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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: …… /…… /……….*    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” …* |  |
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| 24:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |