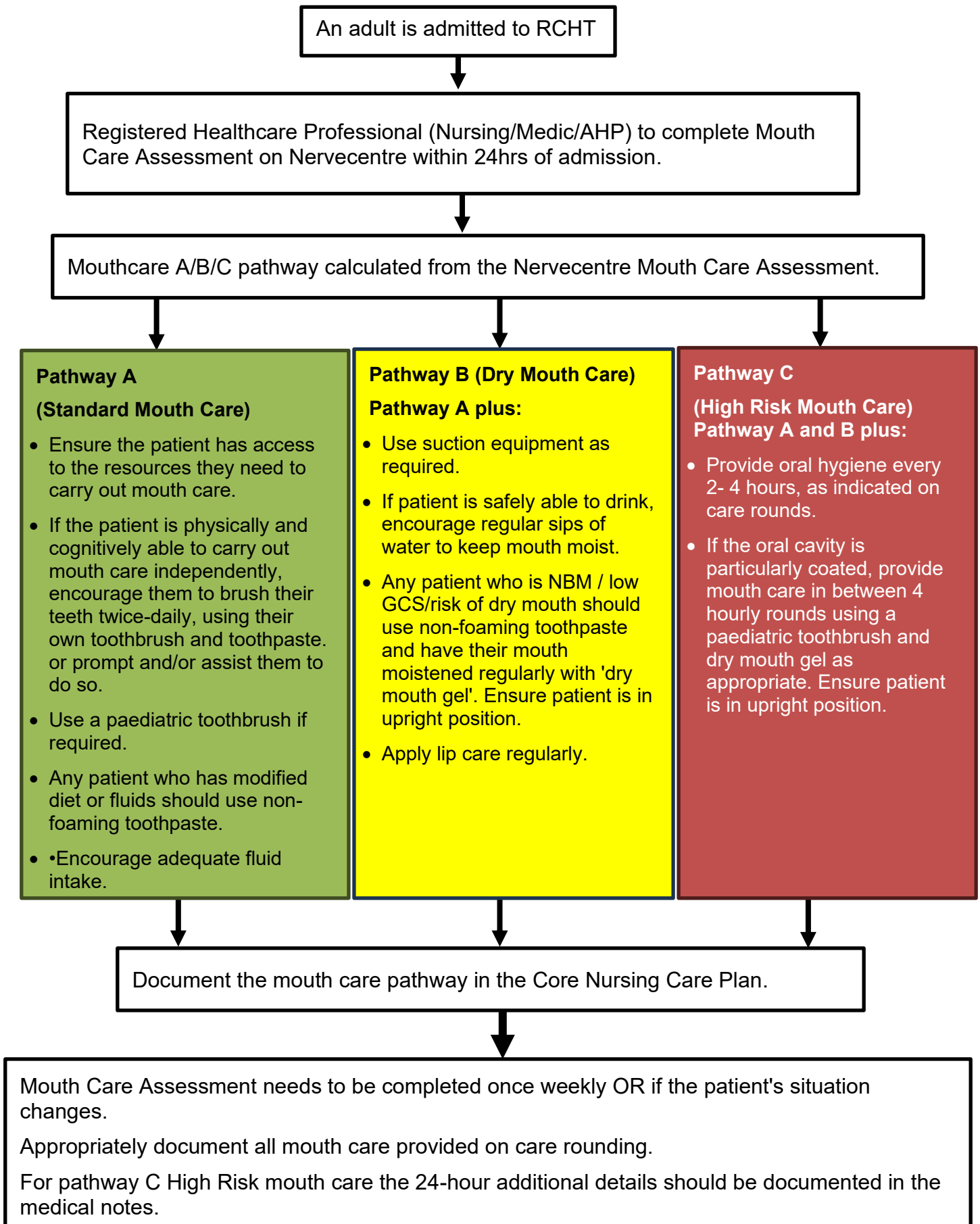


Provision of Mouth Care in an Acute Adult Inpatient Setting Policy and Procedure

V1.0

November 2025

Summary



Escalation of concerns:

- Evidence of oral thrush/bleeding gums/atypical findings – escalate to the appropriate responsible medical team.
- If a doctor feels the **Oral and Maxillofacial Surgery** team needs to be involved, please refer via an internal referral on Maxims to the Oral and Maxillofacial Surgery inpatient service.
- Oral trauma or mobile teeth that pose any airway risk – bleep the on-call Oral and Maxillofacial Surgery SHO via switch.
- In extreme cases where a severe deterioration in oral health is impacting on the oropharyngeal swallow, please refer to the SLT service via Maxims for support.

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1. Introduction

1.1. The aim of this policy is to define the standard for Royal Cornwall Hospitals NHS Trust (RCHT) staff responsible for providing/assisting patients with mouth care to maintain (or improve) oral health.

1.1.1. Regular and effective mouth care is necessary to ensure the maintenance of oral health through the removal of bacterial plaque, dry mouth care, and denture care.

1.1.2. Mouth care refers to care given to the oral mucosa, lips, teeth, gums, palate, and tongue to prevent infection, treat disease, and foster comfort. For staff to provide good daily mouth care they require:

- Knowledge of the importance of mouth care, good oral health, and the links to general health and well-being.
- Skills gained through training on how to carry out mouth care and assessment of the mouth.
- Resources / equipment needed to provide mouth care.
- Support, when necessary, from doctors/dentists/mouth care team.

1.1.3. Good oral health is important for eating and drinking, communication, and the absence of pain and infection. There is increasing evidence linking poor oral health to systemic diseases including cardiovascular disease, diabetes, and hospital acquired pneumonia (Winning et al., 2015).

1.2. Safety Information for all Staff

1.2.1. Following a Medical Device Alert from the Medicines and Healthcare Regulations Agency (MHRA), foam swabs are **banned from use** for mouth care on all RCHT wards due to increased risk of choking.

1.2.2. Note that some dry mouth care gel brands such as **Oralieve** and **BioXtra contain proteins extracted from milk** and will **not** be suitable for patients with a confirmed allergy to milk or vegans, and this must be checked.

- An Incident Reporting Form must be completed by the ward staff if a denture is lost or broken during a hospital stay and the hospital is deemed to be responsible.
- Adults, whether independent or dependant, should be sat up and must not be lying supine for mouth care to reduce the risk of aspiration of toothpaste and saliva.

1.2.3. The Intensive Care Society advises against the use of oral chlorhexidine in non-cardiac surgery patients. As such, the use of chlorhexidine mouthwash is **not** recommended for use in general and neuro intensive care unit patients as it increases the risk of death (NICE 2008).

2. Purpose of this Policy

- 2.1. There is currently no national guidance/policy on mouth care for hospitalised patients, leading to varying practices across hospitals.
- 2.2. This clinical policy provides guidance for RCHT staff to ensure that patients have access to effective daily mouth care and that this is appropriately documented.
- 2.3. **Research has shown:**
 - Hospitalisation is associated with deterioration in oral health and this may lead to hospital-acquired infections, poor nutritional intake, longer hospital stays, and increased care costs (Terezakis *et al.*, 2011).
 - Promoting and supporting patients with regular, effective mouth care can improve patients' overall health and wellbeing (Locker *et al.*, 2002).
 - The Department of Health Document 'Essence of Care 2010: Benchmarks for Personal Hygiene' (2010) states that oral hygiene is a key aspect of nursing.

