Improving Mouth Care for Adult Patients in Hospital

It is the responsibility of a registered nurse to complete the Mouth Care Assessment - or student nurse supervised and countersigned by a RN
Daily mouth care can be a delegated task for health care support workers

Information for nurses and health care support workers
The tools consist of:
- Mouth Care Practice and Resource Guide (MCR)
- Mouth Care Risk Assessment Form (MAF)
- Care Plans A, B, C (MCP)
- Mouth Care Monitoring Form (MCM) This is an example. The format is optional and other monitoring systems can be used.

**Mouth Care Practice and Resource Guide** (provides information on resources required to support practice)
- Ensure all staff have access to a copy. Can be laminated.
- Depending on area of nursing this may be placed at the foot of the bed, in the patient nursing notes or in a visible place near the Patient Status At A Glance Board - PSAAG

**Mouth Care Risk Assessment**
- A registered nurse or student nurse (supervised and countersigned by a RN) is responsible for completing the risk assessment form.
- All patients admitted to hospital for longer than 24 hours will have a mouth care assessment
- Patients who are critically ill/complex needs/Integrated Care Priorities Last Days of Life must have a mouth care assessment within 4 - 6 hours of admission, or in line with local policy
- Patients oral status is highlighted into 3 areas of need

<table>
<thead>
<tr>
<th>Healthy = Score 0</th>
<th>Plan A = mouth care 2 x day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient scored 0 for each category</td>
<td>As a minimum health care standard all patients will require Care Plan A</td>
</tr>
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<table>
<thead>
<tr>
<th>Changes = Score 1</th>
<th>Plan A and</th>
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<tbody>
<tr>
<td>Patient scored 1 for any category</td>
<td>Elements from plan B - additional resources maybe required and or nurse intervention, support or advice</td>
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<table>
<thead>
<tr>
<th>Unhealthy = Score 2</th>
<th>Plan A and</th>
</tr>
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<tbody>
<tr>
<td>Patient scored 2 for any category</td>
<td>Elements from Plan C - more intense nursing intervention and or referral to the medical / dental team</td>
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</table>

The aim of effective mouth care is to ensure the delivery of relevant evidence based mouth care.
Scores
The total score at the bottom of the table demonstrates oral health needs. For example a score of 10 on admission and 2 on discharge indicates mouth care needs are largely being met. There may well in some specialist areas of nursing care be an increase to the total score due to medical treatment/therapy. What you would expect to see in these circumstances is an increase in mouth care delivery, for example patients moving from care plan A to care plan B or even to care plan C.

Each category indicates if the nursing intervention is or is not meeting the desired outcome.

**The total score at the bottom of the table does not indicate which care plan to follow**

- **Resources:** Record if the patient has their own toothbrush/toothpaste/denture care items etc. Where appropriate relatives/carers are responsible for ensuring the patient has these items with them. Patients without a toothbrush after 24 hours will be provided with a toothbrush.

- **Risk:** Record if patient refuses an oral assessment or poses a risk because of tendency to bite staff when performing mouth care. Patients who refuse or pose a risk should be reassessed daily or weekly in line with general health status = R or RS

- **Re-assessment:** Record the re-assessment date

- **SIGN:** Sign the Mouth Care Risk Assessment (black pen)

- **Care Plan:** State which care plan to follow

  - **Score 0** for all categories = Care Plan A and re-assess weekly unless patient condition changes (monthly for long stay patients)
  - **Score 1** for any category = Care Plan B and re-assess weekly unless patient condition changes (monthly for long stay patients)
  - **Score 2** for any category = Care Plan C and re-assess daily (weekly for long stay patients)

- **Mouth Care:** Record who will carry out mouth care i.e. patient carer/relative/staff

### Care Plans

1. The registered nurse or student nurse (under supervision from a registered nurse) will complete the care plan. This reflects the level of care to be delivered and ensures Health Care Support Workers have clear guidance

2. It may be helpful to document the findings from the initial Mouth Care Risk Assessment in the column “patient response to care” to further inform the plan of care. Document significant changes that require additional or less intervention

3. The registered/student nurse will document the mouth care status and highlight any changes

4. All patients will have the minimum of Care Plan A

### Monitoring Mouth Care

It is important to document the delivery of mouth care for all patients. This may be recorded on existing forms, for example, an intentional rounding form. This form is an example and can be used if other monitoring systems are not in place.

- **Action –** MC = Mouth Care  
  OM = Oral Mucosa hourly lubrication  
  - Record if the patient refuses or if mouth care is not performed

- **Sign/Date** - Black pen

Frequency of mouth care may change depending on health status. For example a patient on the Integrated Care Priorities Last Days of Life requires hourly oral lubrication.