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| **Mouth Care Daily Log** *For all patients who require additional mouthcare and / or assistance*

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

Additional Mouth Care  (*see individualised Plan B)*  Assistance (*see support required) Date: …… /…… /……….*  Minimum frequency of mouthcare: 1-2hrly  2-4 hrly  6 hrly  8 hrly  BD This patient is: Swallow disorder  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* | A pair of scissors  Description automatically generated with medium confidence*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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 01:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 02:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 03:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 04:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 05:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 06:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 07:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 08:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 09:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 21:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |