CLINICAL POLICY
Mouth Care for Adult Inpatients

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Purpose:	To provide guidance and standards for all staff whose role can positively impact oral health
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Audience:	Nursing (Adult, Mental Health and Learning Disability) and Student Nursing Associates are included within this policy. Dietetic students are not included within this policy
Dissemination:	This policy will be made available via the Trust intranet
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V1	10/05/2022	New Policy – [redacted]
V2	21/07/2025	Minor amendments to Process for monitoring compliance and training as mouthcare matters is no longer a QI project and IP&C have taken over policy/training. Added Appendix 3 - mouthcare audit

SUMMARY
This Clinical policy provides guidance for staff to ensure that all inpatient environments receive appropriate training in oral mouth care, assessing the persons mouth, how to escalate any issues, have access to identified mouth care equipment, be competent within the Trusts documentation and systems to improve the overall quality of oral mouth care for inpatients.

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ABBREVIATIONS

Abbreviation	*Full Description*
AHP	Allied Health Professionals
GHC	Gloucestershire Health and Care NHS Foundation Trust
MUST	Malnutrition Universal Screening Tool
PPE	Personal Protective Equipment
SALT	Speech and Language Therapy

MOUTH CARE ASSESSMENT
ACTION CARD - MC1

Title: Mouth Care Assessment

FOR USE BY: Clinicians, Nursing and AHP staff.	**LIAISES WITH:** The patient, their family/carers and wider multidisciplinary team as appropriate.

EQUIPMENT:

- Access to the electronic healthcare records
- Admission Screening tool
- Weekly assessment tool
- Daily record
- Knowledge and understanding of the adapted Halstead Oral Assessment Tool

Introduction

All patients admitted to Gloucestershire Health and Care NHS Foundation Trust will have an assessment of their oral hygiene using the adapted Halstead Oral Assessment Tool. This guidance applies to all healthcare professionals and healthcare assistants involved in patients care where mouth care is an important factor.

Word/Term	Descriptor
Trismus	Jaw Stiffness/difficulty opening jaw
Xerostomia	Dry mouth due to lack of saliva
Mucositis	Soreness, reddening and ulceration of the oral cavity
Stomatitis	Inflamed sore mouth can be anywhere in the mouth that disrupts a person's ability to eat, talk and sleep
Periodontitis	Inflammation of tissue around the skin causing shrinkage of gums
Dentate	Has teeth
Edentulous	Without teeth

Clinical Importance of Mouth Care

Oral hygiene should be part of an assessment of the mouth. It is suggested by (NHS Health Education Mouth Care Matters 2019) a mouth care assessment should be undertaken on admission or within 24 hours of admission and should be reviewed weekly. Assessing a patient mouth and delivering appropriate oral care can prevent potential infections, distress and discomfort to the patient as well as reducing the risk of both dental and systemic disease.

Poor oral hygiene can:

- Reduce patient's ability to eat and drink, resulting in compromised nutritional status and varying levels of dehydration
- Reduce the patient's ability to speak due to a dry, painful, mouth
- Reduce the patient's self-esteem due to poor body image.

Patient Assessment

Hospitalised patients may not be able to care for their own oral hygiene. Effective assessment, planning and implementation of mouth care is essential for every patient admitted to the Trust. Patient assessment must conform to the following framework:

Continued.

- Complete the Mouth Care Assessment Screening Tool within 24 hours of admission on all patients
- For independent patients encourage good mouth care and review weekly or more frequently if a patient's health deteriorates
- Patients who require assistance or those who are fully dependent for mouth care are reviewed weekly. Support and assistance given will be documented on the daily mouth care recording sheet within the patient's electronic healthcare records.

Treatment / Management

Treatment should be instigated according to the assessment score, using the following parameters:

- Independent (Green), promote good oral mouth health care as a minimum of twice daily
- Needs supervision/help to clean teeth (Amber), basic mouth care according to action card MC2 and complete daily recording within the patient's electronic healthcare records
- Needs mouth care (Red), assist with mouth care according to action card MC2 or MC3 depending if basic mouth care or advanced mouth care is required. Complete daily recording found within the patient's electronic healthcare records
- Acutely unwell or patients in last days of life mouth care according to action card MC3 and complete daily recording found within the patient's electronic healthcare records.

Physical weakness, lack of coordination and cognitive problems may make performing mouth care challenging. As the normal mouth flora changes it is essential to offer good mouth care according to action card MC2 or MC3 depending if basic mouth care or advanced mouth care is required. The following problems may occur dry mouth, mouth ulcers, periodontitis and stomatitis which may lead to aspirated pneumonia and/or cardiovascular disease.

Chemotherapy and Mouth Care

Oral side effects of chemotherapy are common and generally present as pain or stomatitis from damage to mucous membranes of the mouth, which is largely unpreventable. These problems occur either due to direct effect of chemotherapy or indirect effects of myelosuppression or immunosuppression. In these cases, it is essential to promote/offer good mouth care according to action card MC2 or MC3 depending if basic mouth care or advanced mouth care is required.

Generalised effects: • Xerostomia (dry mouth) • Altered taste perception	Inflammatory changes • Mucositis (sore mouth) • Ulceration
Infectious complications • Periodontal infection/disease • Dental caries • Gingivitis (sore/infected gums) • Viral infections (e.g. herpes simplex)	Indirect effect of secondary to myelosuppression • Gingival bleeding • Atrophy of tongue and buccal mucosa

Check that patients receiving chemotherapy and/or radiotherapy receive the patient leaflet Oral Hygiene and Mouth Care Information and advice for Patients Undergoing Radiotherapy or chemotherapy.

MOUTH CARE ASSESSMENT
ACTION CARD – MC2

Title: Basic Mouth Care

FOR USE BY: Clinicians, Nursing and AHP staff.	**LIAISES WITH:** The patient, their family/carers and wider multidisciplinary team as appropriate.

EQUIPMENT:

- Torch or light source
- Toothpaste
- Soft Small Headed Toothbrush / patients own toothbrush
- MouthEze Oral Cleanser
- 360 Toothbrush
- Biotene
- Bite control block if required
- Moisturiser for lips – if required
- Bowl if required for spitting
- Denture pot and lid
- PPE aprons and gloves
- Tissues/wipes
- Mouthwash/oral mucosa medication
- It is recommended that a toothbrush is air dried but in hospital it is recommended that a toothbrush is stored in a covered container that allows for air to circulate.

Rationale:

Basic mouth care must be encouraged and provided where possible for all patients who have a low risk assessment score on the adaptive Halstead Assessment.

All Patients:

- A mouth care assessment should be undertaken on admission or within 24 hours of admission and should be reviewed weekly using Adapted Halstead Assessment Tool found within the patient's electronic healthcare records.
- Record daily mouth care given on the daily recording chart.
- Check pain score and act accordingly.
- Check MUST score as indicated in clinical area.
- Does the patient drink alcohol above the government recommended limits? Does the patient smoke? – Advise and if patient in agreement refer to appropriate services.
- Assess patient to determine level of support they will require to ensure oral hygiene is met. Some individuals may require advice / prompting only, some individuals will require full assistance.
- If an individual requires any assistance to ensure their oral hygiene needs are met, the member of staff must ensure they gain informed consent to assist the patient prior to commencing any oral care. If an individual is unable to consent, a staff member can complete the task in the individual's best interests under the Mental Capacity Act 2005. Please ensure a formal mental capacity assessment is completed and where they lack capacity to give consent a formal best interest process is completed this must be recorded on the Trust MCA forms and recorded in the individual's healthcare records.
- Patient choice should always be offered and where reasonable patient's wishes should be respected.

Continued.

Standard Mouth Care:

- **Dentate Person (with teeth)** - clean teeth with a toothbrush and not more than a pea sized amount of toothpaste at least twice a day (leave 20 minutes after a meal to allow saliva to buffer back down to neutral PH). Use mouth wash, especially after meals or vomiting to remove debris.
- **Edentate Person (no teeth)** – rinse mouth at least twice a day with water or mouth wash for 1 minute. Use MouthEze Oral Cleanser to clean cheeks, mouth, tongue and gums, but be aware of patient's comfort (e.g. patients with mucositis).
- **Denture or oral appliance** – clean with a moderately firm toothbrush to remove debris. Encourage to remove dentures at night and soak in water or a commercially available denture cleaning agent.
- **Lip moisturiser** – offer to all patients to keep lips moist and so avoid drying and cracking.

Tooth Brushing:

- **Method**: with a toothbrush and not more than a pea sized amount of toothpaste a slow, short horizontal motion on the front, crown and rear of the tooth holding brush at 45-degree angle to the tooth and the gingiva (gum). Brushing should take between 2-3 minutes. A circular motion for brushing teeth is recommended. Gentle brushing of the tongue is also recommended, in a forward motion see: MCM-GUIDE-2019-Final.pdf (hee.nhs.uk), page 88 for Cleaning, Techniques and Routine.
- **Tooth Brushes**: It is recommended that adults use an electronic or similar toothbrush used at home. If the mouth is sore or painful the recommendation is to use a soft small headed toothbrush. The use of these toothbrushes is recommended when patients are dependent on health care professional to provide mouth care. Replace tooth brushes every 3 months or sooner if required.
- **Toothpaste**: Fluoride toothpaste is recommended to prevent dental decay and for patients to bring in their own from home where possible. Where this is not possible a fluoride toothpaste will be supplied by the inpatient wards. It is important to "spit not rinse" to ensure that a film of fluoride toothpaste is left in contact with the teeth, allowing it to be absorbed. For patients with Dysphagia, it is advised the toothpaste to be pressed into the bristles, so it is less likely to fall off the toothbrush. (MCM 2019).

