Mouth Care Matters

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Mouth Care Matters

A guide for hospital healthcare professionals

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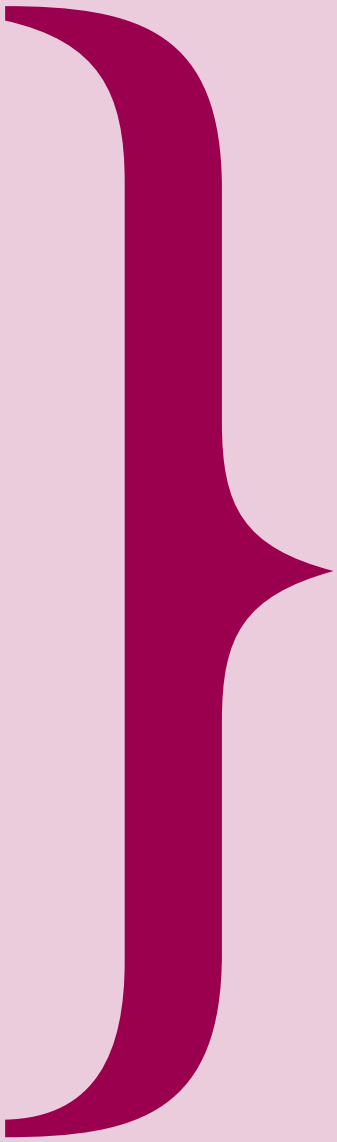
Contents



1 Introduction

Key messages

- MCM is a training initiative to improve the oral health of hospitalised patients
- MCM training comes in various formats
- MCM training is not just for nurses but a range of health care professionals

1.1 What is Mouth Care Matters in hospitals?

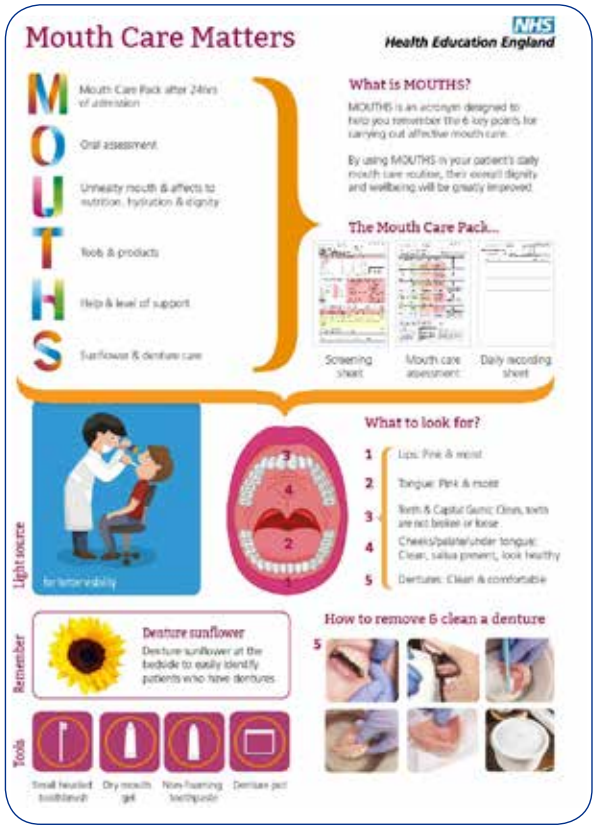
Mouth Care Matters (MCM) is a training initiative aimed at improving the oral health (health of the mouth) of hospitalised adult patients in Kent, Surrey and Sussex.

This guide complements the Mouth Care Matters training that is currently being delivered in hospitals. The information to the best of our knowledge, is up-to-date and evidence-based.

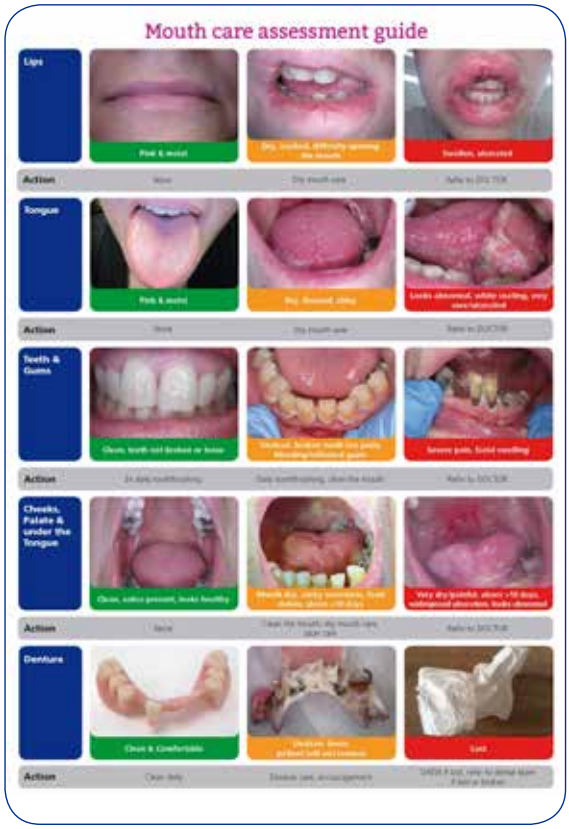
The programme was developed and piloted at East Surrey Hospital, an acute hospital with approximately 650 beds. From a comprehensive review of the current literature, we believe the findings at East Surrey Hospital, with regards to mouth care, are representative of hospitals up and down the country. For this reason this guide includes findings from focus groups, clinical audits, patient cases and direct observations of mouth care being carried out on patients on the wards.

Mouth Care Matters is based on four key themes, hospital staff require the:

- **Knowledge** of the importance of mouth care and 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
- **'Tools'** needed to provide good mouth care
- **Support** when necessary from doctors/dentists/ mouth care team



About 'Mouth Care Matters' posters



Poster to help identify a healthy & unhealthy mouth

1.2 The Mouth Care Matters training programme

Factoring in time for additional training for busy health care professionals can be difficult, therefore MCM training comes in various formats and includes:

- Small group classroom teaching sessions
- Ward-based, hands-on training
- Sessions tailored to specific groups, for example the speech and language team, palliative care, chemotherapy, oncology, doctors, dieticians and pharmaceutical team
- E-Learning
- MCM guide
- MCM resources (posters, newsletters etc.)
- MCM website

1.3 Who is Mouth Care Matters training for?

MCM is not only about training the nursing staff in a hospital; oral health promotion is also important for other health care professionals involved in the care of hospitalised patients including doctors, speech and language therapists, dieticians, occupational therapists and pharmacists. Working together we can form a more holistic approach to patient care, including mouth care.

1.4 Mouth Care Matters team

As part of the Mouth Care Matters training programme, Surrey and Sussex Health Care Trust recruited a mouth care team. This team is responsible for:

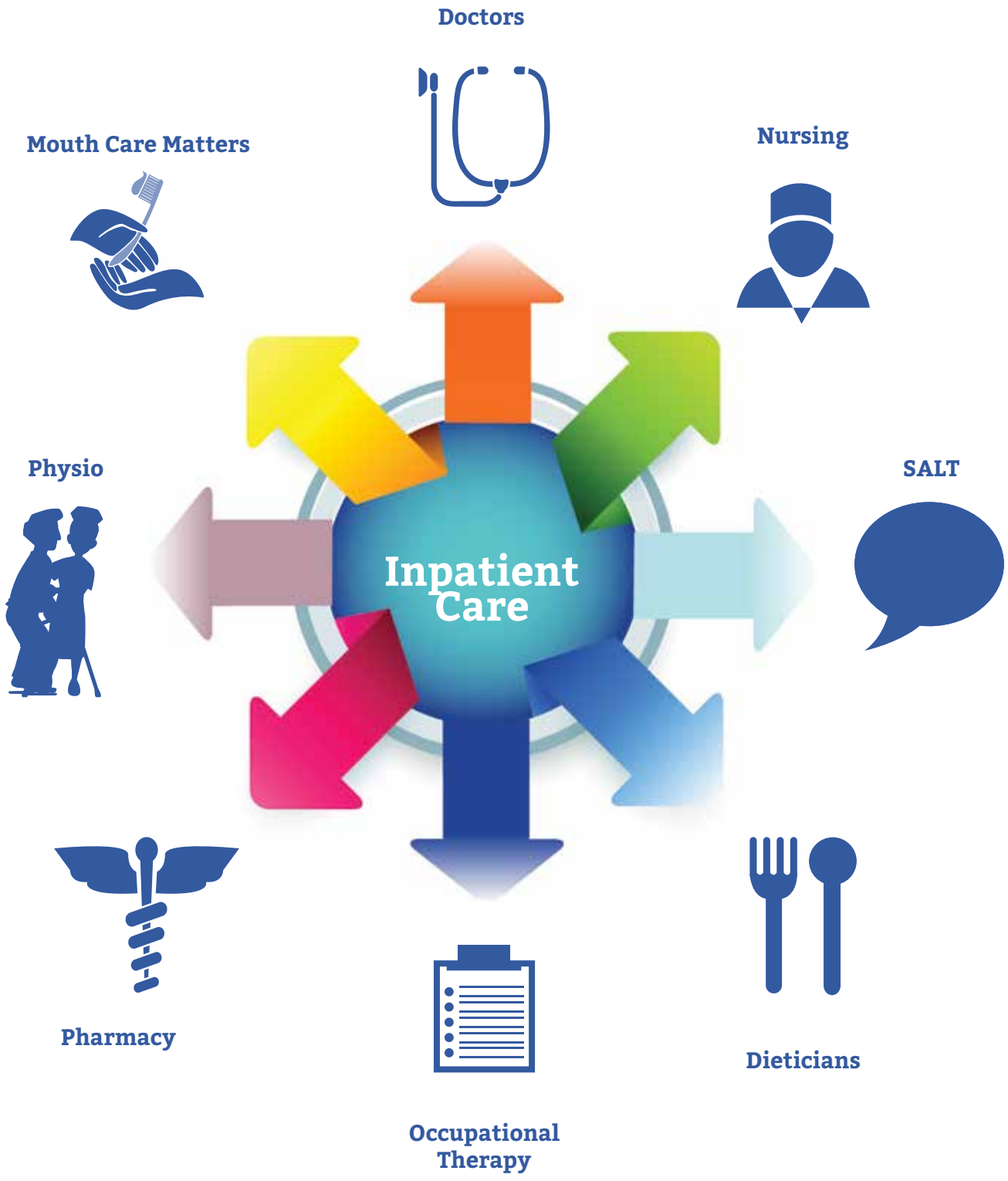
- Ward-based training
- Classroom training
- Supporting staff and carers with mouth care in challenging situations
- Liaising when urgent dental referrals are needed during an inpatient stay
- Signposting patients to appropriate dental services on discharge
- Supporting the hospital with mouth care policies and audit
- Mouth Care Matter promotional and social media work

Mouth Care Matters supports the need for every hospital to have a dedicated mouth care lead.

Roles of health care professionals in mouth care

Health Care Professional	Roles in mouth care and oral health may include:
Doctors	Diagnosing and prescribing for oral conditions such as ulcers and oral thrush
Nursing staff	Carrying out mouth care assessments and assisting or providing mouth care
Speech and language therapist (SALT)	Providing mouth care advice for high risk dysphagia patients
Dietetics team	Nutritional advice taking into account oral health
Occupational therapists (OT)	Helping to advise and/or create aids for toothbrushes for patients with physical disabilities
Pharmacists	Advising patients/carers on drug related oral problems including dry mouth
Physiotherapists	Role can involve looking in the mouth and make other teams aware of poor oral conditions

Diagram to illustrate the Mouth Care Matters team as part of inpatient care



2

Why do we need Mouth Care Matters training?

Key messages

- Oral health has been found to deteriorate in hospitalised patients
- Some patient groups will have an increased risk of developing problems with their mouths
- There are a number of barriers that may prevent nursing staff from providing/ assisting with mouth care

2.1 What is the impact of hospitalisation on oral health?

There is evidence that hospitalisation is associated with a deterioration in oral health of patients (Terezakis et al., 2011). This in turn has been linked to:

- **An increase in hospital-acquired infections (see section 4.2)**
- **Poor nutritional intake**
- **Longer hospital stays**
- **Increased care costs**

Poor oral health is strongly associated with malnutrition and this in turn can affect a patient's recovery (Gil-Montoya et al., 2008), increasing time in hospital.

There are certain groups of patients that will be more at risk of developing mouth related problems due to either one or a combination of medical, cognitive or physical disabilities (see section 18).

Table to show patient groups with increased oral health risk factors:

Dementia	Oxygen therapy
Frail elderly	Ventilated patients
Learning disabilities	Immunocompromised
Palliative care	Head & neck radiation
Chemotherapy	Poor mobility
Delirium	Stroke
Mental health	Physical disability

2.2 We are a changing population

We are an ageing population; it is predicted by 2020, around 20% of the population of the United Kingdom will be aged 65 or older (ADHS, 2009). As people get older they are at a greater risk of developing medical, physical or cognitive problems and may need more help with personal care, including mouth care.

2.3 Our mouths are changing

As people are now living longer, they are also retaining their teeth for longer. In 1968, 37% of the population had no teeth in their mouths and this dropped to only 6% in 2009 (ADHS, 2009). Older people are more likely to have large fillings, crowns, bridges and dental implants, all of which need additional care to maintain and keep healthy. Unfortunately as the population gets older, many people will develop medical, cognitive or physical disabilities that mean they are less able to care for their mouth.

Image shows implants to retain a denture - this will need meticulous cleaning to keep healthy

2.4 We are taking more medication

Patients who are hospitalised are generally more likely to be taking more medication. Dry mouth or xerostomia is a common side effect of over 400 medications (see Section 24 for list of drugs). Having a dry mouth can have a significant negative effect on oral health, causing pain, difficulty in eating, speaking and an increase in dental disease such as dental decay, gum disease and thrush. Steroids and antibiotics can also lead to changes in our immune system and make patients more susceptible to fungal infections
(oral thrush).

2.5 What are the barriers to providing good mouth care in hospitals?

There is a wealth of evidence that shows that mouth care is frequently neglected or not a priority for hospitalised patients. A study of hospitalised patients by Sousa et al., (2014) found that patients' oral health was not being assessed and that hospitals had no policies in place for routine oral health practices. It has also been shown that there is no standardisation in the delivery of oral care

and that a lack of equipment, such as toothbrushes and toothpaste, means that nurses are sometimes improvising with forceps and gauze (Stout, Goulding and Powell, 2009). Common nursing barriers to providing or assisting patients with mouth care in hospital have been researched (Adams, 1996; Preston et al., 2006). These include:

- **Lack of knowledge**
- **Lack of training**
- **Lack of time**
- **Lack of equipment**
- **Lack of oral assessment tools**
- **A disagreeable attitude towards mouth care**
- **Attitude towards own dental health**

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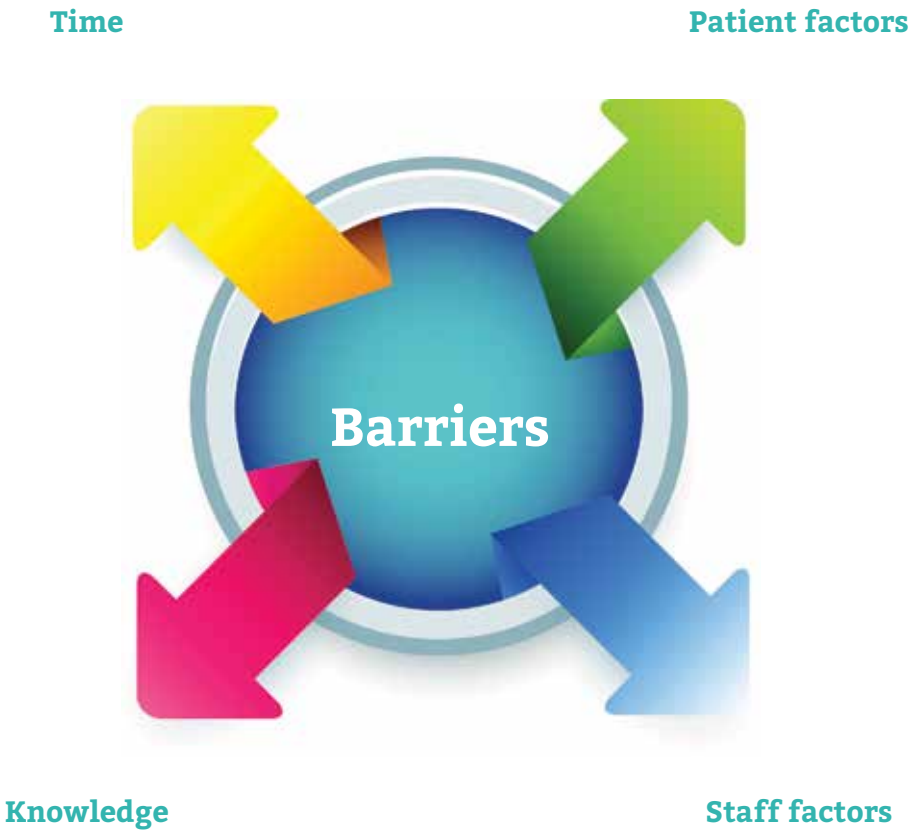
An audit of patient notes at East Surrey Hospital was carried out (January 2015) to look at whether adults who have been hospitalised for more than 24 hours have a record of either a mouth care assessment or mouth care supportive measures.

The results of this audit show that only 15% of patient notes examined in this audit had a completed mouth care assessment, all of which were from either the intensive care or high dependency units.

There was no evidence of any mouth care assessment or mouth care supportive measures in any of the notes examined from the medical wards.

One set of notes did however, specify that the patient was independent and could deliver their own daily mouth care.

Diagram to illustrate the barriers to good mouth care



In a survey of nursing staff on oral care, 95% felt that assessing and providing mouth care is part of their role as a nurse.

Only 53% of the nursing staff that completed the survey had received training in assessing patients' mouths and/or providing or assisting with oral care. Of those who had been trained, the majority had received it as part of their nursing assistant training.

Of 100 people who attended a MCM training session, only 20% had previous training in mouth care.

3

Why is oral health important for hospitalised patients?

Key messages

- Good oral health is the absence of pain and disease with the ability to eat, drink and communicate which is important for quality of life
- Poor oral health can lead to dehydration and malnutrition for hospitalised patients resulting in delayed recovery and an increased hospital stay
- Good oral health is important for patient dignity

3.1 Definition of oral health

Oral health is defined as: 'A standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease or embarrassment and which contributes to general wellbeing' (Department of Health, 1994).

Good oral health is more than just an absence of disease and is important for:

- **Eating and drinking**

  If patients are having difficulty with eating and drinking as a result of a mouth related problem, this may lead to malnutrition and dehydration affecting their recovery and will impact on the length of their hospital stay.

- **Speaking and socialising**

  Poor oral health can affect the ability to speak, smile, kiss or socialise and patients may find it difficult to communicate with hospital staff, family and friends.

Quality of life and dignity

Poor oral health can affect a patient's self-esteem and dignity and this in turn can lead to unhappiness, all of which can impact on a patient's recovery.

3.2 Oral hygiene and oral health

Good oral hygiene practices are essential to ensure the maintenance of good oral health. Oral diseases are largely preventable either through the regular removal of plaque deposits, the delivery of fluoride (most commonly through using a fluoride toothpaste), modifying the diet (reducing frequency of sugar) or through the cessation of risky behaviours such as smoking and alcohol consumption in excess (Public Health England, 2014).

Although good oral hygiene practices may not seem a key priority for hospitalised patients, good oral care will improve not only the patient's oral health and prevent oral pain and infection but will also impact on a patient's overall health and wellbeing. Locker et al. (2002) have shown that in medically compromised patients, oral health problems significantly affect their wellbeing and level of life satisfaction.

3.3 References

DOH Oral health definition (1994).

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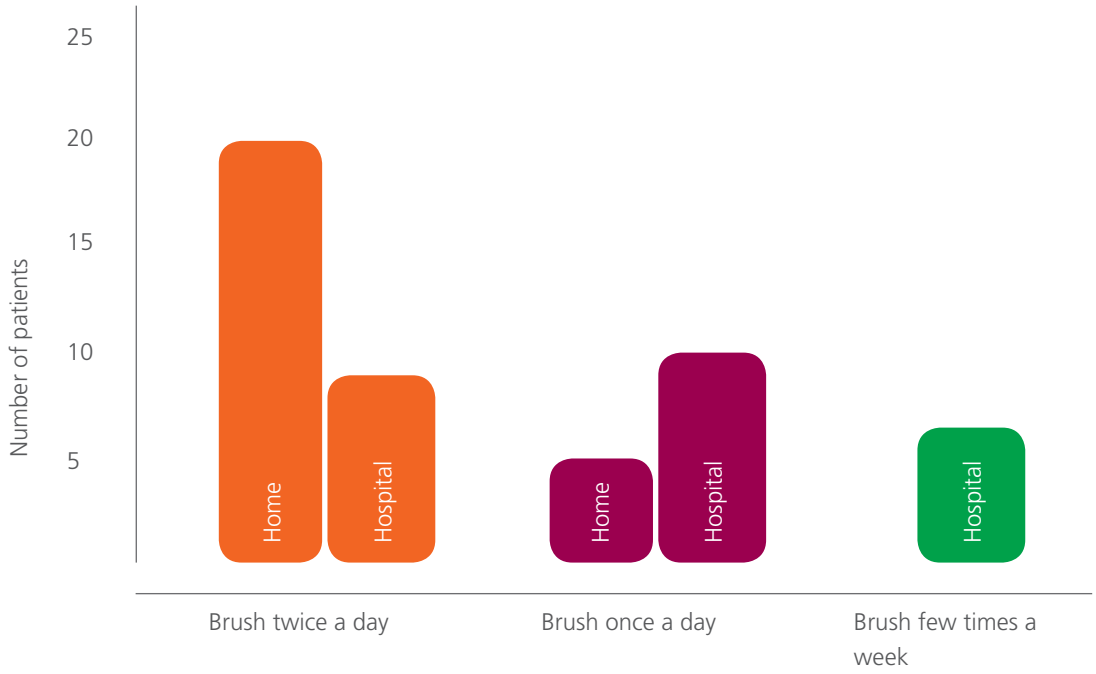
Ben is a 60-year-old patient with Parkinson's disease who has been admitted to hospital for a kidney infection. He has been leaving most of his meals untouched for two days and the doctors think this may be a side effect of his antibiotics and are concerned this may cause his kidney function to further deteriorate. He mentions to a nurse that he has a broken tooth and it is cutting into his tongue causing a large ulcer. The nurse arranges for a dentist to come and see Ben; they smooth the tooth and Ben immediately feels better and starts to eat and drink again.

Graph to show patient questionnaire findings

We asked 25 inpatients at East Surrey Hospital about their oral hygiene both at home and whilst in hospital. The results are represented in the graph below.



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4

Oral health and general health

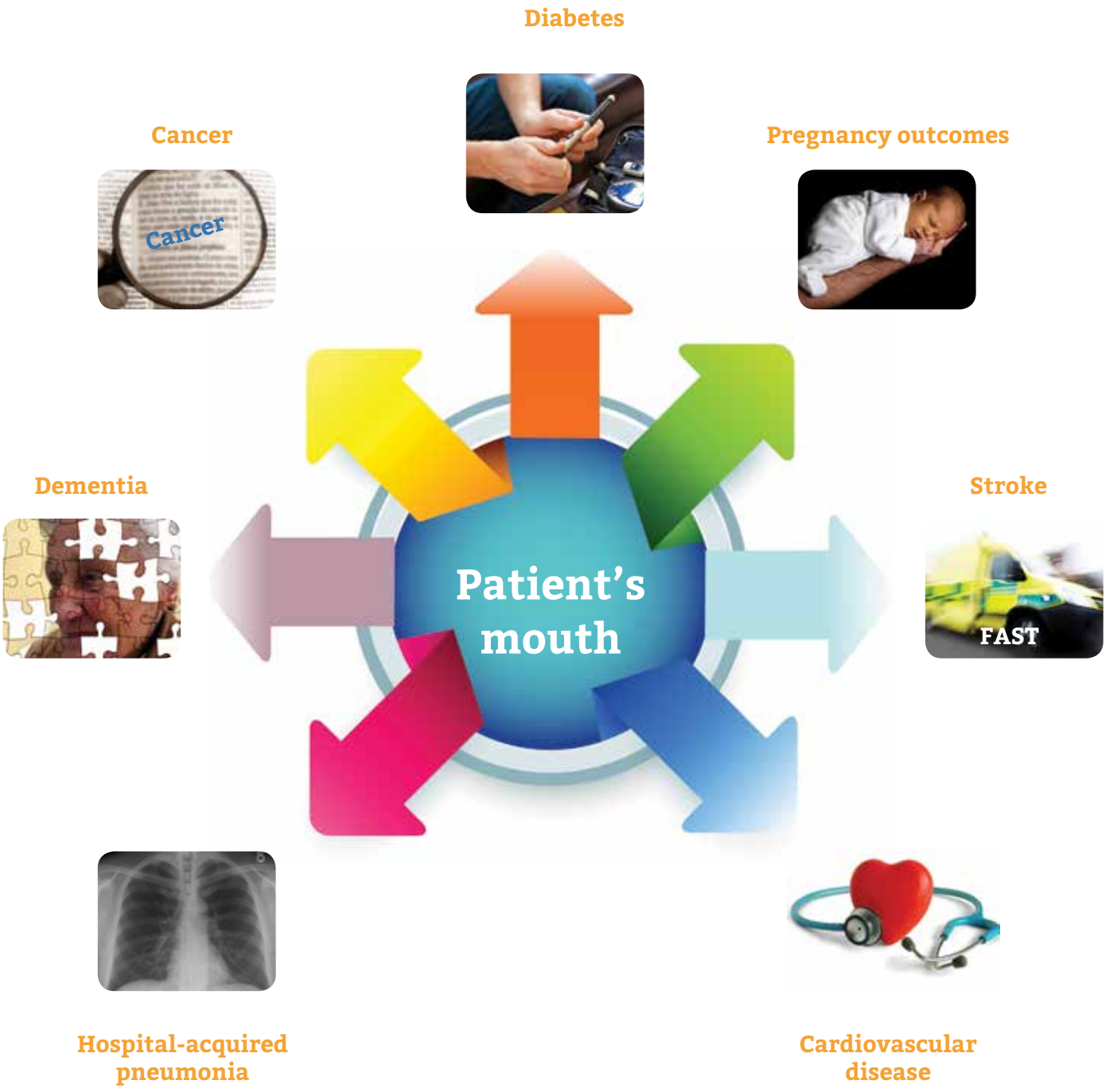
Key messages

- Oral health is linked to general health
- Poor oral hygiene is associated with hospital-acquired pneumonia
- There is a two way relationship between diabetes and gum disease

4.1 Oral health links to systemic disease

There is increasing evidence to show that poor health and poor oral hygiene are linked to general health and chronic systemic disease. This can be broken down into:

- Oral health and hospital-acquired infections
- Oral health and chronic diseases



4.2 Hospital-acquired infections linked to poor oral hygiene

Hospital-acquired pneumonia (HAP)

Dental plaque contains many different species of bacteria, some of which can cause pneumonia. Aspiration (inhalation) of oropharyngeal secretions (including dental plaque) has been found to be associated with pneumonia (Scannapieco, 2006). Patients lying supine in a hospital bed and older patients with decreasing levels of consciousness are more likely to aspirate oral secretions.

HAP increases hospital stays by an average of eight days and mortality rates are high; between 30 and 50% (NICE, 2014).

Ventilator-assisted pneumonia (VAP)

VAP is defined as pneumonia that develops 48 hours or longer after mechanical ventilation is given by means of an endotracheal tube or tracheostomy. Bacteria can colonise the endotracheal tube and VAP results from bacteria invading the lower airways. Intubation can lead to an increase in oral and gastric secretions entering the lower airways and evidence suggests that oral bacteria could be a cause of VAP (Shi et al., 2013).

4.3 Links to general health and systemic disease

Diabetes

There is now a large amount of research indicating a two-way relationship between periodontal (gum) disease and diabetes. Poor glycaemic (blood sugar) control in diabetics may be a risk factor for periodontal (gum) disease and uncontrolled periodontal disease could have an adverse effect on glycaemic control (Taylor et al., 2008).

Cardiovascular disease

There is evidence that in people with periodontal (gum) disease there is an increase in both the prevalence and incidence of cardiovascular disease. There are several theories suggested to explain this, including a similar inflammatory response (Beck et al., 1996), direct bacterial inflammation or an increase in C-reactive protein.

Infective endocarditis

Infective endocarditis results when bacteria enters the blood stream of a susceptible individual and colonises the endocardium (lining of the heart); this leads to inflammation of the endocardium and heart valves. The disease carries a high mortality risk and can be caused by bacteria in the mouth. A study has found that poor oral hygiene and gingival bleeding after toothbrushing is associated significantly with infective endocarditis-related bacteria in the blood (Lockhart, 2009). Oral hygiene, particularly in those who are susceptible, is important in reducing the risk of infective endocarditis (Strom et al., 2000).

Stroke

A relationship between periodontal disease and stroke has been suggested, for similar reasons as for cardiovascular disease (Meurman et al., 2004). However, the evidence is not as substantial.

Pregnancy outcomes

Evidence indicates an association between periodontal disease and adverse pregnancy outcomes. Good oral health is an important part of routine preventive care, and should be emphasised during pregnancy (Xiong et al., 2007).

Dementia

There have been some initial studies suggesting a link between periodontal disease and dementia. It may be that when people develop later stages of dementia the ability to care for their mouth decreases leading to an increase in periodontal disease. However, more studies need to be done to investigate and further establish the link and reasons (Iacopino, 2009, Bei et al.,).

Cancer

The most consistent risk for cancer and periodontal disease is found in oral and oesophageal cancers. There is some evidence suggesting a shared genetic risk for periodontal disease and cancer (Fitzpatrick et al., 2010).

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5

A healthy mouth

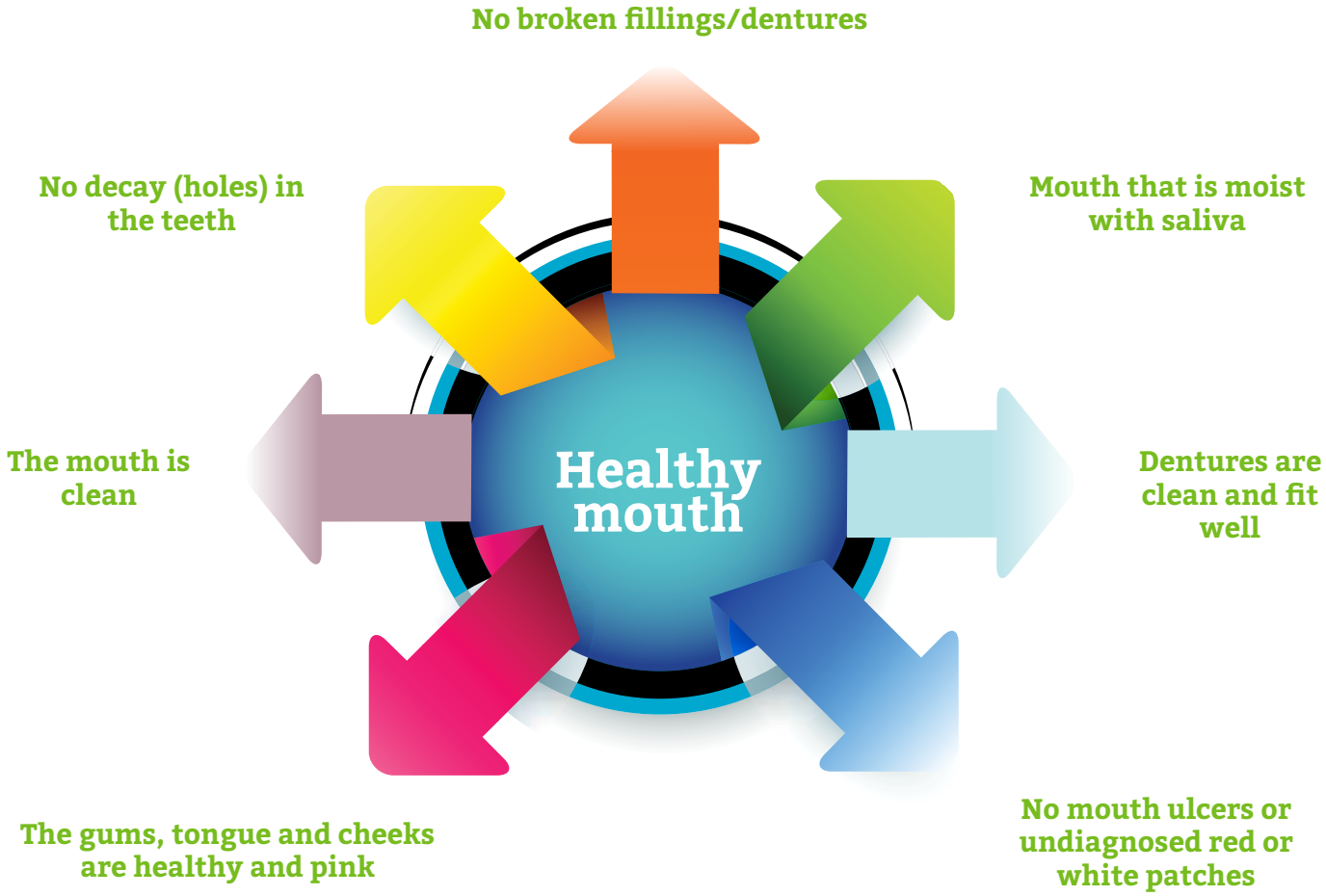
Key messages

- A healthy mouth includes a healthy tongue, palate, cheeks and teeth
- Oral problems can make it harder to eat and drink leading to dehydration and malnutrition
- Hospitals should have a pathway for urgent dental care

5.1 Why 'Mouth Care Matters' and not 'Dental Care Matters'?

Mouth care is an essential part of personal care and without it oral health will deteriorate. Often people will rate the care they receive based on their wwown standards, such as their personal oral care regime. Mouth Care Matters relates to the care and assessment of the whole mouth, with preferences and clinical needs that an individual requires while in the clinical care of the hospital (Essence of Care, 2010).

5.2 What does a healthy mouth look like?



An unhealthy mouth

A healthy mouth

5.3 What could an unhealthy mouth look like?

5.4 When to seek medical/dental advice

Some patients, when admitted to hospital, will have pre-existing oral health problems, such as tooth decay or gum disease. Other patients will have a healthy mouth when initially admitted but during their hospital stay will develop problems related to their mouth.

It would be unrealistic to expect that hospitalised patients should and could have all their dental problems treated whilst they are in hospital. Any urgent mouth related problems (likely to be affecting a patient's general well-being) should be addressed as soon as possible. If health professionals are made aware of non-urgent problems, this is a good opportunity for oral health promotion and patients should be advised to see their dentist or find a dentist for care upon discharge (See section 23).

Some hospitals will have on site maxillofacial/dental departments to directly refer to but some will not. For hospitals where there is no dental department it is important to know whom to contact for dental advice or urgent care when required.

The following table is a guide for when medical/dental advice should be sought. In the absence of dental advice, discuss with the medical team involved in a patient's overall care.

Urgent – Needs referral ASAP	Non urgent – Advise to see dentist on discharge
Thrush (medical)	Broken/decayed teeth, not causing pain
Painful ulcers on-healing ulcers present for more than two weeks (medical)	Chronic gum disease
Dental abscess, swollen face, severe dental pain (ideally dental/ maxillofacial)	Cosmetic dental treatment
Bleeding from the mouth (dental/maxillofacial)	Dentures that are loose
Dental trauma (dental/maxillofacial)	
Dentures lost or broken in hospital (dental)	
Severe dry mouth (medical)	
Patients with physical, cognitive or medical disabilities where hospital staff are struggling with oral hygiene (dental or nurses with enhanced oral health skills)	

5.5 References

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6

Dry mouth (xerostomia)

Key messages

- Dry mouth is a common problem in hospitalised patients, especially in the older patient
- There are many different causes of a dry mouth
- A dry mouth increases the risk of a range of oral problems

6.1 What is a dry mouth?

A dry mouth is caused by a lack of saliva in the mouth. Saliva is a clear watery liquid that is produced and released from the salivary glands around the mouth.

6.2 What are the functions of saliva?

- **Lubrication of the mouth**
- **To help with swallowing and talking**
- **To control the pH of saliva from 6-7.4. Low pH can damage tooth surfaces**
- **Helps to remove food debris from the mouth**
- **Saliva contains enzymes and antigens to protect against bad bacteria**
- **Saliva contains calcium and other minerals which help repair tooth enamel**
- **Saliva helps to keep dentures more securely in place**

6.3 What are the signs and symptoms of a dry mouth?

A dry mouth ranges in severity, so signs and symptoms will vary.

Signs: frothy or stringy tenacious sticky saliva, absence of saliva, dry, crusted and cracked lips, lips sticking together, tongue sticking to palate, teeth sticking to cheeks, increase in decay, fungal infections and fissuring of the tongue.

Symptoms: sensation of dryness, pain with eating, swallowing or speaking, dry cough and burning sensation.

6.4 What are the causes of a dry mouth?

Dehydration

Conditions that lead to dehydration, such as fever, excessive sweating, vomiting, diarrhoea, blood loss and burns can cause a dry mouth.

Medication

A dry mouth can be a side effect of over 400 medications (see section 24). Among the more likely types to cause problems are some of the drugs used to treat depression, nerve pain (neuropathy) and anxiety, as well as some antihistamines, decongestants, muscle relaxants and pain medications.

Systemic health conditions

Conditions such as diabetes, cystic fibrosis, rheumatoid arthritis and Alzheimer's can cause a dry mouth.

Sjögren's disease

A medical condition that causes dry mouth, dry eyes and sometimes presents a secondary autoimmune disease such as rheumatoid arthritis or lupus.

Radiotherapy

Radiotherapy to the head and neck can affect the functioning of salivary glands leading to a reduction in saliva production.

Chemotherapy

Chemotherapy drugs can change the nature of saliva and the amount produced. This may be temporary with normal salivary flow returning after treatment has been completed.

Mouth breathing

Breathing through the mouth can cause the mouth to dry out and is common in people who are on oxygen therapy.

6.5 What is the impact of a dry mouth on hospitalised patients?

A dry mouth is extremely common in hospitalised patients and can have a significant impact on their overall health and quality of life. Patients may complain of a very sore mouth and this may mean that they have difficulty opening their mouths, cleaning their mouths, eating and drinking and wearing their dentures. As a result, dry mouths can affect recovery and cause weight loss.

It is important to be aware that patients may not complain of a dry mouth but complain of difficulty chewing and swallowing or even thirst. Patients with dry mouths can also suffer from sore throats and are more susceptible to problems such as decay, gum disease, thrush and ulcers. Patients who are nil by mouth or end of life will often have very dry painful mouths.

Fissured tongue, often seen in patients with a dry mouth

Very dry mouth with stringy and crusty saliva

6.6 Prevention

Depending on the cause, prevention of a dry mouth may not be possible. If medications are the cause, it may be possible to seek medical advice on the potential to swap to a different drug, which may not have this side effect.

6.7 Management of a dry mouth for hospitalised patients

- **Frequent sips of cold water/sucking on ice chips (need to check with the speech and language therapist team if the patient has swallowing problems)**
- **Chewing sugar-free chewing gum can help some patients who have functioning salivary glands to secrete saliva**
- **Water based mouth moisturising gels or sprays can be used as often as required. These can be applied before mouth cleaning and eating so that it is less painful for patients with a severe dry mouth**
- **Strict control of sugar intake to prevent dental decay. In the long term, these patients may be prescribed high fluoride toothpastes by a dentist**
- **Daily checks for signs of thrush**
- **Use of mild flavoured sodium lauryl sulphate (SLS) free toothpaste to cause less irritation to a sore mouth**
- **Avoid dry food that will be difficult and painful to eat**

A nurse called the Mouth Care Team for advice for an older female patient with a sore mouth that was dry and looked yellow on one side. The patient had been reviewed by her doctor who had diagnosed her with oral thrush and prescribed Nystatin. The patient described to the mouth care team that her mouth was very dry and that she had trouble swallowing medication. The patient had been unable to swallow her medication and the yellow capsule got stuck to her cheek and slowly disintegrated in her mouth causing pain and ulceration. The management was to stop the Nystatin, provide regular dry mouth care and to review the medications and see if they could be changed to a liquid form. The nursing staff, pharmacist and doctor were all informed to highlight the importance of dry mouth as a risk factor for medication safety.

6.8 Saliva substitutes/moisturising agents

There is a move away from calling products 'saliva substitutes' as it is extremely difficult to produce a substance that replaces saliva. More recently, products tend to be marketed as dry mouth products or mouth moisturising products and include gels, sprays and toothpastes. Not all patients will find them effective. Some gels may contain animal products or ingredients derived from milk or egg and staff need to be aware of this when prescribing and administering these products.

The gels can be applied to all parts of the mouth including the lips, tongue and cheeks and should be slowly massaged into the tissues (as if you were massaging a cream to treat dry skin). Gels can be applied with fingers or a small-headed toothbrush or MouthEze cleanser (see section 19.4).

Dry mouth products	Notes on products
Oralieve mouth moisturising gel and toothpaste	Contains traces of whey protein derived from milk
Bioxtra gel/spray and toothpaste	Contains traces of products extracted from milk and eggs
Biotene products	Formulation changed, new formulation no animal products
Saliva Orthana spray	Contains animal products (porcine mucin)
Aquoral spray	No animal products
Xeroxin spray	No animal products
Glandsodane spray	Acidic so do not use long term in patients with natural teeth
Saliveze oral spray	No animal products

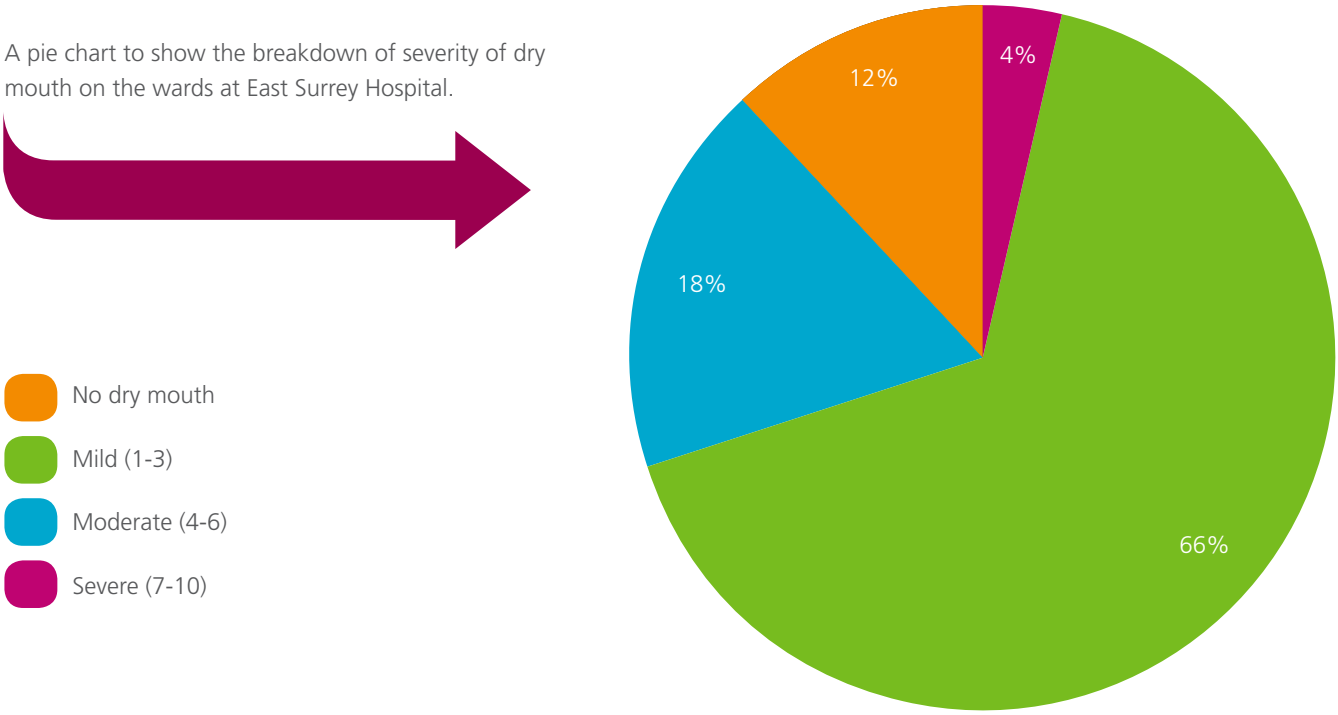
Applying dry mouth gel to MouthEze cleanser

6.9 Mouth audit at East Surrey Hospital

An audit carried out at East Surrey Hospital looked at the incidence and severity of dry mouth using a dry mouth scale (Challacombe scale). This scale identifies 10 signs of oral dryness and produces a score of 0-10.

The mouths of 50 patients at random from a variety of wards were examined for dryness. It was found that over 85% of patients had some form of dry mouth. The chart below shows the severity of dry mouth found, with the majority having a mild dry mouth exhibiting 1-3 signs of dryness.

A pie chart to show the breakdown of severity of dry mouth on the wards at East Surrey Hospital.



6.10 References

Challacombe scale. Available at: http://www.challacombescale.co.uk/index.html (Accessed 21 August, 2015).

{ José was admitted to hospital and on an end-of-care plan. His only complaint was pain from his mouth. The palliative care team were concerned and requested input from the mouth care team. He was seen by the team who found that he had a very dry mouth with bleeding cracked lips and lots of dried oral secretions. His tongue and cheeks were sticking to his palate. Dry mouth gel was massaged all around his mouth and this made José feel more comfortable and helped to alleviate his symptoms. The nursing staff were advised to provide dry mouth care every two hours. José was reviewed every day and his family said that he seemed much more comfortable in his final days. }

7

Dental decay (caries)

Key messages

- Dental decay is caused by bacteria present in dental plaque that convert sugar into acid
- Decay can be prevented by removing bacterial plaque twice daily by brushing teeth effectively and reducing sugar consumption
- Toothpaste containing fluoride strengthens teeth against decay

7.1 What is dental decay (caries)?

The demineralisation (destruction) of tooth tissue (enamel and dentine) due to acid produced by bacteria.

7.2 Signs of dental decay

Decay may first appear as a brown stain on the tooth and will then develop into 'holes' in the teeth, which may lead to teeth fracturing or breaking down. If left untreated the bacteria can spread into the blood and nerve supply (the pulp) of the tooth and cause an infection, which is painful and may develop into a dental abscess.

7.3 Symptoms of dental decay

Initially, dental decay is symptomless but as the 'hole' gets bigger and spreads deeper into the tooth, symptoms can arise. These include pain and sensitivity, particularly to sweet foods.

7.4 Causes of dental decay

The mouth contains up to 650 different types of bacteria that form part of a sticky white substance called plaque that sticks to the teeth. When we eat or drink something sugary the bacteria absorbs the sugar and converts it into acid. The acid attacks the teeth and causes demineralisation; this is where the tooth tissue loses minerals and becomes softer.

Each time we eat, the pH in our mouth drops (i.e. it becomes more acidic) and our teeth are at risk of decay. Sugars make the pH drop even further as they are readily metabolised by the bacteria in comparison to other foods and nutrients. It takes approximately 30 minutes for the pH to return to neutral and is achieved by the neutralising effect of our saliva. Below a pH of 5.5, the teeth are susceptible to demineralisation and decay. Therefore, the more frequently sugar is consumed throughout the day, the greater the amount of time spent in the 'danger zone' and the greater the risk of decay.

Dental decay

7.5 Prevention of dental decay

Dental decay is preventable through the control of sugar in the diet and good oral hygiene. It is important that fluoride toothpaste is used as the fluoride helps to prevent, control (promotes remineralisation) and arrest (stop) decay.

Teeth should be brushed twice daily, once last thing at night and at one other time during the day with a small-headed brush. Brushing should take two minutes to complete using a circular motion with the bristles of the brush directed 45° towards the gum line.

Toothbrushing

7.6 Management of dental decay in hospitalised patients

It is not the role of health care professionals (with the exception of dentists and dental therapists) to diagnose dental decay. However, health care professionals may come across patients with broken teeth, teeth with holes, or teeth with dark staining. If the patient has no symptoms or only complains of intermittent mild pain the patient should be advised to seek dental treatment from their dentist following discharge. If the patient has symptoms affecting their everyday well being (e.g. constant pain, sharp teeth causing ulceration to cheek or tongue, or a swelling next to the tooth), the patient should be referred for dental advice.

There will be some very vulnerable patients in hospital who may not be able to clearly communicate when they are in pain, such as patients with advanced dementia or with low levels of consciousness. If dental decay is found in vulnerable patients during a hospital stay they should be signposted to appropriate services after discharge, for example the salaried dental services who treat special care patients.

8

Diet and oral health

Key messages

- Sugary drinks should be restricted to mealtimes and only water, tea or coffee (with no added sugar) should be drunk in between meals
- Sugar-containing foods and drinks should be avoided at bedtime
- Ideally, sugar should not be added to foods (e.g. cereal) or drinks (e.g. tea and coffee), consider sweeteners instead

8.1 Effects of sugar in teeth

Diet can have an impact on the risk of dental decay and as a result it is important that the amount and frequency of sugar consumed throughout the day is restricted. In hospitals patients are often given sweets and chocolates by visitors and hospital snack trolleys are laden with biscuits. Patients with dry mouths due to dehydration will often crave sweet drinks.

Saliva is our natural defence against decay and helps to neutralise the mouth after we eat food; patients with 'dry mouth' (xerostomia) are therefore at an increased risk of decay. Saliva is produced when we eat to aid digestion and is therefore in abundance after eating a meal. This is why sugary foods should be consumed as a dessert, after a meal as the extra saliva present will help to minimise the 'acid attack' and therefore minimise the risk of decay. Where possible, sugary snacks and drinks should not be consumed between meals.

8.2 Safe snacks

Food and drink that can be eaten in between meals, that do not increase the risk of decay, are shown below:

- √ Plain water
- √ Tea and coffee (no sugar added - sweetener may be used in its place)
- √ Cheese
- √ Whole fresh fruit
- √ Raw vegetables
- √ Breadsticks
- √ Nuts

Many medicines contain sugar and it important that sugar-free alternatives are sought if they are available. This is particularly important for those with dry mouths or oral dysphagia. If no sugar-free alternative is available, administering the medicine at mealtimes will help to reduce the risk of decay.

8.3 Sugar and medication

Nutritional supplements can also increase the risk of decay and advice should be sought from the dietetic team for patients who need diet supplements. For these patients, drinking water to clear the mouth after sugary drinks and the use of a fluoride containing mouthwash would be beneficial.

Hospital snack trolley

Platter of unhealthy foods and drink

9

Fluoride

Key messages

- Use a fluoridated toothpaste twice daily
- Adults should use a toothpaste containing at least 1350ppm fluoride
- If possible spit without rinsing for 30 minutes after toothbrushing

9.1 What is fluoride?

Fluoride is a natural mineral that is found in fruit, vegetables, fish and tea. It is added to toothpaste and has contributed to a significant decline in both the incidence and prevalence of dental decay over the past few decades.

9.2 How does fluoride work?

Fluoride strengthens the tooth enamel, making it more resistant to decay. Applied topically, it is in direct contact with the teeth. This is why dentists advise not to rinse after brushing your teeth, with water or mouthwash, as this washes away the fluoride present in the toothpaste. You need to simply spit out the excess toothpaste; this will ensure that the fluoride is in contact with the teeth for as long as possible, allowing it to work.

Hospitalised patients can be encouraged to do this. For patients with dysphagia, advice can be sought from the speech and language team.

9.3 How much fluoride is enough?

The evidence to support the twice-daily use of fluoridated toothpaste is extensive. The Department of Health Delivering Better Oral Health toolkit (PHE, 2014) recommends that adults should use a toothpaste that contains at least 1350ppm (parts per million) fluoride. This information can be found on the back of the toothpaste. Most over-the-counter toothpastes and those available on the high street contain 1000-1500ppm fluoride, although there are some that have less than 1000ppm or no fluoride at all; these toothpastes will provide little or no protection against tooth decay.

A higher concentration of fluoride provides better protection against decay. For those patients at a high risk of developing tooth decay, Duraphat toothpaste with a concentration of either 2800ppm or 5000ppm may be prescribed by a dentist or a doctor. These should be used in the same way as any other toothpaste; a pea-sized amount, twice daily.

9.4 References

Public Health England (PHE). (2014) Delivering better oral health: an evidence-based toolkit for prevention. Third Edition. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367563/DBOHv32014OCTMainDocument_3.pdf (Accessed 21st August 2015).

10 Tooth surface loss

Key messages

- Tooth surface loss is the wearing away of tooth surface not caused by bacterial activity
- There are three main types of tooth surface loss
- Tooth surface loss is becoming increasingly more common due to changes in lifestyle

10.1 What is tooth surface loss?

Tooth surface loss is the non-carious loss of tooth tissues; that is, it is not caused by bacterial acid, which is the cause of dental decay. There are three main types; erosion, attrition and abrasion. Tooth surface loss is becoming more common with changes in diet, habits, lifestyle, and increasing age.

10.2 Signs of tooth surface loss

As teeth wear away they may appear thinner, shinier, or become shorter.

10.3 Symptoms of tooth surface loss

The symptoms of tooth surface loss can range from no symptoms, to sensitivity to hot and cold, to extreme pain.

10.4 Tooth erosion

Erosion is caused by frequent or prolonged exposure to acid. The acid can be extrinsic (from food and drink) or intrinsic (gastric acid as a result of acid reflux or frequent vomiting).

10.5 Management of tooth erosion in hospitalised patients

Patients should be advised to see their dentist on discharge for monitoring of the erosion. If the patient has severe pain affecting their everyday wellbeing they should be referred for dental advice. Avoid giving sugar or sugar free acidic drinks to patients with dry mouths as it can increase the level of acid attack to the teeth. If a patient is suffering from acid reflux or vomits frequently avoid brushing their teeth until 30 minutes afterwards.

Acidic food and drink include:

- Fruit, especially citrus fruits
- Fruit teas
- Fruit juices
- Fizzy drinks including fizzy water
- Alcohol
- Vinegar

*List is not exhaustive

Tooth erosion

10.6 Tooth abrasion

Abrasion is the wearing away of the tooth surface by a mechanical force; this is most commonly caused by using too much pressure when toothbrushing. It is more common in the older patient, where the gums have receded (shrunk back) exposing the roots of the teeth. Unlike the crown of the tooth, roots do not have a coating of enamel and the dentine is softer and hence will wear away faster. Often people suffer from a combination of erosion and abrasion; the acid attacks cause the teeth to be softer and more prone to being damaged by mechanical forces such as toothbrushing.

10.7 Management of tooth abrasion in hospitalised patients

Patients should be advised to see their dentist on discharge for monitoring of the abrasion. If the patient has severe pain affecting their everyday well-being they should be referred for dental advice. MCM advises that hospitalised patients should use a small headed soft toothbrush and not brush with excessive force.

Tooth abrasion

10.8 Tooth attrition

Attrition is the wearing away of a tooth as a result of tooth-to-tooth contact, this is commonly called tooth grinding or bruxism.

The extent of attrition varies from the wearing away of the enamel, exposure of dentine or in extreme cases the teeth are worn away to gum level. People with learning disabilities and mental health issues are more prone to tooth surface loss.

Clenching and grinding; people will often perceive they grind their teeth when they are stressed.

A lack of teeth; where people have multiple dental extractions the remaining teeth are subjected to a greater force and this can lead to an increase in tooth wear.

Habit; some people constantly chew, for example, gum or tobacco and therefore bring their teeth together more often.

The incidence of grinding is higher in people with learning disabilities.

A tip - how much force to use when brushing a patient's teeth:

- Write your name with your non-dominant hand
- This is the force you should use when brushing your own teeth or another person's teeth

10.9 Management of tooth attrition in hospitalised patients

Patients should be advised to see their dentist on discharge for monitoring of the attrition. If the patient has severe pain affecting their everyday well-being they should be referred for dental advice. However, attrition is generally not painful but if symptoms arise, seek dental advice.

Tooth attrition (with erosion)

11 Periodontal (gum) disease

Key messages

- Gum disease is an inflammatory disease of the gums and bone that supports teeth
- Good toothbrushing is important to help stop the progression of gum disease
- Gum disease can contribute to cardiovascular disease and diabetic control

11.1 Definition of periodontal (gum) disease

Periodontal disease, commonly known as gum disease, is an inflammatory disease of the gums and bone that surround teeth and is caused by bacteria in dental plaque. There are two main stages:

Gingivitis

This is the first stage of gum disease where the gums become inflamed, red and can bleed when brushed. Gingivitis is a reversible condition with good oral hygiene and daily removal of plaque.

Periodontitis

If gingivitis is left untreated it can progress to periodontitis. Periodontitis is where the bone supporting the teeth is affected and in some cases can result in tooth loss. Periodontitis is irreversible, but progression can be halted with treatment and improved oral hygiene.

Dental plaque

Gingivitis

Early stages

Reversible with good oral hygiene

Gums are swollen and red and bleed when brushed

Periodontitis

Later stages can be halted with treatment

Teeth appear longer as gums recede

Teeth may be loose and move (can be an aspiration risk if very loose)

Advanced periodontitis

Moderate periodontitis

11.2 Causes of gum disease

Dental plaque is a soft white substance that adheres to teeth and contains up to 650 different types of bacteria. The bacteria causes an inflammatory reaction in the gums that initially manifests as red, inflamed gums that bleed when brushed and eventually leads to destruction and loss of the bone that supports the teeth. There are additional risk factors for gum disease including smoking, increasing age, medication, systemic disease (e.g. diabetes) and genetics.

11.3 Signs of gum disease

Signs of gingivitis include red, inflamed gums, which bleed upon brushing, and halitosis (bad breath).

Signs of periodontitis include wobbly teeth, teeth look longer as the gums recede and missing teeth.

11.4 Symptoms of gum disease

The gums may or may not be sore and loose teeth may or may not be painful. Gum disease can lead to dental abscesses that can be very painful.

11.5 Management of gum disease in hospital

Regular removal of dental plaque with good oral hygiene is important to reverse gingivitis and help stop the progression of periodontitis. If teeth are very mobile (loose) there is a risk that they could be aspirated or ingested, an urgent referral should be made for dental advice.

Dental plaque can only effectively be removed from teeth by using a toothbrush. Foam swabs and MouthEze cleaners do not remove plaque and should not be used instead of a toothbrush.

12 Oral thrush (candida/ fungal infection)

Key messages

- Thrush is a common fungal infection in hospitalised patients
- Causes include dry mouth, certain medication and poor denture hygiene
- Treatment includes antifungal medication and meticulous oral hygiene

12.1 What is oral thrush?

Oral thrush is an infection in the mouth caused by the fungus candida and it occurs commonly in people who are:

- **Immunosuppressed**
- **Have a dry mouth**
- **Taking antibiotics and/or steroids**
- **Not cleaning dentures effectively**

12.2 Causes of oral thrush

The mouth provides an ideal place for fungal infections to spread, as it is moist and warm. Candida can be present in a healthy mouth and is kept in check by the body's immune system. However, this balance can be disrupted meaning that the candida can thrive and set up an infection.

12.3 Signs of oral thrush

Oral thrush appears most commonly as creamy white or sometimes red patches on the palate, top of the tongue or any areas in the mouth. The white patches can be rubbed off (e.g. when eating or cleaning teeth) and can leave a painful raw area that may bleed. Thrush can develop quickly under dentures that are not removed every night and is often not spotted for this reason. Thrush under a denture is commonly referred to as denture stomatitis.

12.4 Symptoms of oral thrush

Oral thrush can have no symptoms at all or cause soreness and difficulty with eating and swallowing.

Oral thrush

Risk factors for oral thrush:

- Dry mouth (saliva contains antifungal enzymes)
- Steroids including steroid inhalers
- Antibiotic use
- Wearing dentures (especially if not cleaned properly) at night
- Older age
- Impaired immune system
- Smoking

12.5 Management of oral thrush in hospitalised patients

- Keep the mouth as clean as possible; use a small-headed toothbrush to clean teeth, gums and tongue at least twice a day.
- Treat a dry mouth, ensure patient is adequately hydrated and use mouth moisturising products regularly.
- Refer for advice from a medical team who can diagnose thrush and prescribe an antifungal medication. Any underlying causes should also be identified and treated, if possible.
- Advise the patient to leave dentures out of their mouth at night (the mouth will still need to be cleaned as above).
- Dentures should be cleaned thoroughly with a small toothbrush/denture brush to remove debris and plaque.
- Patients should be advised not to smoke.
- If the thrush is thought to be associated with the use of a corticosteroid inhaler the patient should be encouraged to rinse their mouth with water after use.

Denture stomatitis

Oral thrush under denture (denture stomatitis)

Dentures are porous and have very small holes in them, which can harbour fungal species. It is therefore important that dentures are removed at night and are kept clean. The key to keeping dentures clean is removing them regularly and brushing away food debris and plaque deposits. Some patients may wish to use a commercial denture cleaner and instructions should be followed. Dentures should be placed in a named denture pot with water when not in the mouth.

12.6 Antifungal medication

There are a number of different antifungal medications that can be used to treat oral thrush and which one to use will usually depend on where the fungal infection is in the mouth and how severe the infection is.

- Nystatin - prescribed as a rinse, should be held in the mouth four times daily (after meals) for as long as possible for topical effect and then swallowed.
- Miconazole - prescribed as a gel and applied to the affected area four times daily (after meals) and can be swallowed. It can also be applied to the denture surface in contact with the palate and placed in the mouth. It should be sugar-free to help minimise the risk of decay.
- Fluconazole - systemic treatment and prescribed as a tablet. This is generally prescribed when patients have a fungal infection in more than one site.
- Chlorhexidine (0.2%) - cleanse and soak denture in mouthwash for 15 minutes twice a day (British National Formulary).

12.7 References

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

13 Angular cheilitis

Key messages

- Angular cheilitis is when the corners of the mouth become inflamed, cracked, crusty and split
- Bacterial and fungal secondary infection is common
- Treatment involves clearing the infection and protecting the area with a mouth moisturising gel/lip balm/emollient cream

13.1 What is angular cheilitis?

Angular cheilitis is a condition where one or both corners of the mouth become red, inflamed, crusted and cracked.

Angular cheilitis

13.2 Causes of angular cheilitis

Angular cheilitis is more common in adults who wear inadequate dentures that do not sufficiently support the lip, people who drool, have chronic bowel problems or a deficiency of iron or vitamin B. It can become infected by candida, or by bacteria, often Staphylococcus aureus. Patients who are immunocompromised and patients with diabetes are also at increased risk.

13.3 Signs of angular cheilitis

Signs include redness, swelling, crusting and cracking at the corners of the mouth. The corners of the mouth tend to be persistently wet.

13.4 Symptoms of angular cheilitis

Some patients may not have symptoms but for the majority it can be extremely painful.

13.5 Management of angular cheilitis in hospital patients

The treatment of angular cheilitis depends on the cause. For symptomatic relief keep the inflamed area lubricated with a mouth moisturising gel/lip balm/emollient cream. The majority of cases of angular cheilitis have an infectious origin and should be treated as such. Patients may be prescribed fusidic acid and 1% hydrocortisone cream (to counter inflammation) which works effectively for bacterial infection and can be applied to the corners of the mouth. For fungal infections, an antifungal topical treatment such as miconazole gel or nystatin can be applied to the affected area.

Patients using inhaled steroids should rinse with water after use to minimize the amount of residual steroid left in the mouth and reduce the chance of infection.

Patients with poorly fitting or no dentures should be advised to see their dentist on discharge from hospital.

14 Mouth ulcers

Key messages

- There are many causes of mouth ulcers
- Treatment involves alleviating symptoms and treating the cause, if possible
- Ulcers that are present for two weeks or more need to be referred for medical advice

14.1 What is a mouth ulcer?

Mouth ulcers are 'sores' in the mouth. There are many causes of mouth ulcers. Ulcers normally resolve by themselves within a week or two.

14.2 Causes of mouth ulcers

- **Trauma –** a lost filling, broken tooth or sharp edge on a denture can cause persistent rubbing to the tongue or cheek leading to ulceration. Biting the cheek, tongue or lip can also cause ulceration.
- **Aphthous ulcer** (common recurrent ulcers)
- **Infection –** both viral and bacterial e.g. herpes virus
- **Chronic conditions –** anaemia and Crohn's disease
- **Smoking**
- **Cancer of the mouth**
- **Unknown**

14.3 Signs of a mouth ulcer

Mouth ulcers are white or cream in colour and round or oval in shape with red inflammation around them. They are most common on the cheeks and lips. There may be one ulcer or several all at once. Depending on the cause they can range in size from a couple of millimetres to centimetres.

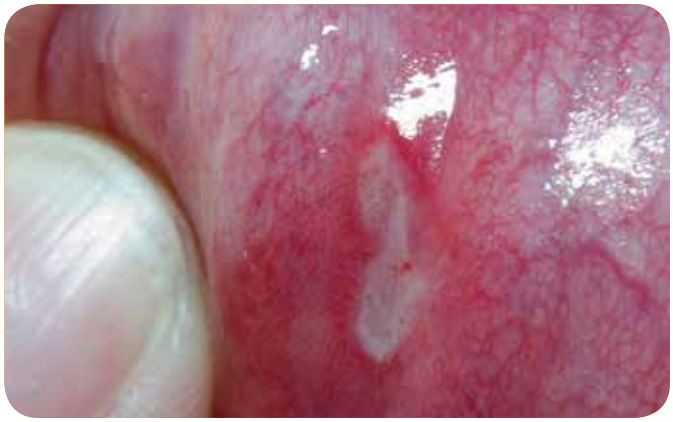
14.4 Symptoms of a mouth ulcer

Ulcers are generally very sore and painful. Ulcers that are not painful and non-healing (lasting more than two weeks) should be referred for further investigation from a specialist maxillofacial team.

Aphthous mouth ulcer

14.5 Management of mouth ulcers in hospital

- For traumatic ulcers if possible remove the cause, for example seeing if a dentist can smooth a sharp tooth or denture. If there is no dental department, advise the patient to see their dentist on discharge.
- Symptomatic treatment, mouth washes including saline rinse, 0.15 % benzydamine hydrochloride (Difflam), or alcohol free 0.2% chlorhexidine gluconate (see section 19.6).
- Try and brush twice a day to keep the mouth clean to prevent infection of the ulcers.
- Maintain hydration and nutrition for the patient.
- Any patient with an ulcer present for more than two weeks should be referred to the attention of the medical team. These patients may need to be referred for specialist advice from the maxillofacial team.



Traumatic mouth ulcer

Traumatic mouth ulcer

{ Alice, an 80-year-old woman, was admitted to hospital after suffering a fall, she had diabetes and was refusing food. On day 16 of her hospital stay a doctor thought her mouth looked swollen and requested a dental review. A maxillofacial surgeon found that Alice had full dentures and this had not been recognised, so they had not been taken out during her hospital stay. When the dentures were removed a suspicious swollen ulcer was found in her mouth and was clinically diagnosed as late stage oral cancer. The dentures were left out of the mouth to allow the swelling to reduce and the patient was booked to see the head and neck cancer surgeon a week later. When the surgeon reviewed Alice, the ulcer had healed and it was in fact a traumatic ulcer caused by the dentures not being removed for two weeks, not a cancer. The patients recovery was improved by removing the dentures and the cause of the trauma, she was in less discomfort and could eat again. Her family were pleased and she was discharged that day. }

15 Excessive drooling

Key messages

- Excessive drooling is most commonly a result of problems with swallowing or posture
- It is important to keep the face moisturised to prevent inflammation of the skin
- Rarely medication will be needed to reduce saliva secretions

15.1 Why do some patients drool?

It is often assumed that drooling is a result of excessive saliva production. However this is very rare. The main cause of drooling is when a person has problems with posture and muscle control or nasal obstruction which results in saliva not being swallowed and drooling from the mouth. Excessive drooling also occurs with neurodegenerative disorders, such as motor neurone disease, Parkinson's disease and multiple sclerosis.

Excessive drooling

15.2 Signs of drooling

Patients will often have saliva dribbling from the side of their mouths and have wet bedclothes and bed sheets.

15.3 Symptoms of drooling

The corners of the mouth may become very sore as a result of the continuous wetness and inflammation.

15.4 Management of drooling in hospitalised patients

Depending on the severity, drooling may result in persistent wetness of the face. The corners of the mouth are particularly susceptible and may lead to angular cheilitis (see section 13). It is important that the area around the mouth is kept as dry as possible with frequent application of moisturising creams to the face and mouth moisturising gels to the lips.

Depending on the cause of the drooling some patients may be referred to the speech and language team for swallowing exercises. Patients may be prescribed medication by their doctors such as hyoscine patches and glycopyrronium bromide, which help dry up salivary secretions.

16 Mucositis

Key messages

- Mucositis is an extremely painful side effect of chemotherapy and head and neck radiotherapy
- Management involves treatment to alleviate symptoms
- Good oral hygiene is important to prevent secondary infection

16.1 What is mucositis?

Oral mucositis is inflammation and ulceration of the lining of the mouth. It is a common side effect of cancer treatment with chemotherapy or head and neck radiotherapy. It can lead to problems swallowing and affect nutrition.