3. Scope

- 3.1. This policy applies to all grades of nursing / health care support staff and those caring for adult inpatients at RCHT.
- 3.2. This policy can also apply to other health care professionals whose role can positively impact on oral health, for example Doctors, Speech and Language Therapists (SLT), Occupational Therapists (OT), Dieticians, Pharmacists and Physiotherapists (PT).
- 3.3. Relatives and carers of patients may wish to be involved in this aspect of care and should be supported to do so.

4. Definitions/Glossary

Acronym / Abbreviation / Term	Meaning
MCM	Mouth Care Matters
SLS	Sodium lauryl sulphate
Xerostomia	Dry mouth
SLT	Speech and Language Therapy
Mucositis	Inflammation and ulceration of the lining of the mouth

5. Ownership and Responsibilities

5.1. Role of the Nutrition Steering Group

The Nutrition Steering Group is responsible for:

- Supporting the delivery and monitoring of this policy.
- Promoting the link between mouth care, oral hygiene, and positive nutrition and hydration.

5.2. Role of the clinical matrons and ward leaders

Care Group matrons and ward leaders are responsible for:

- Ensuring dedicated time is protected for staff to engage in training, education, and auditing compliance in line with this policy.
- Ensuring ward areas have named nutrition and hydration champions and that these roles are not vacant if there are any staffing changes.
- Understanding the need for, and ensuring that, the recommended ward stock of mouth care equipment is present on wards (see Appendix 3).

5.3. Role of nursing staff

All clinical nursing inpatient staff members are responsible for:

- Completing the Mouth Care Risk Assessment on Nerve Centre after the patient has been admitted to the hospital for 24 hours.
- Implementing the recommended care plan in the Core Nursing Care Plan (page 14). See Appendix 4 following the mouth care assessment.
- Carrying out or assisting patients with mouth care in line with their care plan when they are unable to do this for themselves.
- Identifying potential oral health issues and making appropriate referrals to the medical or dental teams.
- Implementing recommendations made by the medical or dental team relating to a patient's oral health.

5.4. Role of Health Care Assistants

All Health Care Assistants are responsible for:

- Carrying out or assisting patients with mouth care in line with their care plan following assessment when they are unable to do this for themselves.
- Raising any potential oral health issues or concerns to the responsible nursing or medical team.

5.5. Role of Nutrition and Hydration Champions

Nutrition and Hydration champions are responsible for:

- As part of the Nutrition and Hydration champion role, to promote best practice mouth care in their ward environments.
- As part of the Nutrition and Hydration champion role, to take part in Train the Trainer training, including mouth care education.

5.6. Role of the Oral Surgery Department

- The oral surgery department within RCHT accepts urgent referrals where a dental or oral problem has been identified that is causing an inpatient significant pain or preventing them from eating or drinking.
- Referrals can be made via Maxims to the 'Oral and Maxillofacial Surgery inpatient service' or by calling extension 3980 to discuss a possible referral.
- The Oral and Maxillofacial surgery department does not carry out routine inpatient dental care.

5.7. Role of the Medical Team

All Medics / Doctors are responsible for:

- The ongoing care of patients. This should involve a routine oral examination as part of a general examination to rule out any oral causes of ill health, for example oral ulceration or oral thrush.
- Prescribing treatments for common oral conditions such as oral thrush and severe dry mouth (for example saline nebulisation).

5.8. Role of Speech and Language Therapists

All SLT staff members are responsible for:

- Considering oral cavity condition and the impact of mouth care on dysphagia and communication as part of routine assessment of patients referred to the SLT service.
- Identifying potential oral health issues in patients referred to the SLT service and making appropriate referrals to the medical or dental teams.
- Communicating any concerns with mouth care to the nursing, medical or oral surgery teams as appropriate and to document this.
- RCHT SLT services do not accept referrals for routine mouth care.
- In extreme cases where a severe deterioration in oral health is impacting on the oropharyngeal swallow, please refer to the SLT service via Maxims for support.

6. Standards and Practice

6.1. Resources/Equipment for Mouth Care

Patients/family/carers should be strongly encouraged to bring in/provide their own mouth care products including toothbrushes.

6.1.1. See Appendix 5 for the Unit 4 Code List.

6.1.2. See Appendix 3 for the recommended Mouth Care Equipment advised to be on materials management ward top up for all inpatient wards.

6.1.3. Pen Torch: Without a light source, it is impossible to fully assess the oral cavity and many conditions especially to the posterior oral cavity can be missed.

6.1.4. Toothbrushes:

- Use of electric/powered toothbrushes significantly reduces plaque and gingivitis over manual toothbrushing. Encourage patients to use their own toothbrush wherever possible.
- If a patient does not have access to a toothbrush at the time of their mouth care assessment, they should be provided with a toothbrush.
- A small brush head is more effective at reaching all parts of the mouth, especially in frail hospitalised patients or those with reduced mouth opening.
- A soft toothbrush can be used for patients with painful mouths or those suffering from acute ulceration or mucositis.

6.1.5. Toothpaste:

- Wards should stock non-foaming fluoride toothpaste.
- Non-foaming toothpastes can be used on any patient and are particularly useful for those with dysphagia.
- A pea-sized amount of toothpaste should be used on a toothbrush for patients with dysphagia.
- The recommendation from Public Health England (PHE) is that toothpaste should contain at least 13500ppm fluoride and for high-risk patients fluoride levels should be higher (PHE, 2021).

6.1.6. Oralieve 360° Toothbrushes:

- These brushes are not for routine mouth care but can be used to clean the teeth of patients unable to tolerate a regular or small headed toothbrush.

- They can be used with adults with painful mouths or adults requiring support clearing thick oral secretions.
- As well as keeping teeth clean, these brushes can also be used to apply Oralieve Moisturising Mouth Gel and to hold fluid to help with hydration.

6.1.7. MouthEze MC3 Oral Cleansers:

- MouthEze oral cleansers are not for brushing teeth. Brushing teeth with a toothbrush is the only effective way to remove dental plaque.
- MouthEze oral cleansers can be used to provide dry mouth care, including the application of dry mouth gels. They can also be used to clean the soft tissues of the mouth and remove food debris and dried saliva.
- There are two different coloured MouthEze oral cleansers to distinguish between day and night.
- They should be replaced every 12 hours: white for day and yellow for night.

6.1.8. Dry Mouth Gels:

- RCHT wards stock Oralieve Moisturising mouth gel.
- Wards should maintain a stock of dry mouth gel that can be provided for patients that are assessed for mouth care pathways B and C.
- Dry mouth gels can be very useful in lubricating the mouth to alleviate symptoms of dry mouth prior to eating and brushing teeth.
- Dry mouth gels must be gently massaged in not layered or coated on.
- If Oralieve Moisturising Mouth Gel is not an appropriate first line option due to discomfort, or patients with a confirmed allergy to milk, or vegans, alternatives can be prescribed by the medical team.

6.1.9. Glycerine Mouth Swabs:

- These may be used in theatres for post-operative patients, they are **NOT** for routine mouth care.
- If used long term, glycerine swabs can worsen dry mouth symptoms, and the lemon component is highly acidic and can result in erosion of tooth enamel.