Mouth Wash

- Should be rinsed around the mouth for 1 minute.
- Helps to freshen breath and dislodge debris.
- Antibacterial mouthwash can help to reduce gum disease and control plaque: leave for an interval of 30 minutes after brushing before using mouthwash.

Types of Mouthwash:

- Commercially available mouthwashes, saltwater solution (1 teaspoon salt to 200mLs water) or plain water may be used.
- Ensure mouthwashes are alcohol free. Alcohol in mouthwashes can be painful if the mouth is sore and may not be suitable for patients of certain faiths.
- If using Corsodyl or chlorhexidine mouth wash, leave an interval of 30 minutes after brushing before using: MINI-MCM-GUIDE-2019-final.pdf (hee.nhs.uk), page 73 for more details.
- Corsodyl is a chemical plaque remover and therefore not indicated in people without teeth (excluding radiotherapy).

Dental Check-Ups:

Individuals should be advised to visit their dentist regularly.

MOUTH CARE ASSESSMENT
ACTION CARD – MC3

Title: Advanced Mouth Care

FOR USE BY: Clinicians, Nursing and AHP staff.	**LIAISES WITH:** The patient, their family/carers and wider multidisciplinary team as appropriate.

EQUIPMENT:

- Torch or light or light source
- Toothpaste
- Soft Small Headed Toothbrush
- MouthEze Oral Cleanser – do not use in place of a toothbrush
- 360 Toothbrush
- Biotene
- Bite control block – if required
- Moisturiser for lips – if required
- Bowl if required for spitting
- Suction – if required
- Denture pot and lid
- PPE apron and gloves
- Tissues/wipes
- Mouthwash/oral mucosa medication.

It is recommended that a toothbrush is air dried but in hospital it is recommended that a toothbrush is stored in a covered container that allows for air to circulate.

Rationale:

Advanced mouth care must be encouraged and provided where possible for all patients who have an adaptive Halstead Assessment risk score of medium or more or are in their last days of life.

All Patients:

- A mouth care assessment mouth care assessment should be undertaken on admission or within 24 hours of admission and should be reviewed weekly using Adapted Halstead Assessment Tool found in the electronic patient record.
- Record daily mouth care given on the daily recording chart.
- Reassess patient weekly as a minimum using Adapted Halstead Assessment Tool.
- Check pain score and act accordingly.
- Check MUST score as indicated in clinical area.
- Does the patient drink alcohol above the government recommended limits? Does the patient smoke? Advise and if patient in agreement refer to appropriate services.
- Assess patient to determine level of support they will require to ensure oral hygiene is met. Some individuals may require advice / prompting only, some individuals will require full assistance.
- If an individual requires any assistance to ensure their oral hygiene needs are met, the member of staff must ensure they gain informed consent to assist the patient prior to commencing any oral care. If an individual is unable to consent, a staff member can complete the task in the individual's best interests under the Mental Capacity Act 2005. Please ensure this is recorded in the individuals notes.
- Patient choice should always be offered and where reasonable patient's wishes should be respected.

Continued.

Dentate Patients (those with their own teeth):

- Using a soft toothbrush and no more than a pea sized amount of toothpaste, brush teeth and tongue after meals or after vomiting. Ideally allow 20minutes after either event, otherwise vulnerable teeth will have acidic saliva brushed into them when the enamel is already softened.

Edentulous Patients (those with no teeth):

- Using a soft toothbrush and no more than a pea sized amount of toothpaste, clean tongue after meals or after vomiting.
- Use 360 toothbrush to clean gums and tongue.
- Ensure patient rinses well with water to ensure all toothpaste is removed as it dries the mouth.
- Use moisturiser or a similar product to keep lips moist and so avoid drying and cracking (see mouth care products guide in appendix).

Patients with Dentures and Removable Appliances:

- Remove dentures/appliance.
- Offer an initial mouth rinse with water to remove residual debris in mouth.
- Follow guidelines as above to clean oral cavity.
- Using a soft toothbrush, brush dentures/appliance.
- Rinse well in cold water before replacing back in mouth.
- Follow patient's usual regimen for overnight soaking of dentures/appliances using appropriate soaking solution and stored in a labelled pot.
- If dentures are ill fitting please leave out of mouth.

