

Mouth Care Pack

To be completed for every patient **24 hours** after admission

Mouth care screening sheet

Patient name	
D.O.B	
MRN Number	
NHS Number	

Any tick in a red highlighted box indicates a **MOUTH CARE ASSESSMENT** is required

1. Patient has:

Toothbrush	Y <input type="checkbox"/>	N <input type="checkbox"/>	Provided <input type="checkbox"/>
Toothpaste	Y <input type="checkbox"/>	N <input type="checkbox"/>	Provided <input type="checkbox"/>
Upper denture	Y <input type="checkbox"/>	N <input type="checkbox"/>	At home <input type="checkbox"/>
Lower denture	Y <input type="checkbox"/>	N <input type="checkbox"/>	At home <input type="checkbox"/>
Denture pot	Y <input type="checkbox"/>	N <input type="checkbox"/>	Provided <input type="checkbox"/>
No teeth	Y <input type="checkbox"/>	(Patient will still require mouth care)	

If 'Y' to dentures, place the sunflower sign at the bedside

2. Does the patient have any pain or discomfort in the mouth?

Severe dry mouth	Y <input type="checkbox"/>	N <input type="checkbox"/>
Ulcers	Y <input type="checkbox"/>	N <input type="checkbox"/>
Painful mouth	Y <input type="checkbox"/>	N <input type="checkbox"/>
Painful teeth	Y <input type="checkbox"/>	N <input type="checkbox"/>
Sore tongue	Y <input type="checkbox"/>	N <input type="checkbox"/>

Other
(please specify):

3. Patients with any of the following will require a mouth care assessment:

<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Learning difficulties
<input type="checkbox"/> Delirium	<input type="checkbox"/> Nil by mouth
<input type="checkbox"/> Dementia	<input type="checkbox"/> Palliative care
<input type="checkbox"/> Dependent on oxygen use	<input type="checkbox"/> Refusing food or drink
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Severe mental health
<input type="checkbox"/> Frail	<input type="checkbox"/> Stroke
<input type="checkbox"/> Head & neck radiation	<input type="checkbox"/> Unable to communicate
<input type="checkbox"/> ICU / HDU	<input type="checkbox"/> Uncontrolled diabetes

4. Level of support:

Requires risk assessment Unable to get to a sink/needs assistance

Patient is fully dependent on others for mouth care

Mouth care assessment required. Record all mouth care on the daily recording sheet

Patient requires some assistance

Unable to get to a sink or needs help with mouth care. Record all mouth care on the daily recording sheet
Please state the assistance patient requires: (i.e: bowl, encouragement, reminder, remove dentures etc)

Patient is independent

Able to walk to a sink and needs **NO** assistance with mouth care

Signed: _____ Name: _____ Date: _____ Job title: _____

Mouth care assessment

Complete **WEEKLY** if the patient has a red box ticked on the mouth care screening sheet or if their condition deteriorates during their stay.

Patient name	
D.O.B	
MRN Number	
NHS Number	

Look in the patients mouth using a light source and carry out a weekly mouth care assessment. Mark as L, M or H in the white box.				Date	Date	Date	Date	Date
	Low risk (L)	Medium risk (M)	High risk (H)*					
Lips	<ul style="list-style-type: none"> Pink & moist 	<ul style="list-style-type: none"> Dry/cracked Difficulty opening the mouth 	<ul style="list-style-type: none"> Swollen Ulcerated 					
Action	None	Dry mouth care	Refer to DOCTOR					
Tongue	<ul style="list-style-type: none"> Pink & moist Clean 	<ul style="list-style-type: none"> Dry Fissured/shiny 	<ul style="list-style-type: none"> Looks abnormal White coating Very sore Ulcerated 					
Action	None	Dry mouth care	Refer to DOCTOR					
Teeth & gums	<ul style="list-style-type: none"> Clean Teeth not broken Teeth not loose Gums not bleeding Gums not inflamed 	<ul style="list-style-type: none"> Unclean Broken teeth (no pain) Bleeding gums Inflamed gums 	<ul style="list-style-type: none"> Severe pain Facial swelling 					
Action	2 x daily tooth-brushing	2x daily toothbrushing & clean the mouth	Refer to DOCTOR or DENTAL TEAM	Advise the patient to visit their dentist on discharge if there are any problems with their teeth that do not require urgent treatment in hospital				
Cheeks, Palate & under the tongue	<ul style="list-style-type: none"> Clean Saliva present Looks healthy 	<ul style="list-style-type: none"> Mouth dry Sticky secretions Food debris Ulcer < 10 days 	<ul style="list-style-type: none"> Very dry/painful Ulcer > 10 days Widespread ulceration Looks abnormal 					
Action	None	<ul style="list-style-type: none"> Clean the mouth Dry mouth care Ulcer care 	Refer to DOCTOR	An ulcer present for more than 2 weeks must be referred to the doctor				
Dentures	<ul style="list-style-type: none"> Clean Comfortable 	<ul style="list-style-type: none"> Unclean Loose Patient will not remove 	<ul style="list-style-type: none"> Lost Broken and unable to wear 					
Action	Clean daily	<ul style="list-style-type: none"> Denture care Denture fixative Encourage removal 	DATIX if lost or refer to the DENTAL TEAM if broken	Remember to place the denture sunflower at the patients bedside. Advise the patient to visit their dentist if the denture is loose				
*For patients who are unable to communicate or cooperate with a mouth care assessment, some signs of a mouth related problem may include; not eating/drinking, facial swelling & behavioural changes								

Signed:

Dry mouth care
 Frequent sips of water unless nil by mouth
 Moisturise dry mouth gel onto the tongue, cheeks and palate
 Hydrate with a moist toothbrush
 Apply lip balm to dry lips
 Keep mouth clean

Ulcer care
 Rinse mouth with saline
 Anti-inflammatory mouth spray – discuss with doctor
ULCER PRESENT FOR MORE THAN 2 WEEKS; REFER TO DOCTOR

Denture care
 Advise the patient to leave denture out at night in a named denture pot with a lid
 If the patient has oral thrush, soak in chlorhexidine (0.2%) mouthwash for 15 minutes twice a day, rinse thoroughly and encourage the patient to leave the denture out whilst the mouth heals