6.2. Mouth Care Training

- 6.2.1. It is the recommendation of this policy for any adult inpatient ward staff involved in the screening, assessment and or delivery of mouth care to watch the below six bite sized videos and complete the associated questions on the NHS E-Learning for Health (ELFH) Portal.
- 6.2.2. ELFH contains e-learning programmes developed in partnership with the NHS, 3rd sector and professional bodies and can be accessed for free, 24/7 by health and care professionals.
- 6.2.3. ELFH is accessed via <https://portal.e-lfh.org.uk/>.
- 6.2.4. To register you will need:
 - A valid NHS email address.
 - To fill in your personal details for account creation.
 - Your current job role and workplace.
- 6.2.5. You will then receive an email detailing your ELFH username and temporary password to log into ELFH. You will then be required to set your own password.
- 6.2.6. In the training search bar type '**Mouth care bite-sized video training**'.
- 6.2.7. Then select the module which contains 6 videos which cover the below six key areas of inpatient mouth care delivery:
 - Oral and General Health.
 - Brushing Teeth.
 - Denture Care.
 - Dry Mouth Care.
 - Managing Resistance to Mouth Care.
 - Mouth Care at the End of Life.
- 6.2.8. Upon completion of the six videos and associated questions under the 'My Activity' tab select 'Certificates' and there will be a certificate available to download as evidence of completion of this module.
- 6.2.9. The long-term goal remains to have these videos transferred to ESR and for completion to be reportable.

6.3. Mental Capacity Act, Safeguarding and Mouth Care

- 6.3.1. The Mental Capacity Act 2005 applies to people in England and Wales who cannot make some or all decisions for themselves. The ability to understand and to make a decision when it needs to be made is called 'mental capacity'. People who work with or care for others, who lack capacity to make decisions for themselves, have a legal duty to consider the Code of Practice.
- 6.3.2. This will also include providing mouth care for such patients on the wards; any treatment or care provided should be in the patient's best interests and should be the least restrictive on the individual's rights and freedom of action and clearly documented.

6.4. Infection and Prevention:

When carrying out mouth care and oral assessments, it is important that:

- 6.4.1. Staff are bare below the elbow and hand hygiene is carried out immediately before and after contact with a patient's mouth.
- 6.4.2. As a minimum, staff should wear apron and a fresh pair of gloves immediately before contact with a patient's mouth, and they must be changed in between patients and/or after completing a procedure or task. If there is a risk of body fluid splashes, eye protection should be worn.
- 6.4.3. For patients with suspected or confirmed respiratory infections, fluid resistant face mask should be worn. If patient is suspected or confirmed Tuberculosis, staff should wear FFP3 and must be fit tested for it. If with unexplained vomiting, carry out mouth care and oral assessment when symptoms subside.
- 6.4.4. Manufacturers of the MouthEze MC3 oral cleanser recommend that they are replaced every 12 hours. They can be rinsed in water within 12 hours.
- 6.4.5. Toothbrushes should be rinsed in water and allowed to air dry.
- 6.4.6. Toothbrushes and toothpaste must not be stored or left in shared or communal toilets and bathrooms.
- 6.4.7. Clinical hand wash basins (such as those in multi-bedded room) must not be used other than for hand washing purposes only.
- 6.4.8. **Toothbrushes must not be left in water as this increases risk of bacterial colonisation and structural breakdown of the toothbrush.**

6.5. Identifying patients that require support or who are fully dependent for mouth care:

- 6.5.1. All patients who have been admitted to hospital for more than 24 hours should have the Mouth Care Risk Assessment on Nervecentre carried out to identify the level of support required with mouth care.
- 6.5.2. The Mouth Care Risk Assessment directly links to the Mouth Care Care Plan section of the Core Nursing Care Plan (Page 14).

6.6. Defining Risk:

- 6.6.1. A low-risk patient is someone identified as being independent with mouth care with no comorbidities increasing their chances of having problems with their mouth.
- 6.6.2. Following assessment Pathway A, patients should have their Mouth Care Assessment reviewed every seven days or if their health status changes (e.g. deterioration in condition, surgery, intubation etc).
- 6.6.3. Following assessment Pathway B or C, patients should have a Mouth Care Care Plan completed and all mouth care should be documented daily on the recording sheet. These patients should also have their Mouth Care Risk Assessment reviewed every seven days or if their health status changes (e.g. deterioration in condition, surgery, intubation etc).

6.7. Oral Health High-Risk Groups (may include the following groups of patients, however, not exhaustive)

- Adults with dementia.
- Adults with Learning Disabilities.
- Adults on a palliative/end of life care pathway.
- Adults having Systemic Anti-Cancer Therapy.
- Adults on intensive care.
- Adults who are immunocompromised.
- Adults receiving head and neck radiation therapy.
- Adults who have had a stroke.
- Adults with severe mental health conditions.
- Adults receiving oxygen therapy.
- Adults with physical disability leading to reliance on others for mouth care.
- Adults who are Nil By Mouth.

- Adults identified to have dysphagia.
- Adults who are frail and elderly.
- Adults with uncontrolled diabetes.
- Adults with a diagnosis of delirium.

6.8. Completing a Nervecentre Mouth Care Assessment:

- 6.8.1. The Mouth Care Assessment can be found under the 'Core Nursing category of assessments on Nervecentre for a breakdown of the assessment see Appendix 6.
- 6.8.2. The Mouth Care Assessment should only be completed by a registered healthcare professional, and the resulting Care Plan implemented and documented in the core nursing care plan booklet (See Appendix 4).
- 6.8.3. The assessment should be initially within 24 hours of admission then repeated weekly throughout admission or if there is a change in presentation.
- 6.8.4. The assessment defines which Adults:
 - May require increased support with mouth care.
 - May require increased frequency of mouth care.
 - May require further products such as dry mouth gel to be used as part of routine mouthcare.
- 6.8.5. Appendix 7 The Mouth care visual assessment guide can be used to as a visual aid to support observational assessment of the oral cavity.
- 6.8.6. Consent should be gained prior to carrying out the assessment process – if the patient is unable to give informed consent, consider whether this would be in the patient's best interest, and document the outcome in the medical notes.
- 6.8.7. If the patient upon completion of the assessment is categorised within Pathway C, Documentation using the daily care rounding or the 24-hour care diary must be completed for all mouth care episodes and the Mouth Care Assessment will need weekly completion for the duration of their admission.
- 6.8.8. Nursing staff can request training/support on the use and completion of the Mouth Care Assessment from the ward nutrition and hydration champions or from practice educators.
- 6.8.9. Any relevant information to providing daily mouth care must be documented. For example, if a patient only accepts mouth care from their 1:1 external carer, this should be documented in the medical notes.

6.9. Documentation

- 6.9.1. The outcome of the Nerve Centre assessment care pathway A/B/C should be clearly marked, dated and signed in the Mouth Care section of the Core Nursing Plan -Adult on Page 14 (CHA3897) and each weekly re-assessment should be documented, dated and signed using the care plan.
- 6.9.2. For patients requiring support with mouthcare, regardless of their Mouthcare A/B/C pathway, mouthcare should be documented on the daily care rounding (CHA3061).
- 6.9.3. For patients with increased Mouth care needs or assessed as Pathway C 'High Risk Mouth Care' the daily care rounding should be used in combination with further clinical details being documented in the medical notes.

6.10. Auditing

- 6.10.1. See appendix 8 designed as a repeatable audit tool
- 6.10.2. During the first-year implementation of this policy quarterly auditing of adult inpatient wards of mouth care is recommended for reporting to the Nutrition Steering Group and specific areas of need may be requested to carry out an increased frequency of auditing.
- 6.10.3. Mouthcare outstanding assessments have been added to the Nervecentre and will form a part of point in time snapshot audits of mouthcare assessment completion in line with this policy.

6.11. Levels of Assistance:

6.11.1. Independent:

- Adults should only be assessed as being independent if they are able to complete mouth care/denture care without any assistance.
- Note that some adults may say they can cope when they need assistance or may be worried about asking the staff for assistance with mouth care. Staff should still offer support with mouth care to these patients.

6.11.2. Some Assistance Required:

- This includes adults with a physical disability that may affect their manual dexterity: for example, a Parkinsonian associated tremor or arthritis, or those with mild cognitive changes who may need reminders for mouth care.

6.11.3. Fully Dependent:

- Adults who are fully dependent on another person for mouth care, inclusive of those with altered levels of consciousness, profound and multiple learning disabilities, advanced dementia, moderate-severe cognitive changes and upper limb weakness/reduced coordination i.e. stroke/neurology/trauma etc.

6.12. Frequency of Mouth Care

- 6.12.1. Mouth care frequency for adults assessed as Pathway A and B (See Appendix 4) should be encouraged to brush their teeth twice a day with fluoride toothpaste and to continue with the mouth care regime that they would normally carry out in their home environment (denture care, flossing, mouthwashes etc.)
- 6.12.2. For adults assessed as Pathway C High Risk (See Appendix 4), this is advised every 2-4 hours.

6.13. Toothbrushing

- 6.13.1. There are no medical contraindications for toothbrushing. Where possible a toothbrush should be used for brushing patients' teeth as this is the only effective way of removing plaque bacteria from the tooth surface.
- 6.13.2. A small-headed, soft/medium texture toothbrush, angled at 45 degrees towards the gingivae (gum) using a gentle but firm vibrating movement (in small circles) is the most effective way of removing plaque bacteria from the tooth surface (See appendix 9).
- 6.13.3. For patients who are Nil By Mouth or who have been assessed by a SLT as having dysphagia, a smear (a very small amount) of non-foaming sodium lauryl sulphite free (SLS free) toothpaste can be used.
- 6.13.4. An SLT may recommend the use of oral suctioning alongside mouth care for high-risk patients, but it is important that toothbrushing is still carried out daily with these patients.

6.14. Denture Care

- 6.14.1. It is vital that patients who wear dentures are identified, and that appropriate denture care is given. Good denture hygiene reduces the risk of patients developing oral denture stomatitis (thrush).
- 6.14.2. Dentures must be removed at least once a day for cleaning and to assess the mouth for redness or ulceration.
- 6.14.3. Dentures should be removed at night, cleaned, and placed into clean water into a named denture pot with a lid.
- 6.14.4. Staff/patients should put dentures in a labelled denture pot with a lid when the dentures are not in the mouth.

- 6.14.5. Wards must have a supply of denture pots to provide to patients where necessary to help prevent the loss of a denture during a hospital stay.
- 6.14.6. If a patient has been treated for oral thrush or denture stomatitis, their denture should be cleaned and soaked in chlorhexidine (0.2%) mouthwash solution for 15 minutes twice daily (BNF Online).
- 6.14.7. Patients are at risk if dentures are painful in the mouth or broken. Some patients are not tolerant of their dentures and do not routinely wear them. It is advisable that dentures that are not regularly worn are taken home/to a safe place by the patient's carer/family to reduce the chance of them becoming lost during a hospital stay.

6.15. Dry Mouth Care:

- 6.15.1. Hospitalised adults are at increased risk of experiencing a dry mouth. A severely dry mouth increases the risk of other oral complications such as dysphagia, dental decay, oral thrush, oral ulceration, and general oral discomfort.
- 6.15.2. Dry mouth can also impact directly on dysphagia (swallowing) and communication.
- 6.15.3. For adults assessed as Pathway B and C (see Appendix 4), a dry mouth gel such as Oralieve Moisturising Mouth Gel is recommended. These should be available on the wards for nursing staff to use without a prescription. Adults assessed as independent can use this as necessary or the gel can be applied by nursing staff.
- 6.15.4. Dry mouth gel can be applied every two hours using a MouthEze MC3 oral cleanser or toothbrush. Gel can be applied to the tongue, palate, lips, buccal sulcus and buccal mucosa.
- 6.15.5. Dry mouth gel should be massaged into the soft tissues of the mouth not just left coating the tissues.
- 6.15.6. If Oralieve Moisturising Mouth Gel is not available on the ward, a dry mouth gel (such as Biotene Oral Balance) can be prescribed by a doctor.
- 6.15.7. Ensure that the patient is brushing twice daily with a non-foaming (SLS free) fluoride toothpaste as SLS can dry the mouth out further.

6.16. Mouth Care and Dysphagia

- 6.16.1. Please refer to the RCHT Clinical guidelines 'Oropharyngeal Dysphagia Management in Adults Guideline' for detailed information on oropharyngeal dysphagia.
- 6.16.2. As with all patients, it is important that patients who are at risk of dysphagia maintain good oral hygiene whilst they are in hospital.

6.16.3. When cleaning the mouth of a patient who is at risk of dysphagia, extra care should be taken to reduce the risk of aspirating toothpaste by:

- Positioning a patient receiving mouth care sat upright and out of bed where possible.
- Using non-foaming toothpaste and thorough at least twice daily mouth care IF not advised more frequently by the Mouth Care Risk Assessment on Nerve Centre and associated Care Plan in the Core Nursing care plan booklet.
- Following the Mouth Care, Care Plan for patients assessed as Pathway C High Risk.
- Ensuring non-foaming toothpaste is being used (See Appendix 3).
- Nursing staff must be aware of and follow any special guidance from the SLT team relating to mouth care for high-risk patients.

6.17. Palliative Care: Mouth Care at End of Life

6.17.1. Mouth care is an essential component of good quality nursing care and palliative patients are known to be at higher risk of developing oral health problems (Salamone et al 2013).

6.17.2. Staff should use clinical judgment and patient symptoms to guide frequency and levels of assistance when providing mouth care for those on end-of-life care.

6.17.3. Please refer to the RCHT Intranet and [EndOfLifeCarePlanAndSymptomAssessmentChartClinicalGuideline.pdf](#) for end-of-life care symptom assessment and guidance advice.

6.17.4. Please liaise with the Palliative Care Clinical Nurse Specialist Service for end-of-life care symptom management support.

6.17.5. The aim of assessing and providing good regular mouth care at the end of life is to clean and hydrate the mouth, promoting comfort and dignity.

6.17.6. Where possible, ward staff can share patient mouth care with the family. Helping a loved one at the end of their life is important and can allow family and friends to feel useful during a time in which they have little control.

6.18. Common Mouth Care Problems

Oral Symptom	Potential Contributing Cause	Suggested Treatment
Dry mouth (Xerostomia)	Side effects from medication, oxygen therapy, dehydration, damage to salivary glands as a result from treatments, reduced	Regular sips of fluid/mouth care, reviewing need for oxygen or switching to humidified oxygen, review medication, moistening agents such as Oralieve

Oral Symptom	Potential Contributing Cause	Suggested Treatment
	ability in managing own mouth care, mouth breathing at the end of life	Moisturising Mouth Gel (only effective alongside regular mouth care) and saliva substitutes, chewing sugar free gum (if able), Pilocarpine drops
Dry, cracked lips	Dehydration, use of oxygen therapy	Regular mouth care and cleansing of lips, lip lubricant such as Oralieve Moisturising Mouth Gel or lip balms
Mouth ulcers	Side effects from medication/ treatment, ill-fitting dentures, idiopathic, squamous cell carcinoma, infections	Symptomatic relief may include Difflam mouth wash, Bonjela gel, aspirin mouth wash, salt water mouth wash
Bleeding gums	Gingivitis (caused by poor oral hygiene), vitamin C deficiency, leukaemia	Twice daily brushing with fluoride toothpaste and toothbrush, daily interdental cleaning (if possible), seek underlying cause if poor oral hygiene is not considered to be the cause
Coated tongue	Dehydration, poor mouth care, infection	Regular mouth care including dry mouth care, antifungal treatment if candida is suspected
Oral thrush	Medication, oxygen therapy, dehydration, poor oral/denture care	Topical Nystatin oral solution, miconazole gel or systemic Fluconazole capsules
Halitosis	Poor mouth care (past and present), gum disease, infection, or from the disease itself	Regular mouth care with fluoride toothpaste and mouth wash, oral Metronidazole may be of benefit
Altered taste sensation	Medication, Chemotherapy and Radiotherapy treatment	Refer to dietician
Difficulty swallowing (dysphagia)	Oral thrush, deterioration/ altered conscious level	Assessment of oral cavity to rule out thrush infection, swallow assessment, thickened fluids if indicated
Communication difficulties	Dry mouth, dehydration	Regular mouth care and comfort sips if able

6.19. Intensive Care and Mouth Care

- 6.19.1. Endotracheal tubes can harbour respiratory pathogens, increasing risk of ventilated-associated pneumonia; mouth care for such patients reduces this risk (Shi et al., 2013).
- 6.19.2. Pneumonia carries a mortality risk, and it is therefore important that mouth care is provided for all hospitalised patients whether they are intubated, non-ambulatory, or independent.
- 6.19.3. Access to mouth care can be challenging due to reduced oral cleaning space in intubated patients.
- 6.19.4. The Intensive Care Society advises against the use of oral chlorhexidine in non-cardiac surgery patients. As such, the use of chlorhexidine mouthwash is not recommended for use in general and neuro intensive care unit patients as it increases the risk of death (NICE 2008).
- 6.19.5. Taking evidence into consideration, mouth care for ventilated patients should include:
 - 12 hourly mouthcare assessment, grading oral structures and hygiene to assign patient to the A (standard)/ B (dry mouthcare) /C (high risk) pathway based on risk. The Intensive care specific assessment plan, scoring details and descriptions available on Care Vue.
 - Toothbrushing at least twice daily, ideally with a non-foaming (SLS free) toothpaste to remove bacterial plaque.
 - The use of a small headed toothbrush with suction if appropriate.
 - Dry mouth care with two hourly application of dry mouth gel to the mouth and lips (if required).
 - A meta-analysis conducted by Janakiram et al (2018) found that the Modified Bass Technique was more efficient at removing plaque (See Appendix 9.)
 - Minimise traumatic ulceration caused by endotracheal tubes using specifically designed fasteners and bite blocks for those patients who are intubated for prolonged periods.

6.20. Oral Suctioning in Mouth Care

- 6.20.1. Some adults may require oral suctioning during mouth care to reduce the risk of saliva or residue from mouth care products being aspirated e.g. those with low alertness levels, severe cognitive impairment or dysphagia.
- 6.20.2. Competent staff who have received device training on delivering suctioning can make use of oral 'Yankauer' suction to the anterior of the oral cavity.

6.20.3. Oral suctioning should only be used on a case-by-case basis and have sound clinical rationale in its application.

6.20.4. Any use of oral suctioning must be clearly documented in the medical notes.

6.21. Dementia and Mouth Care:

6.21.1. Adults with dementia should be supported by hospital staff with mouth care.

6.21.2. Some adults may simply require a reminder to brush their teeth, others may be dependent on staff for their mouth care.

6.21.3. Some patients with mid to late-stage dementia may develop reflexes that make mouth care difficult such as closing their lips, clenching their mouth, biting and moving their head.

6.21.4. Strategies for delivering mouth care in this cohort which can be generalised to populations with cognitive impairments:

- Develop a routine, providing mouth care at the same time each day.
- Please refer to any patient specific documentation such as the 'This Is Me' or 'Hospital Passport' before providing mouth care to best understand individual needs.
- Take time, be kind, and patient.
- Ask a carer/family member who is more familiar to the patient to help with providing mouth care.
- Use short sentences, simple instructions, reminders, and prompts. For example, sometimes placing a toothbrush in front of a patient or in their hand will be a sufficient reminder.
- Provide distractions with conversation, singing, or by giving the patient something to hold in their hands.
- Use a hand-over-hand technique (carer's hand over patient's hand), guiding the patient to brush their teeth.
- A non-foaming toothpaste (SLS- free) may be more tolerable.
- Some adults with dementia may at times decline mouth care, it is important to stop and document that the patient is declining mouth care at that time and to try again at a different time of day.

7. Dissemination and Implementation

- 7.1. This document will be made available on the Royal Cornwall Hospital Trust intranet. It will also be ratified and disseminated through the Nutrition Steering Group.
- 7.2. The policy will be presented to the clinical Matrons via Nutrition Steering group and once the policy is agreed. The mouth care policy will be emailed to the clinical matrons and clinical ward leaders for awareness.
- 7.3. The Mouthcare policy once agreed will be supplemented by the delivery of a safety brief detailing the ward based operational delivery of mouth care in relation to this policy for inpatient clinical staff working with adults.
- 7.4. As detailed in section 8 mouth care training there will be six educational bite sized mouth care videos available for ward level training and education on ESR.
- 7.5. The mouth care screening and assessment processes detailed in this policy will be incorporated into Speech and Language Therapy training and education delivery.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	<ul style="list-style-type: none"> • Completion of the Nervecentre Screen / Assessment within 24 hours of admission. • That the mouth care Screen /Assessment is repeated every 7 days of admission. • Accuracy documenting the A/B/C mouth care pathway in the core nursing plan. • Accuracy of documenting mouth care in daily care rounding in line with the A/B/C mouth care pathway determined frequency.
Lead	Nutrition Steering Group.
Tool	Inpatient flow reporting on Nervecentre. Spot check point in time ward level Audits. Appendix 8 Audit tool.
Frequency	Suggest within the first year of policy implementation. <ul style="list-style-type: none"> • Quarterly ward led audits using Appendix 8 the audit tool. • Spot check point in time Audits for identified areas of identified need. Use of Nervecentre Inpatient flow dashboard to identify areas where further support may be required. Overdue assessment point in time data to be included in SLT quality report to NSG.

Information Category	Detail of process and methodology for monitoring compliance
	Frequency of auditing after 12 months to then be reviewed and agreed by Nutrition Steering Group.
Reporting arrangements	Reporting through the Speech and Language Therapy Quality report to Nutrition and Hydration Steering Group.
Acting on recommendations and Lead(s)	Nutrition and Hydration Steering Group.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within an appropriate time frame. A lead member of the appropriate service areas will be identified through Nutrition Steering Group to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

- 9.1. Policy document to be reviewed every three years
- 9.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.
- 9.3. Where the revisions are minor, e.g. amended job titles or changes in the organizational structure, approval can be sought from the Executive Director responsible for signatory approval and can be re-published accordingly without having gone through the full consultation and ratification process.
- 9.4. Any revision activity is to be documented in the Version Control Table as part of the document control process.

10. Equality and Diversity

- 10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).
- 10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Provision of Mouth Care in an Acute Adult Inpatient Setting Policy and Procedure V1.0
This document replaces (exact title of previous version):	New document
Date Issued/Approved:	14 October 2025
Date Valid From:	November 2025
Date Valid To:	November 2028
Directorate / Department responsible (author/owner):	Directorate: Nutrition Steering Group. Authors: Alexander Bond, RCHT Acute SLT Lead / RCHT Dysphagia Lead. Laura Olds, RCHT Specialist Dental Nurse. Jenna Thompson, RCHT Specialist Stroke SLT.
Contact details:	07826 906354
Brief summary of contents:	This policy defines the standard for Royal Cornwall Hospitals NHS Trust (RCHT) staff responsible for providing/assisting patients with mouth care to maintain (or improve) oral health.
Suggested Keywords:	Inpatient, Adult, Mouth Care. NSG.
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Nutrition Steering Group (NSG). Therapies Senior Management Team.
General Manager confirming approval processes:	Clare Rotman
Name of Governance Lead confirming approval by specialty and care group management meetings:	Becky Osborne
Links to key external standards:	None required

Related Documents:

Adams, R. (1996) Qualified nurses lack adequate knowledge related to oral health, resulting in inadequate oral care of patients on medical wards. *Journal of Advanced Nursing*; 24: 552-560.

Becker, R. 2009. Palliative care2: exploring the skills that nurses need to deliver high quality care. *Nursing Times*. 105, (14): 18-20.

Brennan, L.J., Strauss, J. 2014. Cognitive Impairment in Older Adults and Oral Health Considerations: Treatment and Management. *Geriatric Dentistry*; 58(4): 815-828.

Costello, T. and Coyne. I. 2008. Nurses' knowledge of mouth care practices. *British Journal of Nursing*. 17, (4): 264- 268.

Department of Health. (2010) *Essence of Care: Benchmarks for Personal Hygiene*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216697/dh_119976.pdf (Accessed: 01 January, 2015).

Gil-Montoya, J.A. Subirá, C., Ramón, J.M. González-Moles, M.A. 2008. Oral Health- Related Quality of Life and Nutritional Status. *American Association of Public Health Dentistry*. 68(2), pp. 88-93.

Joint Formulary Committee. *British National Formulary* (online) London: BMJ Group and Pharmaceutical Press
<<http://www.medicinescomplete.com>> [Accessed on 5/1/16].

Klompas, M., Speck, K., Howell, M.D., Greene, L.R., Berenholtz, S.M. (2014) Reappraisal of routine oral care with chlorhexidine gluconate for patients receiving mechanical ventilation: systematic review and meta-analysis. *JAMA Intern Med*; 174 (5): 751-761.

Locker, D., Matear, D., Stephens, M., Jokovic, A. (2002) Oral health-related quality of life of a population of medically compromised elderly people. *Community Dental Health*; 19 (2): 90-97.

Locker, D. (1992) The burden of oral diseases in a population of older adults. *Community Dental Health*; 9 (2): 109-124.

Pearson LS.,Hutton (2002).A controlled trial to compare the ability of foam swabs and toothbrushes to remove dental plaque. *J Adv Nurs*. 2002 Sep;39(5):480-9.

Information Category	Detailed Information
	<p>Poisson, P., Laffond, T., Campos, S., Dupuis, V., Bourdel- Marchasson, I. Relationships between oral health, dysphagia and undernutrition in hospitalised elderly patients. Gerodontology 2014, doi: 10.1111/ger.12123.</p> <p>Public Health England. (2014) Delivering better oral health: an evidence-based toolkit for prevention. Third Edition.</p> <p>Scannapieco, F.A. (2006) Pneumonia in non-ambulatory patients. Journal of the American Dentists Association; 137 (2): S21- S25.</p> <p>Shi, Z., Xie, H., Wang, P., Zhang, Q., Wu, Y., Chen, E., Ng, L., Worthington, H.V., Needleman, I., Furness, S. (2013) Oral hygiene care for critically ill patients to prevent ventilator-associated pneumonia (Review). Cochrane Database of Systematic Reviews; 8: 1-125.</p> <p>Terezakis, E., Needleman, I., Kumar, N., Moles, D., Agudo, E. (2011) The impact of hospitalization on oral health: a systematic review. Journal of Clinical Periodontology; 38 (7): 628-636.</p> <p>Watson, M. et al. 2011. Palliative adult network guidelines. 3rd ed. Anglia.</p> <p>Winning, Gerard J. Linden. 2015. Periodontitis and systemic disease. BDJ team. Article number 15163 (2015).</p> <p>Salamone, K. et al. 2013. Oral care of hospitalised older patients in the acute medical setting. Nursing Research and Practice. Article ID 827670.</p> <p>Department of Health (2013). Health Building Note 00-09 Infection Control in the Built Environment. Available at (https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-09_infection_control.pdf). Accessed 14 April 2025.</p> <p>Department of Health (2016). Health Building Note 00-02: Sanitary Spaces. Accessed at <https://www.england.nhs.uk/wp-content/uploads/2021/05/DH_HBN_0002.pdf > Accessed 14 April 2025.</p>
Training Need Identified?	Yes
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet

Information Category	Detailed Information
Document Library Folder/Sub Folder:	Clinical / Speech and Language Therapy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
November 2025	V1.0	Initial issue	Alexander Bond, RCHT Acute SLT Lead / RCHT Dysphagia Lead.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team
rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Provision of Mouth Care in an Acute Adult Inpatient Setting Policy and Procedure V1.0
Directorate and service area:	Speech and Language Therapy, Clinical Support
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Alexander Bond: Acute SLT team lead and Dysphagia Lead
Contact details:	01872 252470

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Inpatient staff involved in the screening /assessment and operational delivery of mouth care.
2. Policy Objectives	This clinical policy's goal is to set an RCHT standard for mouthcare screening / assessment and operational delivery alongside providing guidance for RCHT staff to ensure that patients have access to effective daily mouth care and that this is appropriately documented.
3. Policy Intended Outcomes	Implementation of mouthcare screening / assessment within 24 hours of admission and every 7 days or if presentation changes. To set a measurable /auditable standard of mouthcare provision in RCHT.

Information Category	Detailed Information
4. How will you measure each outcome?	See Audit Tool appendix 9. Care group compliance reporting to Nutrition and hydration Steering Group. Monitoring of incident reporting.
5. Who is intended to benefit from the policy?	All Adult inpatients at RCHT.
6a. Who did you consult with? (Please select Yes or No for each category)	<ul style="list-style-type: none"> • Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	<p>Please record specific names of individuals/ groups:</p> <p>Ian Moyle – Head of Nursing and Chair for Nutrition and Hydration Steering Group.</p> <p>Sally Parker – Speech and Language therapy Professional lead.</p> <p>RCHT Infection and Prevention Control.</p> <p>Nutrition and Hydration Steering Group members.</p>
6c. What was the outcome of the consultation?	Ratified in April 2025 Nutrition Steering Group.
6d. Have you used any of the following to assist your assessment?	<p>National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:</p> <p>No.</p>

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	

Protected Characteristic	(Yes or No)	Rationale
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Alexander Bond, Acute SLT Team Lead and Dysphagia Lead.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
[Section 2. Full Equality Analysis](#)

Appendix 3. Recommended Mouth Care Equipment for RCHT Ward Stock

(Alongside a standard toothbrush and toothpaste).

ILA747 Oralieve Moisturising Mouth Gel:

This can be used on any pink oral mucosal surfaces (e.g. lips, tongue, gums), and are water based so appropriate for O2 users.

ILA920 Oralieve Ultra Mild Toothpaste (Non-Foaming):

Designed for dry mouths and patients who may be Nil By Mouth to support oral hygiene.

IMC010 360 Toothbrush:

Designed to clean oral mucosal surfaces. Ideal for dry mouths with a coating building up on the soft tissue in the mouth, these are gentle on soft tissues yet effective at cleaning teeth.

PED009 Paediatric 360 Toothbrush:

Better for patients with reduced jaw opening. Ideal for dry mouths with a coating building up on the soft tissue in the mouth.

MRA186 Paediatric Soft Toothbrush:

For patients with damaged oral mucosa / experiencing discomfort / pain with mouth care.

ILA1083 Oralieve Nourishing lip balm:

For dry mouth and dry lip care formulated to hydrate and relieve cracked lips. Apply as often as needed for continuous hydration and comfort.

Appendix 4. Core Nursing Care Plan (Adult) - Mouth Care Section



Place patient sticker **within** this box



Mouthcare		
Applicability		
For patients who have a care need identified following completion of the mouthcare assessment on Nervecentre (pathway B and C)		
Goals		
<ul style="list-style-type: none"> To provide responsive and personalised mouthcare that delivers better clinical outcomes for the patient 		
Standard care interventions		
<ul style="list-style-type: none"> Use a light source when assessing the condition of the patient's mouth Implement the relevant pathway as indicated by the mouthcare assessment on Nervecentre Reassess weekly unless patient condition changes If fungal infection suspected (candida/thrush), gums are red, swollen and bleeding or ulcers present for ≥ 3 weeks then refer to medical staff. <p>Pathway B (8-15) <input type="checkbox"/></p> <ul style="list-style-type: none"> If the patient is physically and cognitively able to carry out mouth care independently, encourage them to brush their mouth (teeth, tongue, palate and gums) twice-daily, using their own toothbrush & fluoride toothpaste. If not, prompt and/or assist them to do so. Use a paediatric toothbrush if required. Any patient who has modified diet or fluids should use non-foaming toothpaste. Encourage adequate fluid intake Use suction equipment as required. If patient is safely able to drink, encourage regular sips of water to keep mouth moist. Any patient who is NBM / low GCS / risk of dry mouth should use non-foaming toothpaste and have their mouth moistened regularly with 'dry mouth gel'. Ensure patient is in upright position. Apply patient's own lip balm regularly (or ask family to bring in). <p>Denture care <input type="checkbox"/></p> <p>Actions for those triggering pathway B who have dentures</p> <ul style="list-style-type: none"> Wash dentures using liquid soap and toothbrush, soak in a labelled denture pot with clean water overnight and rinse well before re-fitting. For patients with reduced alertness, dentures should be removed, cleaned and stored in a clean labelled container, with a small amount of water. If fungal infection confirmed, soak dentures in chlorhexidine (0.2%) mouthwash for 15 minutes daily. Rinse thoroughly. <p>Pathway C (16-41) <input type="checkbox"/></p> <p>Pathway B plus:</p> <ul style="list-style-type: none"> Provide oral hygiene every 2-4 hours, as indicated on CARE rounds. If the oral cavity is particularly coated, provide mouth care in between 4 hourly rounds using a paediatric toothbrush and dry mouth gel as appropriate. Ensure patient is in upright position. 		
Additional/Individualised care interventions (not listed above)		
Print:	Signature:	Date: Time:
Review		
Date: Time: Update required: Yes / No If yes, please indicate below: Print Name: Signature:	Date: Time: Update required: Yes / No If yes, please indicate below: Print Name: Signature:	Date: Time: Update required: Yes / No If yes, please indicate below: Print Name: Signature:

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Appendix 5. Unit 4 Mouth Care Equipment Codes

Product	Unit 4 Code	Cost
Oralieve Moisturising Mouth Gel	ILA747	£40.12 (box of 70) – 0.57p each
Oralieve Nourishing lip balm	ILA1083	£16.20 (pack of 20 – 0.81p each
Oralieve SLS free Toothpaste	ILA920	£35.98 (box of 70) – 0.51p each
Oralieve Adult 360 Brush	IMC010	£21.20 (box of 10) - £2.12 each
Oralieve Paed 360 Brush	PED009	£29.50 (box of 10) - £2.95 each
Small headed toothbrush	MRA186 (although this says paed, it's the right size for an adult)	£0.96 (pack of 25) – 0.3p each
Denture pot	MRA144	£3.23 (box of 100) – 0.3p each
Denture pot lid	MRA145	£4.06 (box of 100) – 0.4p each
Pen torch	FFE1552	£1.66 (pack of 6) – 0.27p each
Disposable mouth mirrors	IER071	£20 (box of 200) – 0.1p each
MC3 Mouth Cleanser – White	FRME01	£8.75 (pack of 25) – 0.35p each
MC3 Mouth Cleanser - Yellow	PAD252	£8.86 (pack of 25) – 0.36p each
Brightly coloured pot alternative to denture pots	GMZ1033 or YOM200	£7.20 (box of 8) – 0.90p each

Appendix 6. Mouth Care Screen / Assessment Tool on Nervecentre

Summary

The screening and assessment tool are based on the referenced NHS England's' Mouth Care Matters initiative, guidance on inpatient assessment of mouth care.

Selection of any risk factors when completing the initial mouthcare screen will necessitate the completion of the mouth care assessment. Where no risk factors are selected the mouth care screen will place patients on the Pathway A- Standard mouth care pathway.

The Nervecentre mouth care assessment encompasses assessment of the following with the total score determining the mouthcare pathway outcome:

- Levels of alertness (scored 1-10).
 - Alert and compliant (1), Reduced insight /independence (2), Sedated / uncooperative / delirium (8), GCS<8 (10).
- Lip condition (scored 1-4).
 - Smooth Pink and Moist (1), Dry /Cracked (2), Bleeding (3), Ulcerated (4).
- Tongue condition (scored 1- 3).
 - Clean Pinkand Moist (1), White / yellow coating (2), Blistered / Cracked/Dry (3).
- Saliva / secretions (scored 1- 4).
 - Normal (1) Thick Stringy or Dry (2), Dried or pooling secretions (3), Absent (4).
- Teeth / denture condition (scored 1-2).
 - Clean no debris (1), Debris / plaque / ill-fitting dentures (2).
- Nutritional intake (scored 1 - 11).
 - Normal (1), Modified (3), NBM/ Oral Trials / Enteral or Parenteral feeding (11).
- Respiratory status (scored 3-4).
 - Oxygen Therapy (3), Mouth Breathing (4).