Patients whose Conscious Level or Health Status Precludes them from Assisting with own Mouth Care:

- Ensure patient is positioned in the recovery position to ensure all fluids can drain easily from mouth to avoid a choking hazard.
- If using suction, no more than 120mm/Hg or 20 kPa. Use a Yankeur sucker.
- Follow mouth care guidelines as above.
- If mouth is dry, use an artificial saliva to moisture and hydrate the mouth.
- Moisturiser or a similar product to keep lips moist and so avoid drying and cracking.
- Offer Taste for Pleasure to patients who are unable to swallow safely. Please see the 'Taste for Pleasure' section of the Eating and drinking at the end of life patient and carer information.

1. INTRODUCTION

1.1 Oral health is an integral part of a person's physical health (Tredget et al 2019). Poor oral hygiene, leading to periodontal disease can increase risks to pulmonary disease, diabetes, atherosclerotic vascular disease and kidney disease (Kane 2017). Poor oral hygiene can increase the risks of infections including hospital-acquired Pneumonia, impede communication (Pace and McCullough 2010) whilst reducing the patient's ability to eat and drink, resulting in compromised nutritional status and varying levels of dehydration. People with severe mental illness have poorer oral health and physical health than the general population (Tredget et al 2019). The aim of this policy is to provide guidance and standards for all of the Trust inpatient staff whose roles can positively impact upon their oral health and mouth care.

2. PURPOSE

2.1 The purpose of this clinical policy is to detail the process, provide guidance and standards, for all Trust inpatient staff who are responsible for providing and/or assisting patients with their mouth care needs with the aim to maintain (or improve) their oral health. Supporting and providing good, regular mouth care for inpatients is an essential aspect of care (Department of Health 2010) and contributes to good oral health and, in turn, improves general health, dignity and wellbeing (Locker et al 2002). Mouth care assessments using the adapted Halstead tool (Australian Institute of Health and Welfare 2009) will be completed on admission and weekly thereafter. Daily recording of mouth care provided will be documented within the patient's health care records.

2.2 For all inpatient staff to provide good daily mouth care and good oral health, they require the following: -

- Practical and theoretical knowledge of how to perform and implement effective mouth care along with an understanding of how good oral hygiene links to a patient's general health and wellbeing.
- Appropriate training to perform mouth care assessments, to be able to recognise an unhealthy mouth and escalate appropriately.
- Upskilling to use the Trust's electronic documentation to accurately record the patient's mouth care.
- Resources/equipment needed to provide good effective mouth care.
- Support, when necessary, from doctors / dentists / mouth care champions / multidisciplinary team.

2.3 Implementation of this policy will ensure that:

- Inpatients have access to effective daily mouth care.
- Patients are supported in maintaining good oral health.
- The development of oral infections and oral pain is reduced.
- Patients' dignity, self-esteem and general well-being are maintained.
- Staff Knowledge, skills and awareness around the importance of mouth care meet the standards expected by the Trust.

3. SCOPE

3.1 This policy applies to all clinical staff both registered and non-registered working within a physical and mental health inpatient ward environment. Mouth Care policies and action

cards are posted on the Trust intranet site.

4. DUTIES

4.1 General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, the trust will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with legislation, Health and Safety are provided.
- Ensuring this policy is adhered to and for ensuring mechanisms are in place for the overall implementation, maintenance, monitoring and revision of this policy.

Managers and Heads of Service will ensure:

- All staff are aware of and have access to policy documents.
- All staff have access to training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.
- A minimum of one mouth care champion per inpatient ward area.

4.2 Role of the Mouth Care Champions:

- Act as a role model cascading and promoting best practice for mouth care to all colleagues.
- Keep all colleagues up to date with information, guidance and mouth care products.
- To ensure that colleagues are aware of the Mouth Care Policy and where to locate it.
- Promote and support colleagues in keeping accurate documentation using the Trust Electronic Patient Record (EPR) Systems.
- Support with delivery/signposting to relevant mouth care training for all colleagues and communicate any feedback to the Learning and Development Team.
- To participate in the initial launch of improving mouth care within our inpatient ward areas.
- Promote oral health within the workplace and raise awareness of the Oral Health Foundation Campaign “National Smiles month”.

4.3 Role of all Inpatient Registered and Non-registered staff (including bank, agency and locum staff)

- Read and adhere to the Trust Mouth Care policy.
- To implement this policy daily as part of normal practice.
- To support the mouth care matters initiative, partake in the education sessions and cascade best practice within their clinical working environment.
- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Participate in the appraisal process.

- Ensure that all care and consent comply with the Mental Capacity Act (2005).

4.4 Role of the Speech and Language Therapists

- Provide advice on oral health and mouth care in relation to eating and drinking problems associated with dysphagia.
- Support inpatient staff to assess the mouth and identify oral problems that may affect a patient's ability to eat, and drink associated with dysphagia.
- To cascade current best practice for mouth care.
- Provide advice on the importance of providing effective oral care to patients who are nil by mouth.

4.5 Role of the Dental Team

- To advise inpatients who have problems with their teeth, but do not require urgent treatment whilst in hospital to visit their own dentist on discharge.
- To assess inpatients who have been referred with a dental problem causing significant pain or preventing the patient from eating.

5. MENTAL CAPACITY ACT COMPLIANCE

5.1 Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. POLICY DETAIL

6.1 Procedure for Patients being Admitted:

- All patients admitted to hospital will have a mouth care assessment completed within 24 hours of admission to identify the level of support required with mouth care.
- All patients requiring a referral for dental services must meet the criteria or they will be signposted on how to find a dentist after discharge. This information will be documented on their discharge summary and advised for this to be completed at home by patient or carer.
- A low-risk patient is someone identified as being independent, or has carer/parental support, with regards to caring for their mouth and does not have any condition that would increase their chances of having problems with their mouth. Low risk patients should have their mouth care risk assessment reviewed every seven days or if their health status changes using the adaptive Halstead assessment tool. Some patients may appear as independent but may be finding it difficult to maintain good oral hygiene for example, frail older patients with reduced manual dexterity or patients with mobility problems that find it difficult to access or stand at a sink.
- High-risk patients should be referred to the Doctor in the first instance and if necessary to the Dental team for assessment and treatment.
- All patients should have their Mouth care recorded on the daily care plan within their healthcare record.

Oral health high-risk patient groups include the following: -

- Dementia
- Learning disabilities
- Autism
- Palliative/end of life care
- Chemotherapy
- Immuno-compromised
- Head and neck radiation therapy
- Stroke
- Mental health illnesses e.g. Depression, Psychosis
- Oxygen use
- Physical disability e.g. Arthritis, Parkinson’s
- Nil by mouth
- High risk dysphagia
- Frail elderly
- Uncontrolled diabetes
- Mobility problems including Neurodisability
- Delirium
- Reduced level of consciousness
- Dehydration/reduced fluid intake
- Anorexia
- Vomiting
- Mouth ulcers/candida
- Patients with poor oral hygiene and dental caries.

6.3 Learning Disabilities and Mouth Care

- The oral health of those with Learning Disabilities (LD) can often be put at risk because of poor communication and a general lack of understanding about their needs.
- People with mild LD may need reminders to brush their teeth daily. Those with moderate to severe LD may require more assistance or be fully dependent on others for mouth care. These patients/service users have poorer oral health compared to that of the general population and have higher levels of gum disease as well as Gingivitis, higher rates of toothlessness, higher plaque levels and poorer access to dental services (MCM 2019).

6.4 Mental Health and Mouth Care

- Mental illness can range from minor distress to severe disorder of mind or behaviour. Lack of oral health care can have a significant impact upon general health, self-esteem and quality of life (British Society for Disability and Oral Health 2000).
- Mental health conditions can cause patients to neglect their personal hygiene including mouth care. This can lead to a rapid development of decay and gum disease resulting in dental infection and pain (Brennan and Strauss 2014). These patients are also less likely to accept and receive treatment when they experience dental problems. Mental health patients may need daily reminders helping them by motivating and encouraging them to look after their oral hygiene. This maybe at different times of the day and when they are more receptive.

6.5 Dementia and Mouth Care

- The incidence of dementia is increasing in the older population. It is suggested as dementia progresses tooth decay and gum disease will increase as individuals find it more difficult to keep up with their oral hygiene routine (Dementia UK 2021). Encouraging good mouth care routines when a person is in the early stages of dementia can prevent pain, infection and complex treatment in later stages (Geddis-Regan et al 2021). As a person with dementia deteriorates, they are often unable to verbally express toothache or express pain, this decline in cognitive function can cause behavioural changes that directly affect oral health. The Abbey pain scale is to be used to assess the measurement of pain in people with dementia who are unable to verbalise. In many cases there is an increased risk of dry mouth due to medication and mouth breathing. In turn this may lead to decreased function, such as difficulty in eating and drinking, and increased dental pain (Brennan and Strauss, 2014).
- Patients with Dementia can experience increased confusion when admitted into hospital as their normal routine and surroundings change (Dementia UK 2021). It is important therefore that staff take the time to support patients with dementia in mouth care and this can be done in a number of ways. Some patients may simply require a reminder to brush their teeth. Others may be dependent on others for their oral care, although patients with mild to late-stage dementia may develop reflexes that make tooth brushing difficult such as closing their lips, clenching their mouth, biting and moving their head.

