎 Plan B |
| **tongue** | Very dry -/ painful Ulcer (more than 10 days),  Widespread ulceration,  Looks abnormal |  |  |  |  |  |  |  | 🞎 Plan C |
|  | Clean and Comfortable |  |  |  |  |  |  |  | 🞎 Plan A |
| **Dentures** | Unclean,  Loose / uncomfortable  Patient will not remove |  |  |  |  |  |  |  | 🞎 Plan B |
|  | Lost  Broken and unable to wear |  |  |  |  |  |  |  | 🞎 Plan C |
|  | No oxygen / Nasal Cannula, Mobilising, Normal secretions, and diet |  |  |  |  |  |  |  | 🞎 Plan A |
| **ITU**  **Patients** | Slightly increased / decreased secretions, Reduced diet, Tracheostomy / Face Mask, RR 14-20, Frequent turning self, Maxillofacial surgery |  |  |  |  |  |  |  | 🞎 Plan B |
|  | Dry and copious secretions, Infections, NBM/NG/PEG/ PEJ / TPN, RR>20, NIV/ETT, Inert/Prone/SCI, Learning Disabilities, Dementia, Delirium |  |  |  |  |  |  |  | 🞎 Plan C |