Mouth Care Matters

Mouth Care Assessment

To be completed for every patient after admission and review weekly

`Please attach patient identification sticker

Are there any oral health concerns from resident/ family or staff

No concerns ☐ Denture problems ☐

Pain/discomfort ☐ Broken/Loose teeth ☐ Lip/cheek biting ☐ Dry mouth ☐ Poor oral hygiene ☐

Difficulty opening mouth ☐ Resistant to mouth care ☐ Drooling ☐ Poor swallow ☐ Strong bite reflex ☐

Look in resident's mouth with a **LIGHT SOURCE**. Carry out **WEEKLY** assessment. Mark as **L**, **M** or **H** in the white box under today's date & sign.	**LOW RISK (L)**	**MEDIUM RISK (M)**	**HIGH RISK (H)***	**Date**	**Date**	**Date**
Lips	• Looks healthy	• Dry/cracked/split • Difficulty opening mouth	• Swollen • Ulcerated			
Action	**Routine mouth care**	**Lubricate lips regularly**	**Refer to dental/medics**			
Tongue	• Looks clean & healthy	• Dry/fissured/shiny • Soft or hard coating/debris	• Looks abnormal • Creamy white coating • Very sore/ulcerated			
Action	**Routine mouth care**	**Dry mouth care Brush/clean tongue**	**Refer to dental/medics**			
Teeth/gums	• Clean • No broken/loose teeth	• Unclean • Bleeding or swollen gums	• Severe pain • Facial swelling • Broken. wobbly teeth • Bleeding from gums not improving with brushing			
Action	**2 x daily tooth-brushing**	**2 x daily tooth-brushing & clean the mouth**	**Refer to dental/medics**			
Cheeks/palate/under tongue An ulcer present for more than **2 weeks** must be referred to medics	• Clean • Looks healthy	• Mouth dry • Food debris • Ulcer <10 days	• Very dry/painful • Ulcer>10 days • Widespread ulceration • Looks abnormal			
Action	**Routine mouth care**	**Clean the mouth/dry mouth care/ulcer care**	**Refer to dental/medics**			
Dentures	• Clean • Comfortable	• Unclean • Loose • Resident will not remove	• Lost • Broken and unable to wear			
Action	**Routine mouth care**	**Denture cleaning, fixative, encourage daily removal to allow mouth to breathe**	**Report if lost or refer to dental team if broken or cannot wear**			
Saliva/Secretions	• Moist mouth • No persistent drooling	• Mouth feels sticky • Some secretions visible in mouth that can be removed • Saliva pooling in mouth	• Mouth full of dried secretions , difficult to remove • Strong gag reflex			
Action	**Routine mouth care**	**Clean the mouth/dry mouth care/ regular oral suctioning**	**Dry mouth care/ oral suctioning/ Refer to dental if no improvement**			
Mouth opening /bite reflex	• Good mouth opening	• Tends to bite on toothbrush or suction tube but will open mouth • Needs encouragement to open mouth	• Does not open mouth • Teeth clenches tightly together • Bites on toothbrush and does not open			
Action	**Routine mouth care**	**Carry out mouth care in shorts bursts so person can rest. Encourage mouth opening.**	**Brush sides of teeth and gums & do not attempt to force mouth open**			
For residents who are unable to communicate or cooperate with a mouth care assessment, signs of mouth related problems may include not eating/drinking, facial swelling, bleeding, bad breath and changes in behaviour.			**Signature:**			

Mouth care includes brushing the teeth, cleaning the tongue, palate and cheeks and removing dried secretions. **It should be carried out at least twice a day**	**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.

MOUTH CARE PLAN		**Patient identification sticker**
I have my own teeth ☐	I have missing teeth ☐	I have no teeth ☐
I have a denture Yes ☐ No☐ If yes , I have a top denture ☐ I have a bottom denture ☐ I have both top and bottom denture I like to wear my denture Yes ☐ No☐ (If no keep in a denture pot with no water) I need help putting my denture in and out of my mouth Yes ☐ No☐ I need help to clean my denture twice a day with soap & a denture brush Yes ☐ No☐		
I can brush my teeth and clean my mouth Yes ☐ No☐ I need some help to brush my teeth, tongue & mouth Yes ☐ No☐ (help may include bringing a bowl/ or holding hand when brushing) I need someone to brush my teeth, tongue & mouth Yes ☐ No☐		
I like to use a manual toothbrush ☐ electric toothbrush ☐		
I like to use a regular toothpaste ☐ non-foaming toothpaste ☐		
The dentist/doctor has advised or prescribed a special mouth rinse or spray Yes ☐ No☐ Provide details/name		
I struggle to open my mouth when having mouth care Yes ☐ No☐ I might bite down on a toothbrush or the suction tube so be careful Yes ☐ No☐		
I have a dry mouth and need regular dry mouth care Yes ☐ No☐ If yes, this includes lip balm ☐ Dry mouth gels ☐		
I produce lots of secretions and need regular oral suctioning Yes ☐ No☐ I have a swallowing problem therefore need more regular mouth care Yes ☐ No☐		
To be completed by dental department, my last dental assessment was on (insert date)		
From completed by (print, sign and date)		
From reviewed by (print, sign and date)		
From reviewed by (print, sign and date)		