Tips for delivering oral care for patients with dementia or cognitive issues include:

- Develop a routine, providing mouth care at the same time each day.
- Encourage the patient to participate in mouth care and where required use the hand-over-hand technique.
- Take time be kind, calm and explain what you are doing.

- Asking a carer/family member who is more familiar to the patient to help with providing mouth care (Johns Campaign 2014). Use short sentences and simple instructions and use reminders and prompts.
- Use the handle of a toothbrush to improve access to the whole mouth.
- Distraction with singing or by giving the patient something to hold in their hands.
- Use toothbrushes and toothpaste that the patient is familiar with. Although a non-foaming toothpaste (currently being trialled) may be useful as it may be more tolerable.
- Some patients with Dementia, cognitive issues or mental health conditions may be very resistant to mouth care. It is important to respect this and stop. Staff must document that the patient is unable to tolerate and to try again at a different time or day.
- **Where a person with Dementia or cognitive issues is unable to give consent to mouth care, due to lacking the mental capacity, a formal mental capacity assessment should be completed. A formal best interest process should be followed, to establish if it is in the person's best interest to proceed with mouth care without their consent.**

6.6 Palliative Care: Mouth Care at the End of Life

- Oral 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).
- In palliative care, the emphasis is on quality of life, and it helps to think holistically about our patients and their families' needs (Becker 2009).
- An assessment of the mouth will help to identify any changes to the teeth, tongue, soft tissues and lips. If a person is no longer able to eat and drink the frequency for mouth care should increase to hourly but will be led by the person on how this may be tolerated.
- Providing regular mouth care to patients who are dying is to clean and hydrate the mouth prompting comfort and dignity. It is recognised that a pain free mouth impacts positively upon a patient's physical, sociological and psychological being (Costellos and Coyne 2008). Maintaining a comfortable mouth is not only reassuring for the patient but also their family. For more information and how to deliver this mouth care please follow action card MC3 attached to this policy.
- Taste for Pleasure can be incorporated into a patients care plan after their usual mouth care.
- Further information can be found in Mouth Care Matters in End-of-Life Care published by the RCN (2021).

6.7 Stroke and Mouth Care

- A stroke can have a profound effect on the oral and facial tissues resulting in difficulties in basic tasks such as eating, drinking swallowing and communication. This in turn affects basic oral functions contributing to oral infection and decay (British Society of Gerodontology 2010).
- Facial paralysis and loss of sensation can cause food debris to accumulate and pool on the affected side. Dry mouth is the most common oral side effect of medication increasing the risk of oral infection and diseases.
- Oral health can be challenging for patients who have physical impairments as a result of a stroke. Challenges such as physical weakness, lack of coordination and cognitive problems can make oral hygiene impossible for some patients. Therefore, as with all other aspect of care following a stroke, to maintain and promote independence in oral

care skills goals should be set (Raghunatha et al 2019).

- It is recommended all oral health as part of personal care should be included within initial assessment for stroke. Talbot et al (2005) suggest there is much evidence to demonstrate that nursing professionals lack basic training in oral assessments, protocol and oral hygiene within stroke units across the UK.

6.8 Dysphagia

- Dysphagia has numerous causes, including stroke, and is most frequently seen in older aged patients. Dysphagia has been linked to oral candidiasis, oral self-care dependency and salivary hypofunction (Poisson et al 2014).
- It is important that hospitalised patients with dysphagia maintain good oral hygiene as this can improve swallow function and prevent aspiration pneumonia, dehydration and malnutrition. When cleaning the mouth of a patient with dysphagia, extra care should be taken to reduce the risk of the patient aspirating toothpaste or any debris that may be present in the oral cavity.
- Nursing staff should be aware and follow any special guidance from the SALT team relating to oral care for very high-risk patients.

6.9 Suctioning in Mouth Care

- Some patients may require oral suctioning during mouth care to reduce the risk of saliva or residue from mouth care products such as toothpaste being aspirated (content entering the lungs).
- This can be due to multiple reasons, e.g. the patient is too drowsy, the patient cannot follow instructions due to confusion, and/or the patient has severe dysphagia which puts them at high risk of aspiration.
- Staff who have received training on delivering suctioning can make use of 'Yankeur' Suction.