It is very important for patients to maintain good oral hygiene to reduce the risks of secondary infection (bacterial or fungal) of the lesions in the mouth.

16.2 Signs of mucositis

The mouth may appear shiny, red and inflamed with ulcers and may bleed.

16.3 Symptoms of mucositis

Mucositis is very painful and may affect swallowing and speaking leading to dehydration and nutritional problems. Saliva may become thick and sticky.

16.4 Management of mucositis in hospitalised patients

Mucositis is a debilitating condition that can result in a patient being unable to eat or drink. Treatment involves minimising the symptoms and can include:

- Systemic analgesia
- Cleaning the mouth after eating using a soft toothbrush
- Using an SLS free toothpaste with a mild flavour to minimise irritation
- Holding and swirling ice chips in the mouth (excluding patients with swallowing difficulties)
- A diet of soft, bland, warm food
- Benzydamine hydrochloride 0.15% 15 ml, 2-3 hourly for up to 7 days (mouth wash or spray)
- Alcohol free chlorhexidine (0.2%) mouth rinse may or may not be tolerated by patients
- Moisturising the mouth regularly with a dry mouth moisturising gel

Gelclair is a barrier mouth gel that some patients find very effective. It forms a protective film by coating the oral mucosa. Using gelclair an hour before mealtimes can help with making eating more comfortable.

Episil is an oral liquid that forms an adhesive film alleviating symptoms and can be used before meals. There are other preparations available.

Visit www.ukomic.co.uk, an excellent website with further information on mucositis.

17 Oral cancer

Key messages

- It is important to identify signs and symptoms of oral cancer
- Patients with suspicious signs and symptoms should be referred for specialist advice
- There are many painful oral side effects of chemotherapy and head and neck radiotherapy and regular mouth care is very important

17.1 What is oral cancer?

There are many different types of cancer in the mouth involving the lips, cheek, tongue, palate, salivary glands, larynx and pharynx.

Risk factors for oral cancer include smoking tobacco, alcohol, chewing betel quid with tobacco, genetic factors and Human Papillomavirus (HPV).

17.2 What are the signs and symptoms of oral cancer?

The following list is not exhaustive but some more common signs and symptoms include:

- A non-healing ulcer that is present in the mouth for more than two weeks
- A white or red patch on the tongue, palate or on the mouth lining
- Swellings in the mouth with no obvious cause
- Unexplained changes in speech and swallowing

Squamous cell carcinoma

17.3 Management of suspected oral cancer in hospital

If there are unexplained signs or symptoms in the mouth, the patient should be referred to a specialist (maxillofacial team) for further investigation.

Treatment of hospitalised patients undergoing cancer treatment

Both chemotherapy and radiation to the head and neck can affect the mouth and make it often too painful to provide good oral hygiene. Good oral hygiene is very important to help prevent fungal and bacterial infection. The following advice may be helpful for a painful mouth:

- Use a soft, small headed toothbrush to clean the mouth twice daily
- Mild flavoured or non-flavoured toothpaste maybe more readily accepted
- A saline mouthwash after every meal will help to clear the mouth of food debris
- A doctor or dentist may prescribe an alcohol free chlorhexidine mouthwash or benzydamine hydrochloride mouthwash
- A dentist might advise and prescribe a high fluoride toothpaste or mouthwash as teeth can be at greater risk from decay due to the lack of saliva
- See section 16.4 for management of mucositis

{ An older female patient was in hospital for ten days following a fall. During her stay she mentioned to her doctor that her denture was rubbing in her mouth. The doctor asked for a dental referral. On examination there was a swelling the size of a golf ball attached to her tongue. A biopsy was arranged and confirmed that the swelling was a late stage squamous cell carcinoma. This was not related to her stay in hospital but highlights the importance of mouth care assessments for all vulnerable patients. }

18 Patients with increased oral health risk factors

Key messages

- Patients with cognitive disorders may find it difficult to communicate or cooperate with mouth care in hospital
- Physical disabilities can add barriers and make it more difficult to carry out good oral hygiene
- Patients with systemic diseases are more susceptible to oral problems

18.1 Why are some patients more at risk from mouth care problems?

There are some groups of patients that will be more at risk from developing problems with their mouth whilst in hospital including those with:

1. **Cognitive disorder/disabilities –** making it harder to understand the need for mouth care and cooperating with mouth care.
2. **Medical disabilities –** being more susceptible to dry mouth, ulceration etc.
3. **Physical disabilities –** leading to difficulties in carrying out personal mouth care or mobility problems making it harder to get to a sink.

18.2 Signs of mouth related problems in vulnerable patients

Patients with cognitive impairment such as learning disabilities or dementia may find it difficult to communicate to carers when they are in pain or have problems with their mouth. Patients who are acutely unwell may lack the energy or be able to speak up when they have oral problems. Hospital staff should be aware of signs that may suggest that the patient has problems with their mouth:

- Change in behaviour or co-operation with mouth care
- Leaving out previously worn dentures
- Facial swellings
- Reduced intake of food and/or drink, particularly hard foods and cold things
- Frequent pulling at the face or mouth
- Increased restlessness, moaning or shouting
- Disturbed sleep
- Self harm
- Aggressive behaviour

All patients that are hospitalised for more than 24 hours should have a mouth care risk assessment as part of their general assessment to exclude oral related problems.

The next sections discuss some groups of patients that are more at risk of being susceptible to oral related problems or may require more assistance with mouth care.

18.3 Dementia and oral health

The incidence of dementia is increasing in the older population. This decline in cognitive function frequently causes behavioural changes that directly affect oral health. The loss of interest and ability to complete everyday tasks such as toothbrushing can cause rapid development of dental caries and periodontal disease. This population group often have heavily treated teeth (lots of fillings, crowns, bridges and even implants that need increasing care with age). There is also an increased risk of dry mouth due to medication and mouth breathing. In turn this may lead to decreased function, such as difficulty eating and drinking, and increased dental pain (Brennan and Strauss, 2014).

Table showing the types of disabilities that may affect oral care

Cognitive Disorder/Disabilities	Medical Conditions	Physical Disabilities
Learning disabilities	Diabetes	Frail older patient
Dementia	Xerostomia	Arthritis
Mental health conditions	Oxygen therapy	Stroke
Delirium	Chemotherapy	Cerebral palsy
Depression	Head and neck radiotherapy	Parkinson's disease
Amnesia	Palliative care	Muscular degenerative disease
	Polypharmacy	Mobility problems

18.3.1 Mouth care for patients with dementia

Patients with dementia can be supported by hospital staff to care for their mouths 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 toothbrushing difficult such as closing their lips, clenching their teeth, biting and moving their head (ADI, 2013).

Tips for delivering oral care include:

- Develop a routine, providing mouth care at the same time each day
- Taking time and being kind and patient
- Asking a carer/family member who is more familiar to the patient to help with providing mouth care
- Use short sentences and simple instructions and use reminders and prompts - sometimes placing a toothbrush in front of a patient will be a sufficient reminder
- Use the handle of a second toothbrush to improve access to the whole mouth
- Distraction with singing or by giving the patient something to hold in their hands
- A three-headed toothbrush if co-operation and access to the mouth is limited (see page 69)
- Hand-over-hand technique (carer's hand over the patient's hand), guiding the patient to brush their teeth
- A non-foaming toothpaste (SLS free) may be useful as it may be more tolerable
- Some patients with dementia may be very resistant to mouth care, it is important to stop and record that the patient is not compliant and try again at a different time or day

18.4 Mental Capacity Act

The Mental Capacity Act 2005 covers people in England and Wales who cannot make some or all decisions for themselves. The ability to understand and 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 have a legal duty to consider the Code

Providing dry mouth care to a patient with dementia

of Practice. 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 be the least restrictive on the individual's rights and freedom of action.

18.5 Learning disabilities and oral health

The oral health of people with moderate to severe learning disabilities has been found to be poorer than that of the general population. People with learning disabilities have been found to have poorer oral hygiene, consistently higher rates of untreated decay (Anders and Davies, 2010) and are more likely to have severe gum disease when compared to the general population (Scott, March and Stokes, 1998).

18.5.1 Mouth care for patients with learning disabilities

People with mild learning disabilities may need a simple reminder to brush their teeth daily. Those with moderate to severe learning disabilities may require more assistance or be fully dependent on another individual for all mouth care.

18.6 Mental health conditions and oral health

Mental health conditions can cause patients to lose motivation for personal hygiene including mouth care. This can cause a rapid development of decay and gum disease and can result in dental infection and pain (Brennan and Strauss, 2014).

It has been found that poor oral health status is significantly associated with depression and a decrease in toothbrushing (Park et al., 2014). In addition to their poor oral hygiene and oral health, Park et al. (2014) found that those with depression are less likely to receive treatment when they experience dental problems.

18.6.1 Mouth care for people with mental health conditions

People with mental health conditions may require motivation from hospital staff to encourage them to look after their mouths. This may include daily reminders and encouraging patients at different times of the day when they are more receptive.

18.7 Intensive care – ventilated patients and oral health

Ventilated patients are at an increased risk of developing ventilator-assisted pneumonia. Studies have shown that oral plaque can harbour respiratory pathogens (Scannapieco, Stewart and Mylotte, 1992) increasing their risk of ventilator-associated pneumonia. Oral hygiene care for such patients reduces this risk (Shi et al., 2013). There is a wealth of knowledge and clear guidelines for hospitals, intensive care wards and nursing staff to ensure that these critical care patients receive the correct mouth care measures to prevent further impact to their health (Tablan et al., 2004; NICE, 2008). Pneumonia carries a risk of mortality of up to 25% (cited in Sjögren et al., 2008) and it is therefore important that oral hygiene care is promoted for all hospitalised patients.

Access to the mouth due to space for cleaning can also be challenging in patients that are intubated. Toothbrushes should have a small head and a long handle. (p. 69)

The pressure of the endotracheal tubes can lead to the development of traumatic ulceration to the lips. There are many devices such as masks, fasteners and bite blocks on the market that are now used to prevent this.

18.7.1 Mouth care for ventilated patients

A Cochrane systematic review has found that oral care for ventilated patients using chlorhexidine mouthwash or gel reduces the risk of ventilated-associated pneumonia by 40% (Shi et al., 2013). A more recent study has concluded that the use of chlorhexidine for cardiac surgery patients can prevent the incidence of ventilator-associated pneumonia (VAP) but not for non-cardiac surgery patients (Klompas et al., 2014). Currently individual hospital trusts are reviewing their policies on the use of chlorhexidine.

Taking this evidence into consideration, mouth care for ventilated patients should include:

- Toothbrushing twice daily ideally with a non-foaming (Sodium Lauryl Sulphate (SLS free)) toothpaste to remove bacterial plaque
- The use of a small headed toothbrush or a suction toothbrush

- Dry mouth care with 2 hourly application of dry mouth gel to the mouth and lips (if required)
- Minimising traumatic ulceration caused by endotracheal tubes using specifically designed fasteners and bite blocks

18.8 Head and neck cancer treatment and oral health

Head and neck cancer patients present a unique group of patients whose oral care requires particular attention. Such cancers are often treated with radiotherapy directed at the tumour site, sometimes alongside the use of chemotherapy. Both of these treatment modalities greatly impact on the oral health of patients. It is reported that 40% of chemotherapy patients will experience oral mucositis (inflammation of the oral tissues) and many patients rate this as the most distressing aspect of their cancer treatment (UKOMiC, 2012).

18.8.1 Mouth care for head and neck cancer patients

Patients who have received radiation to the head and neck are also likely to have a dry mouth due to reduced salivary gland function. Dry mouth care, good oral health and a reduced sugar diet are important for these patients to minimise their risk of decay. Patients with mucositis may find that their mouth is too painful to brush their teeth; a soft toothbrush to clean the teeth and mouth along with application of dry mouth gel may help. See section 16.4 for other ways to help mange the symptoms of mucositis.

18.9 Stroke, dysphagia and oral health

Patients who have suffered a stroke are likely to have some physical disability, which could impact their oral care. More than a third of stroke patients reported difficulty with tooth cleaning; the degree of physical disability following stroke strongly relates to the degree of difficulty with tooth cleaning (Hunter et al., 2006). Furthermore, the physical weakness, lack of coordination and the cognitive problems that can accompany a stroke may prevent a person from maintaining good mouth care on their own (Brady et al, 2007).

Dysphagia (difficulty swallowing) has numerous causes, including stroke, and is most frequently seen in elderly patients. The reduced oral clearance (removing food from the mouth) in such patients negatively impacts their oral health and a study by Poisson et al. (2014) found that dysphagia was related to oral thrush, reduced saliva and dependency on others for oral care. When cleaning the mouth of a patient at risk of dysphagia, extra care should be taken to reduce the risk of a patient aspirating toothpaste or any debris that may be present in the mouth.

18.9.1 Mouth care for patients who have had a stroke

Tips for oral care for these patients may include:

- Support from carers and nursing staff
- If possible sit the patient in an upright or semi-upright position for toothbrushing
- If the patient is able to spit out following mouth care this should be encouraged
- Suction toothbrushes are available and may be used if the patient is has been assessed by a speech and language therapist and this is deemed to be necessary when carrying out oral care
- Hand-over-hand technique with the patient
- Regular dry mouth care
- Use the handle of a second toothbrush to improve access to the whole mouth. A mouth guard or finger prop may also be useful
- Consider adaptations to toothbrush handle (occupational therapists can help with this) or an electric toothbrush, which has a larger handle and is easier to use
- Use suction if you are trained to do so

Nursing staff should be aware and follow any special guidance from the speech and language therapy team relating to oral care for very high-risk patients.

18.10 Physical disability and oral health

Physical disability can be caused by a wide variety of diseases and illnesses and may impact on oral health in a number of ways. Physical disability that affects the hands and arms such as arthritis and paralysis, will inevitability affect an individual's ability to complete oral hygiene tasks (Avcu et al., 2005), which will in turn negatively impact their oral health status. Mobility problems can also mean that patients have difficulty accessing a sink area and prevent them from carrying out toothbrushing or denture care.