Total Score	Pathway Category
6-7	A -Standard mouth care
8-15	B- Dry mouth care
16-41	C- High Risk mouth care

Appendix 7. Mouth Care Assessment Visual Guide

Reference: [Mouth Care Matters Resources - Mouth Care Matters](#)

Mouth Care Matters **Mouth care assessment guide** NHS Health Education England

Lips			
Action	None	Dry mouth care	Refer to DOCTOR
Tongue			
Action	None	Dry mouth care	Refer to DOCTOR
Teeth & Gums			
Action	2x daily toothbrushing	Daily toothbrushing, clean the mouth	Refer to DOCTOR
Cheeks, Palate & under the Tongue			
Action	None	Clean the mouth, dry mouth care, ulcer care	Refer to DOCTOR
Denture			
Action	Clean daily	Denture care, encouragement	DAIX if lost, refer to dental team if lost or broken

ACTION PLAN

AUDIT GUIDANCE

Mouthcare Pathways

Ward	Date
Improvement Action	Evidence
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
<i>Title: Who, will do what, and why by when?</i>	
Action Plan Agreed By Ward Leader	<i>Print Name & Sign</i>
Action Plan Agreed By Clinical Matron	<i>Print Name & Sign</i>

Nervecentre Screen / Assessment:
To pass, the screen /assessment must have been completed within 24 hours of admission and be repeated every 7 days if remaining an inpatient.

Core Nursing Plan Mouth care Page 14:
To pass, the Core Nursing Care Plan must be completed and have a printed name and signature of a ward registrant.

Care Rounding
To pass, the form must have been completed with mouth care documented in line with the assessed (on Nervecentre) mouth care pathway.

Pathway A & B = At least twice daily.
Pathway C = Every 2-4 hours.

Mouth care equipment:
To pass, **no** mouth care equipment should be stored in water due to the increased risk of bacterial colonisation.

Are the details correct?

- Does the assessed mouth care pathway on Nervecentre correspond with the documented pathway in the core nursing care plan?
- When a patient has been re-screened / assessed after 7 days of admission has this been re-documented in the core nursing care plan?
- Do the patients details on their denture pot match the patient.

**Pathway A
(Standard Mouth Care)**

Ensure the patient has access to the resources they need to carry out mouth care.

If the patient is physically and cognitively able to carry out mouth care independently, encourage them to brush their teeth twice-daily, using their own toothbrush & toothpaste. or prompt and/or assist them to do so.

Use a paediatric toothbrush if required.

Any patient who has modified diet or fluids should use non-foaming toothpaste.

Encourage adequate fluid intake

**Pathway B
(Dry Mouth Care)**

All of pathway A *plus*:

Use suction equipment as required.

If patient is safely able to drink, encourage regular sips of water to keep mouth moist.

Any patient who is NBM / low GCS / risk of dry mouth should use non-foaming toothpaste and have their mouth moistened regularly with 'dry mouth gel'. Ensure patient is in upright position.

Apply lip care regularly

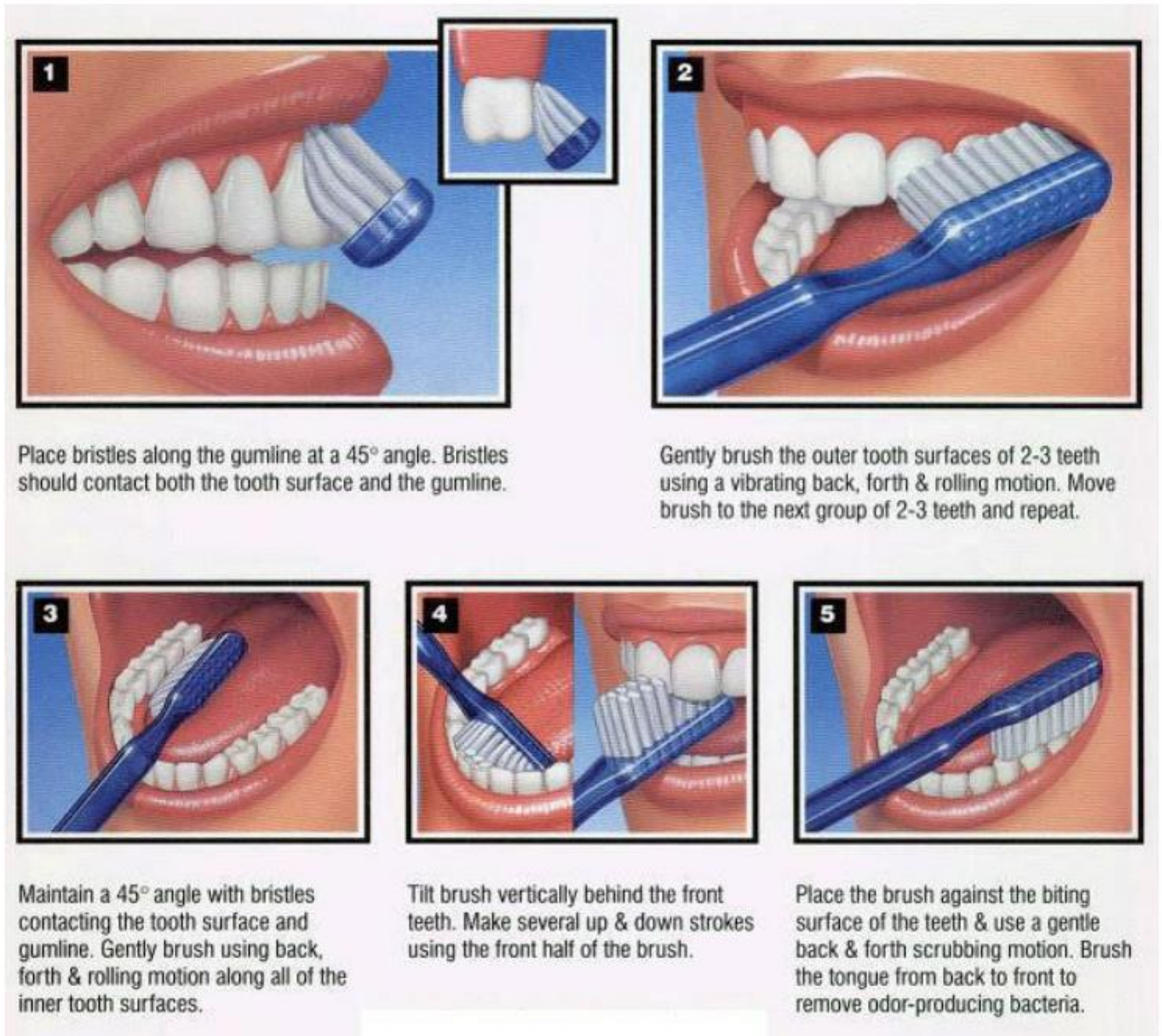
**Pathway C
(High Risk Mouth Care)**

All of pathway A & B *plus*:

Provide oral hygiene every 2-4 hours, as indicated on care rounds.

If the oral cavity is particularly coated, provide mouth care in between 4 hourly rounds using a paediatric toothbrush and dry mouth gel as appropriate. Ensure patient is in upright position.

Appendix 9. The Modified Bass Toothbrushing Technique



Dr Sujit, Brushing technique: Bass and modified bass method. Medchrome tube best medical videos <https://tube.medchrome.com> [online].