6.10 Equipment and Tool Kit

- In order to carry out mouth care assessments and provide effective mouth care, staff must have access to and have knowledge of how to use the equipment. (See Mouth Care Product Guide for further information within appendices).

6.11 Dentures

- Good denture hygiene is essential to prevent the risk of developing problems such as oral thrush that may be as a result of food and debris collected under the denture (Otukoya R, Shepherd E 2018). It is important to know if patients have dentures on admission. Dentures often go missing in hospital and can affect patient's ability to eat and communicate. Loss of dentures could also result in the psychological wellbeing as well as the cost to patients (Blinks et al, 2017). If dentures have been lost during the patient's admission to hospital refer to the managing personal property policy CLP112. Dentures should be cleaned as a minimum once a day and ideally after meals. They should be removed overnight and stored in water in a labelled denture pot. Ill-fitting dentures should be removed and a dental referral made if appropriate as they not only cause pain but problems with eating and speech.

7. DEFINITIONS

- **Aspiration -** breathing of debris (food/fluid) into your airways (can also happen when food from your stomach comes back up into your throat) which can lead to chest infections and aspiration pneumonia.
- **Caries** – Plaque bacteria that weakens and destroys tooth enamel.
- **Angular cheilitis** – Swollen red area to the corner or both corners of the mouth.
- **Dental Plaque** – a biofilm composed of microorganisms that attach to the teeth and causes caries and infections of gingival tissue.
- **Dysphagia** – difficulties with eating, drinking and swallowing.
- **Gingivitis** – Bacterial infection causing inflammation of the gums at the base of the teeth.
- **Halitosis** – offensive breath commonly caused by poor oral hygiene, dental or oral infections.
- **Mouth Care (Oral Hygiene)** – to maintain, cleanliness and hygiene of the teeth and oral structures of the mouth in a health state.
- **Mucositis** – Pain and inflammation of the lining of the mouth.
- **Oral Candidiasis** – Overgrowth of yeast like fungus in the mouth.
- **Periodontal Disease** – Gum infections that damage soft tissue and bone that supports the teeth.
- **Stomatitis** – inflammation of the lining of soft tissue structure in the mouth.
- **Tartar** – hardened plaque adhered to teeth.
- **Ulceration -** ulcers which are white, small punched out lesions of epithelial surface of the mouth, probably or viral origin.

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Key Performance Indicators Comprise: • Every patient has a mouth care assessment tool that has been completed within 24 hours of admission • Every patient has a mouth care assessment weekly using the adaptive Halstead assessment tool • Every medium to high-risk patient assessed has been escalated to a doctor • There has been a referral to the relevant dental services following escalation.		
Regular audits will be undertaken on the following to look at compliance with this policy including: • IPC and Mouth Care Champions will complete the same audit yearly approximately 6 months apart. If any issues are identified issues to be addresses and repeat audit to be completed	Bi-annually	Report findings to be presented at QAG and IPC committee meeting

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

9.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident

Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

10.1 There lacks formal training in oral health for care staff both registered and non-registered. This has resulted in staff not having the correct knowledge of oral and dental disease to assess and refer individuals appropriately, something that needs to be addressed urgently (British Society for Disability and Oral Health 2000). Lack of training, lack of mouth care assessments, tools, policies and equipment has been cited as barriers to providing good mouth care in hospitals (Binks et al, 2017). To address gaps in training, knowledge and skills the Trust recommends all inpatient staff including student nurses comply with the following (Dietetic students are not included in this policy).

- Mouth Care Champions to provide support on the use and completion of the Mouth Care Assessment tool and Daily care plan documentation.
- An eLearning package is available on the Trust learning system Care to Learn.
- All inpatient staff to complete eLearning every 3 years.
- All staff to have clear understanding and knowledge of the correct PPE when carrying out mouth care to prevent cross infection and contamination.
- Mouth Care Champions will be available within clinical environment to support inpatient staff with this skill.

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12. ASSOCIATED DOCUMENTS

GHC Eating and drinking at the End of Life Patient and Carer information leaflet

Appendix 1 Mouth Care Product Guide:

Mouth Care Product Guide

Appendix 2 Competency – click here to download an editable version

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Assessment of Competence for Non-Registered Practitioners working within the Mental Health and Physical Health inpatient setting.
Clinical Skill: Performing Mouth Care (Oral Hygiene)