18.10.1 Mouth care for patients with physical disability

The level of assistance for mouth care will vary for patients and tips include:

- Ensuring that patients have access to a bowl and mouth care products (toothbrush etc.)
- Assisting patients who are unable to brush their own teeth or dentures
- Consider adaptations to toothbrush handle (occupational therapists can help with this) or an electric toothbrush, which has a larger handle and is easier to use

18.11 End of life care and oral health

The oral health of end of life and palliative care patients is crucial but is an area that has often been overlooked. End of life patients are susceptible to a range of problems with their mouths including dysphagia, dry mouth, thick mucus secretions, nutritional and taste problems, mucositis, and denture related problems. Poor oral health can have a big impact on the function and quality of life for these patients.

18.11.1 Mouth care for end of life patients

Mouth care for palliative care patients should seek to make the patient as comfortable as possible in the least invasive way:

- For patients with mouths use dry mouth gels or hydrate the mouth with a soft toothbrush dipped in water or with a fine water spray
- Twice daily brushing of teeth and gums using a fluoridated toothpaste and toothbrush
- Clean dentures at least once daily and remove and store in water overnight
- Prescription of topical pain relief for example Difflam (benzydamine hydrochloride) spray or mouth wash
- Regular removal of oral/dried secretions with gentle suctioning or a toothbrush/MouthEze cleanser

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A member of the Mouth Care Team saw a palliative care patient who had an extremely dry mouth, cracked lips and was in an emotionally distressed state. On assessing the patient's mouth there was a total absence of saliva, crusted mucous attached to the cheeks and palate and thick tenacious plaque on the patient's teeth.

The patient's mouth care consisted of the use of a pink foam swab and some pink coloured water to moisten the mouth (but this was not being recorded so it was uncertain how frequently this was being done). No toothbrushing was being carried out as nursing staff said that they were worried that the patient would not be able to tolerate this very well.

With the help of nursing staff, to help calm the patient, dry mouth gel was massaged into the patient's lips, cheeks and palate. The patient's mouth was also cleared of debris (using a MouthEze cleanser) and toothbrushing (using a toothbrush) was carried out.

Nursing staff were advised to apply dry mouth gel to the patient's lips and intra orally every 2 to 3 hours and were reminded of the importance of regular toothbrushing. A Mouth Care Recording Pack was completed and nursing staff were reminded of the importance of recording all mouth care on a daily basis.

On review, the patient was receiving the appropriate dry mouth treatment every 2 hours. Toothbrushing was being carried out daily and this was being appropriately recorded. Nursing staff reported that the patient now appeared to be more comfortable and was very welcoming of mouth care when given.

19

Having the ‘right tools’ for mouth care and assessment on the wards

Key messages

- Patients must be able to access the appropriate tools for effective mouth care
- A manual toothbrush with a small head and soft bristles is recommended for dependent hospitalised patients
- Dry mouth products can help with the common symptoms of dry mouth

Recommended mouth care products on the wards for all care staff:

- Pen torch (for nursing staff)
- Small-headed toothbrush
- Sodium Lauryl Sulphate (SLS) free toothpaste
- Dry mouth moisturising gels
- MouthEze cleanser
- Denture pot with a lid that is labelled with the name of the patient

One of the barriers that prevents hospitalised patients from receiving good effective mouth care is a lack of 'tools', or unsuitable products, for example, a soft bristled small-headed toothbush is more appropriate than a large headed hard bristled toothbrush for a palliative care patient with a sore mouth and limited mouth opening.

The following section describes recommendations for mouth care products based on experiences of the Mouth Care Matters team. The team have found for consistency and compliance it is better to limit the number of products (for example one type of toothpaste) but make sure the products available are most appropriate for hospitalised patients.

We recommend that where possible, patients should be encouraged to bring in their own mouth care products into hospital or ask a family member or carer to do this for them.

19.1 Pen torches

Rationale

It is essential to be able to see clearly into a patient's mouth. Without a light source it is impossible to fully assess the mouth and many conditions especially at the back of the mouth will be missed.

19.2 Toothbrushes

Rationale

A toothbrush used properly is the only tool that will remove bacterial plaque from the teeth and mouth.

Manual small headed

MCM recommends that hospitals stock small-headed toothbrushes for hospital patients. A small head is more effective at reaching all parts of the mouth. A soft toothbrush can be used for patients with very sore mouths, or those suffering from acute ulceration or mucositis. There are several companies that market small-headed toothbrushes for hospitalised/intensive care patients. An alternative is a children's toothbrush.

Adaptations can be made to toothbrushes to aid grip for people with poor manual dexterity; a small flannel can be wrapped around a toothbrush, for example. Some hospital occupational therapists will also be able to make adaptations to toothbrush handles for those with poor grip such as patients with arthritis or after suffering a stroke.

Three-headed toothbrush

A three-headed toothbrush (see page 69) can be used for patients whose cooperation with toothbrushing is limited. These toothbrushes simplify the toothbrushing technique by brushing multiple surfaces of a tooth at the same time, and therefore can be completed in less time. However, they are not as effective at removing dental plaque as normal manual or electric toothbrushes and should only be used as a last resort. Three-headed toothbrushes should be used with toothpaste and placed over the teeth. A forward-backwards motion is used to mechanically remove plaque from the teeth.

Aspirating toothbrush

An aspirating toothbrush is one that can be connected to the suction tubes; this will help to remove excess saliva or water from the mouth during toothbrushing. This may be particularly useful in unconscious or intubated patients who are at risk of aspirating. They should be used in the same way as a manual toothbrush using circular motions to clean all tooth surfaces. However, if a non-foaming toothpaste is used the need for aspiration toothbrushes is less.

Electric toothbrush

Electric or powered toothbrushes have many benefits and can be used if supplied by the patient. They often have small heads, which are ideal for cleaning all areas of the mouth. If the toothbrush has a rotating action, circular motions are not required and the toothbrush can be simply placed on the tooth surface with the bristles directed towards the gum margin and held there before moving onto the next tooth.

How to store a toothbrush

Ideally toothbrushes need to be stored so that the head can be air-dried following use. In hospitals, due to the number of spores in the air this is not feasible.

The cross infection team advises that toothbrushes should be covered. Ideally this would be in a covered container for air circulation rather than a plastic bag.

Product box

Barriers to mouth care:

75 year old Ranj was admitted to hospital and brought his powered toothbrush. He had problems with grip and could only clean his teeth adequately with this powered toothbrush. However there was nowhere for him to charge his toothbrush. A member of the mouth care team discovered this and was able to find a place on the ward where the toothbrush could be charged every few days.

Small headed toothbrush

Aspirating toothbrush

Three-headed toothbrush

19.3 Toothpastes

Rationale

To clean teeth and a source of topical fluoride to help strengthen teeth.

It is important that fluoridated toothpaste is used twice daily to help protect teeth against tooth decay. For adults, toothpaste should contain at least 1350ppm fluoride (or 1.1% sodium fluoride). A pea-sized amount should be used and it is important to "spit not rinse" (spit out excess toothpaste but do not risne out the mouth with water) to ensure that a film of toothpaste is left in contact with the teeth, allowing it to be absorbed. Patients should be advised not to eat and drink for at least 30 minutes after toothbrushing.

High fluoride toothpaste (e.g. Duraphat) with 2800ppm or 5000ppm fluoride may be prescribed by a doctor or dentist for patients who are at a high risk of dental decay. These toothpastes should be used in the same way as any other toothpaste.

Sodium Lauryl Sulphate (SLS) is the ingredient added to many toothpastes that makes them foam. This can have a drying effect on the oral tissues and therefore should be avoided in patients who already have a dry mouth. Similarly, for those patients at risk of aspirating, such as intubated patients, a SLS free toothpaste could also be beneficial so as to reduce this risk as far as possible.

We recommend that the hospital provides non-foaming toothpastes (Sodium Lauryl Sulphate (SLS) free) for patients with a dry mouth or patients who are at risk of aspirating. The table top right, details toothpastes that are SLS free. It is important to note that some toothpastes such as Oralieve contain proteins extracted from milk and therefore, will not be suitable for patients with a confirmed allergy to milk or vegans and this should be checked.

Patients who are edentulous (have no teeth) still need their mouths cleaned.

Brands of non-foaming (SLS free) toothpaste and the fluoride content

Sensodyne daily care gel	1450ppm
Sensodyne daily care	1450ppm
Oranurse unflavoured toothpaste	1450ppm
Sensodyne pronamel	1450ppm
Retardex toothpaste	1000ppm
Aquafresh children's little teeth	1400ppm
Oralieve moisturising toothpaste	1450ppm
BioXtra toothpaste	1450ppm
Biotene toothpaste	1000ppm

19.4 Foam swabs

Foam swabs have been used to frequently clean and hydrate the mouths of patients.

In 2012 the Medicines and Healthcare Regulations Agency (MHRA) published a medical device alert on the safety of oral swabs with a foam head and the risk of choking. The problem raised was that the foam heads could detach during use. In Wales a foam head had become detached when a carer was carrying out mouth care for an elderly patient. The foam head could not be retrieved and the patient subsequently died. Reports from the MHRA show that there continues to be regular reporting of foam head detachment. The alert advised not to use the swabs in patients who were likely to bite down and not to soak them before use.

19.4.1 Are mouth swabs needed for oral care?

Research shows that oral foam swabs are not an effective means to remove dental plaque and should not be used as an alternative to toothbrushing (Pearson, 2002). They tend to be used in patients with dry mouths to re-hydrate the mouth with water. Alternatively, they are also sometimes used for patients with excess secretions to help clear the mouth to reduce the aspiration risk.

Top Tip!

When placing a pea sized amount of toothpaste (smear on the brush head for dysphagia patients) on a toothbrush, press the paste into the bristles so it is less likely to fall off the brush.

19.4.2 Mouth Care Matters' findings

A survey carried out on nursing staff at Easy Surrey Hospital showed that foam swabs were used by 60% of staff. Observations by the mouth care team have seen on several occasions foam swabs being soaked in a variety of liquids on the wards, including fruit juice. Several nurses have reported at mouth care training sessions that part or all the foam heads have become detached while using them.

19.4.3 Alternatives to foam swabs

A small headed toothbrush is the best tool to clean the teeth, gums and tongue and can also be beneficial for dry mouths when soaked in water/dry mouth moisturising gels.

MouthEze 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 tenacious dried saliva. They are gentle enough to use on patients with sore mouths and yet strong enough, with a hard plastic handle, to reduce the choking hazard.

19.4.4 How to use a MouthEze cleanser

Start by checking the integrity of the MouthEze by tugging at the head. Hold the handle between your thumb and forefinger and roll between your fingers to create a rotating motion. They can also be used to apply dry mouth gels. For patients with excess saliva, MouthEze can be used along with suction. Manufacturers recommend that MouthEze cleansers should be changed every twelve hours. They should NOT be used to clean the teeth, a toothbrush is the most effective means of removing bacterial plaque.

Foam swab

MouthEze cleanser

Top Tip!

Some patients such as those with severe brain injury or dementia will have a strong bite reflex. Care must be taken with a toothbrush/MouthEze cleanser. Patients must be supervised unless they have been assessed as being able to use independently.

19.4.5 Dry mouth moisturising products

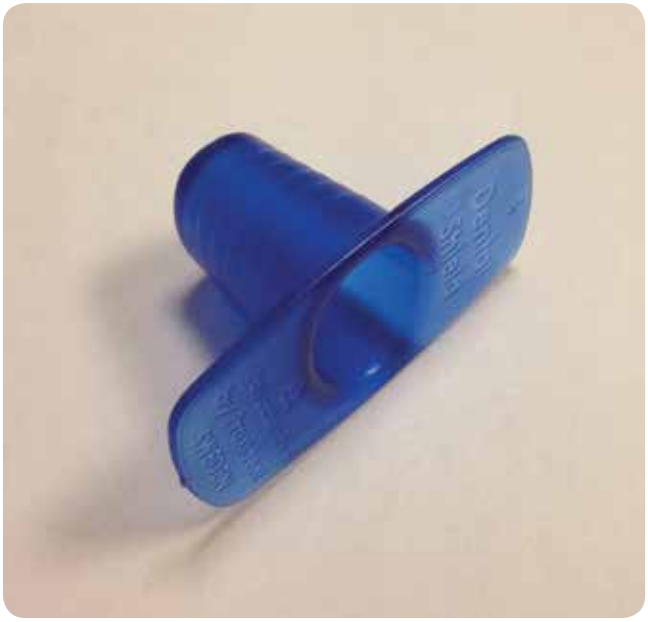
Rationale

To provide long lasting relief for a severe dry mouth and can be used to soften dried secretions so that they can be removed more readily.

There are different products available including gels, sprays and mouth rinses (see section 6.8).

Dry mouth moisturising gels can be massaged into all areas of the mouth (cheeks, palate, tongue) using a finger, toothbrush or MouthEze cleanser before meals to help with eating or before toothbrushing for very sore mouths. Dry mouth gels can be mixed with a couple of drops of water to make it more palatable to patients.

Dry mouth gel



Finger guard

19.5 Finger guard

Rationale

To prevent patients biting down on fingers during mouth care.

A finger guard is a solid plastic guard that can be used by carers to aid toothbrushing for those patients who lack compliance or those who find it difficult to keep their mouths open. It is placed between the patient's teeth, which will help with access for toothbrushing, and will also help to protect the fingers of the person assisting brushing.

19.6 Prescribed/on the advice of a dentist/ doctor

Chlorhexidine gluconate

Chlorhexidine can be prescribed but is also available over the counter as 'Corsodyl' mouthwash, gel or spray. Chlorhexidine is often used by patients with gum disease or following oral surgery as it has anti-bacterial properties. It is not suitable for routine use and should only be used on the advice of a dentist or doctor as long-term use can lead to staining of the teeth.

Despite its antibacterial activity, it does not penetrate dental plaque and therefore is no substitute for brushing the teeth twice daily with a toothbrush and toothpaste; the plaque that builds up on teeth daily needs to be removed mechanically with a toothbrush.