Name:	**Ward/Hospital:**

AIM:	To be competent and confident when assessing and assisting/performing mouth care on our inpatients.
OBJECTIVES:	The Non-Registered healthcare practitioner will be able to: • Demonstrate an understanding of the knowledge required to perform mouth care assessments • Select the mouth care product that meets the patients needs • Perform mouth care on a Simulation Manikin using a variety of mouth care products • Be assessed as competent to carry out mouth care on individuals in our care
TRAINING:	~~Attendance at a centrally held training session or~~ completion of the Mouth Care E Learning package
ASSESSMENT:	Completion of the Mouth Care assessment via E Learning Practical assessment using performance criteria below on Simulation Manikin Assessors in clinical practice must be a Registered Practitioner or a Mouth care champion who has undertaken Mouth care training and is competent in the procedure themselves and be undertaking the procedure regularly.
RISK ASSESSMENT:	MEDIUM (level of risk of harm due to user error)
UPDATE:	Competence to be reviewed annually at appraisal. Record of competency to be kept by staff member, copy retained locally within individuals personal file and copy emailed to Learning Team

UNDERPINNING KNOWLEDGE
It is expected that the Non-Registered Healthcare Practitioner will be able to: ▪ Define the national drivers striving to improve mouth care ▪ State what is mouth care, why it matters and the impact on patient's recovery/healing/return to health ▪ Discuss the importance of gaining individual patient consent ▪ Explain the difference in care for patient's own teeth, dentures, dental plates, bridges etc. ▪ List the PPE required to perform this task safely adhering to Infection Prevention Control policies ▪ Recognise an unhealthy mouth that may indicate cause for concern (infection, pain and dryness) and be confident to escalate information/gain immediate assistance in accordance with locality / organisational policy ▪ Select the appropriate mouth care product to meet the patient's needs ▪ Accurately complete all mouth care documentation within the electronic patient record system in accordance with professional codes of practice and trust policy with appropriate onward referral I certify that the above named healthcare practitioner has successfully completed the theoretical assessment which covers the above.

Signed:		Date:	

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Print Name:		Position:	

CLINICAL SKILL		
PERFORMANCE CRITERIA - The Non-Registered Healthcare practitioner will:		**Performed Safely (✓)**
1.	Describe the equipment required to undertake mouth care and inform the assessor - how evidence-based practice maintains quality control - What safety checks need to be carried out on the equipment/products	
2.	Demonstrate the appropriate hand hygiene and use of PPE prior to, during and after the procedure	
3.	Explain the procedure to the patient and where possible gain informed consent or if unable to give consent, complete the task in the individuals best interest under the Mental Capacity Act (2005)	
4.	Prepare and position the individual (patient) adequately giving appropriate reassurance, ensuring privacy and dignity are maintained	
5.	Assessment and visual examination of the individual's mouth to establish mouth care required	
6.	Select appropriate equipment and mouth care products required (Refer to Mouth care product guide within Mouth care policy)	
7.	Ensure correct removal and cleansing of dentures or dental plate if applicable	
8.	Correct brushing of patient's teeth and gums using a manual or battery-operated toothbrush. Staff must not assist patient to floss	
9.	Dispose of clinical waste and equipment in accordance with infection prevention / control measures	
10.	Ensure the patient is comfortable before leaving	
11.	Accurately record procedure within the electronic patient record system	
12.	Report any changes or concerns to nurse in charge of ward in accordance with care plan	
I confirm that the above-named healthcare practitioner has completed the assessment competently on the Simulation manikin.		
Signed:		Date:
Print Name:		Position:

ASSESSOR COMMENTS

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CANDIDATE COMMENTS

DECLARATION			
I confirm that I have had theoretical and practical instruction on how to safely and competently perform Mouth care, and agree to comply with the policy and procedures of the Trust. I acknowledge that it is my responsibility to maintain and update my knowledge and skills relating to this competency.			
Signed:		Date:	

SPONSOR/PEER REVIEW			
To ensure the content is accurate, current and evidenced based, competencies are required to be peer reviewed by subject matter experts within the specialty. It is your responsibility, as the author, to ensure this is undertaken and the peer review section is signed by the appropriate person.			
Author's Name:	[redacted]	Position:	Professional Development & Clinical Skills Lead
Peer Review Name:	Hannah Williams	Position:	Deputy Director of Nursing and Quality
Signed:	Hannah Williams	Date:	17/05/2022

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1 copy in portfolio, 1 copy retained locally in personal file

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Appendix 3 - Mouthcare Audit

Ward Date	
No of patients admitted during the last 7 days	
How many of those new patients have had mouthcare admission assessment completed within 24 hours of admission	
Total number of patients on the ward on the day of the audit	
How many patients at the time of the audit have had a weekly mouthcare Assessment completed using the adapted Halstead Assessment tool?	
How many patients refused a weekly mouthcare assessment	
How many dental referrals were required	