The alcohol free chlorhexidine should be used for patients with dry mouths or sore mouths. Chlorhexidine comes as a mouthwash, a gel or a spray. Up to 12 sprays can be given and should target the gum margin where the gum meets the teeth.

The action of chlorhexidine can be neutralised by ingredients in toothpaste and therefore they should not be used together.

If advised to use chlorhexidine mouthwash, gel or spray do not use at the same time as brushing with toothpaste. Leave an interval of 30 minutes.

Benzydamine hydrochloride

Also known as 'Difflam', Benzydamine hydrochloride may be prescribed to patients with a sore mouth to help ease their symptoms. It does not have an antibacterial effect like Chlorhexidine but an anti-inflammatory effect and is very useful for sore painful mouths. Benzydamine hydrochloride comes as a mouth rinse or a spray. Benzydamine hydrochloride can be prescribed or bought over the counter.

19.7 References

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20

Recording mouth care for hospitalised patients – The Mouth Care Pack

Key messages

- Every adult hospitalised for more than 24 hours should have a mouth care risk assessment completed to identify high risk patients
- Low risk patients should have their mouth re-assessed every seven days
- High risk patients should have a mouth care assessment on initial screening and all oral care must be recorded daily

Inconsistencies in recording mouth care

100 members of nursing staff at East Surrey Hospital were asked where mouth care should be recorded in the hospital notes. Responses varied including: skin bundle, hydration sheet, drug chart, and oral health risk assessment (however there was uncertainty as to where to find it). This was echoed in the 2014 East Surrey hospital CQC inspection, that recommended 'a review of mouth care is undertaken so that staff are clear where this should be recorded in the patient's care record'

20.1 Why do we need to record mouth care?

Recording mouth care is important for several reasons including:

- Identifying patients who are at higher risk of developing problems with their mouth
- Highlighting patients who need support with mouth care
- Compliance with Essence of Care 2010
- Recording daily mouth care and mouth care needs ensures continuity of care between different health care professionals
- An essential part of general care
- If it is not recorded, it can be assumed it is not being done

20.2 The tool - Mouth Care Pack

The Mouth Care Matters team have worked closely with the nursing staff at East Surrey Hospital to develop a Mouth Care Recording Pack that is comprehensive and achievable to use on a busy ward.

The recording pack consists of three parts:

- Mouth care screening (front page - to help identify high risk patients)
- Mouth care assessment (inside pages - to plan what support and care is needed)
- Daily recording sheet (back page)

20.3 Guide for completing the Mouth Care Pack

For patients who are in hospital for 24 hours or less

A Mouth Care Recording Pack does not need to be completed for patients who are in hospital for less than 24 hours.

For patients who are in hospital for 24 hours or more

A mouth care risk assessment should be completed for every patient that is hospitalised for more than 24 hours. The risk assessment will identify whether patients are at low risk or high risk for developing oral problems.

A low risk patient is someone identified as being independent with regards to caring for their mouth and not suffering from 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 (for example the patient has surgery).

A high risk patient should have a mouth care plan completed and all mouth care recorded on the daily recording sheet.

High risk groups include:

- Chemotherapy
- Delirium
- Dementia
- Dependant on oxygen use
- Dysphagia
- Frail
- Head and neck radiation
- ICU/HDU
- Learning difficulties
- Nil by mouth
- Palliative care
- Refusing food or drink
- Severe mental health
- Stroke
- Unable to communicate
- Uncontrolled diabetes

Patient Record Audit

An audit of patient notes at East Surrey Hospital was carried out to ascertain if there was any record of mouth care. We found that 15% of patient notes examined in this audit had a completed mouth care assessment, all of which were either from the intensive care or high dependency units. There was no evidence of any mouth care assessment or mouth care supportive measures in any of the notes examined from the other wards.

20.4 Completing the mouth care screening sheet

The mouth care screening sheet should be completed and signed by a registered nurse or a nursing assistant who has had mouth care training (ward based/classroom).

For patient privacy on a ward the curtains should be drawn.

Explain to the patient and ask permission before carrying out the risk assessment.

The questions on the form are very straightforward, any answers in the red section mean that the patient is high risk and needs to have a mouth care plan completed.

20.5 Notes on the mouth care screening sheet

Toothbrush and toothpaste

Ask the patient (carer if appropriate) whether they have their own toothbrush and toothpaste. Patients/carer/family should always be encouraged to bring in their own toothbrush and toothpaste. If the patient cannot answer, for example they are unconscious/sedated or do not have family/carer then they should be provided with a small-headed toothbrush and non-foaming toothpaste. This should be recorded on the form.

Dentures

Unfortunately dentures are known to go missing in hospitals and are not always removed from the patient's mouth during long hospital stays so it is important to know if they have dentures on admission. Again, patients should be encouraged to bring their own denture pot, denture cleaning brush and denture cleaning tablets if used. Patients are high risk if dentures are very painful in the mouth or broken. There are some patients who find it difficult to tolerate dentures and do not routinely wear them especially when in hospital and unwell. It is advisable, if possible, for dentures that are not worn to be taken home to a safe place by the patient's carer/family to reduce the chance of them getting lost during a hospital stay.

Existing mouth problems

Do they have existing problems with their mouth? The patient should be asked about pain and dry mouth. For any patient that is unable to answer due to cognitive problems/degree of sedation they should be deemed high risk and a mouth care plan needs to be completed.

20.6 Level of support

The level of assistance for mouth care required by the patient from nursing staff should be assessed on an individual basis and not assumed. (For more information about assessing patient independence, see section 21).

Fully dependent

Patients who are fully dependent on another person for mouth care include people who are unconscious, have severe learning disabilities, late stage dementia etc.

Some assistance

Examples of patients that need some assistance are those with a physical disability that may affect their manual dexterity for example a Parkinson associated tremor or arthritis or those with a mild learning disability that need reminding about toothbrushing.

Independent

Independent patients are able to look after their mouth and dentures on their own. It must be appreciated that some patients think, or do not want to disclose, that they might need some help with care including mouth care. Hospital staff should to be sympathetic to these patients. Patients should be assessed as being independent if they can get out of bed, walk to the bathroom and brush their teeth without assistance.

Additional comments

Actions or comments may include relevant information for example the patient's mouth care routine is supported by a named carer, they have an electric toothbrush or they are more cooperative at certain times of the day.

Mouth care pack

Mouth Care Matters

NHS
Health Education England

Mouth Care Pack

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

Mouth care screening sheet

Patient name	
D.O.B	
MRN Number	
NHS Number	

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

1. Patient has:

Toothbrush	Y ☐	N ☐	Provided ☐
Toothpaste	Y ☐	N ☐	Provided ☐
Upper denture	Y ☐	N ☐	At home ☐
Lower denture	Y ☐	N ☐	At home ☐
Denture pot	Y ☐	N ☐	Provided ☐
No teeth	Y ☐	(Patient will still require mouth care)	

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

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

Severe dry mouth	Y ☐	N ☐
Ulcers	Y ☐	N ☐
Painful mouth	Y ☐	N ☐
Painful teeth	Y ☐	N ☐
Sore tongue	Y ☐	N ☐

Other ☐ (please specify):

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

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

4. Level of support: Requires risk assessment; Unable to get to a sink/needs assistance

Patient is fully dependent on others for mouth care ☐

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

Patient requires some assistance ☐

Unable to get to a sink or needs help with mouth care. Record all mouth care on the daily recording sheet

Please state the assistance patient requires: (i.e: bowl, encouragement, reminder, remove dentures etc)

Patient is independent ☐

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

20.7 Mouth care assessment (middle pages of the mouth care pack)

This section needs to be completed once a week or if the patient's situation changes, for example if a patient is admitted to intensive care and intubated they would become high risk.

The form should be completed and signed by a registered nurse or a nursing assistant who has had mouth care training.

For patient privacy on a ward the curtains should be drawn.

It is very difficult to look inside the mouth without adequate lighting. The bedside lamp should not be solely relied on for light. A pen torch can provide sufficient lighting for assessing a patient's mouth.

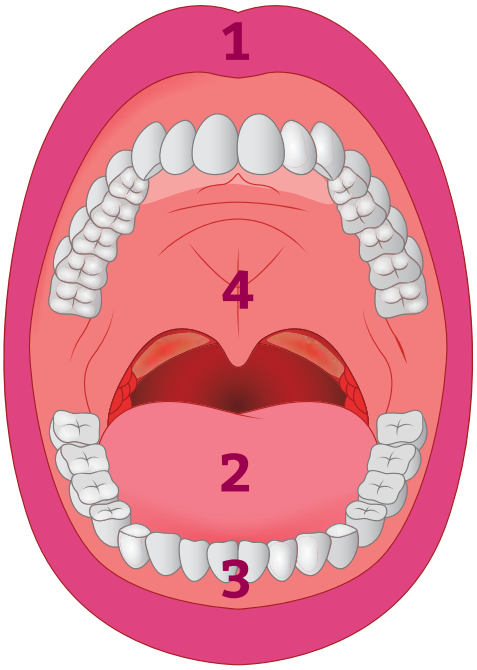
Wear disposable gloves. Although not strictly necessary we have found that some staff prefer to also wear a disposable apron and a mask when carrying out mouth care.

The form assigns a low, medium or high risk to patients, assesses different parts of the mouth (lips, tongue, gums, saliva, visible teeth, dentures and mouth cleanliness) and recommends any actions necessary.

Advice on dry mouth care, ulcer care and denture care is provided on this page.

Looking in the patient's mouth

Start with the lips and look in the mouth in a systematic way:



1 Lips: Pink & moist

2 Tongue: Pink & moist

3 Teeth & Gums: Clean, teeth are not broken or loose

4 Cheeks, palate, under the tongue: Clean, saliva present, looks healthy

5 Dentures: Clean & comfortable

Mouth care assessment

Mouth Care Matters

NHS
Health Education England

Mouth care assessment

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

Patient name	
D.O.B	
MRN Number	
NHS Number	

Look in the patients mouth using a light source and carry out a weekly mouth care assessment. Mark as L, M or H in the white box.

	Low risk (L)	Medium risk (M)	High risk (H)	Date	Date	Date	Date	Date
Lips	• Pink & moist	• Dry/cracked • Difficulty opening the mouth	• Swollen • Ulcerated					
Action	None	Dry mouth care	Refer to DOCTOR					
Tongue	• Pink & moist • Clean	• Dry • Fissured/shiny	• Looks abnormal • White coating • Very sore • Ulcerated					
Action	None	Dry mouth care	Refer to DOCTOR					
Teeth & gums	• Clean • Teeth not broken • Teeth not loose • Gums not bleeding • Gums not inflamed	• Unclean • Broken teeth (no pain) • Bleeding gums • Inflamed gums	• Severe pain • Facial swelling					
Action	2 x daily tooth-brushing	2x daily toothbrushing & clean the mouth	Refer to DOCTOR or DENTAL TEAM	Advise the patient to visit their dentist on discharge if there are any problems with their teeth that do not require urgent treatment in hospital				
Cheeks, Palate & under the tongue	• Clean • Saliva present • Looks healthy	• Mouth dry • Sticky secretions • Food debris • Ulcer < 10 days	• Very dry/painful • Ulcer > 10 days • Widespread ulceration • Looks abnormal					
Action	None	• Clean the mouth • Dry mouth care • Ulcer care	Refer to DOCTOR	An ulcer present for more than **2 weeks** must be referred to the doctor				
Dentures	• Clean • Comfortable	• Unclean • Loose • Patient will not remove	• Lost • Broken and unable to wear					
Action	Clean daily	• Denture care • Denture fixative • Encourage removal	DATIX if lost or refer to the DENTAL TEAM if broken	Remember to place the denture sunflower at the patients bedside. Advise the patient to visit their dentist if the denture is loose				

*For patients who are unable to communicate or cooperate with a mouth care assessment, some signs of a mouth related problem may include; not eating/drinking, facial swelling & behavioural changes.

Signed:

Dry mouth care

Frequent sips of water unless nil by mouth Moisturise dry mouth gel onto the tongue, cheeks and palate

Hydrate with a moist toothbrush

Apply lip balm to dry lips

Keep mouth clean

Ulcer care

Rinse mouth with saline

Anti-inflammatory mouth spray – discuss with doctor

ULCER PRESENT FOR MORE THAN **2 WEEKS**; REFER TO DOCTOR

Denture care

Advise the patient to leave denture out at night in a named denture pot with a lid

If the patient has oral thrush, soak in chlorhexidine (0.2%) mouthwash for 15 minutes twice a day, rinse thoroughly and encourage the patient to leave the denture out whilst the mouth heals

20.8 Daily recording sheet

This sheet is for staff to record any mouth care procedures carried out by hospital staff, for example dry mouth care, toothbrushing and denture hygiene. It also enables staff to record if patients have not had daily mouth care/assessment carried out for reasons including poor compliance, having another procedure carried out or being asleep. This section of the pack should be completed as many times as necessary during the day. For instance some patients will require two-hourly dry mouth care while others may only need assistance with cleaning their dentures once a day.

If you refer a patient for mouth related problems, mark as medical referral (MR) on the daily recording sheet. It is important to record a patients refusal (R) for mouth care, if it becomes consistent, medical advice should be sought and a mouth care assessment carried out.

20.9 References

Department of Health (2010) Essence of Care 2010: benchmarks for the fundamental aspects of care. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216691/dh_119978.pdf (Accessed 21st August 2015).

A member of the mouth care team saw a 101 year old lady who had been an in-patient at the hospital for six days. The patient did not have dementia and was not confused but she did need assistance with her oral care because she was very frail, had limited mobility and was at risk of falling. The patient complained of a sore palate and a sore dry tongue. The patient was wearing an upper denture and still had her own lower teeth. The patient reported that since she had been admitted to the hospital nobody had helped her clean her teeth or her denture and that she had not removed her denture since being admitted. The patient said that when she is at home she brushes her teeth and denture once daily and removes her denture at night and soaks them in water. There was no toothbrush, toothpaste or denture pot present in the patient's room and the patient said that nobody had asked her about her oral care since she had been admitted to the hospital. The patient was asked if she had requested help with oral care and she said that she didn't like to trouble the nurses because she knows that they are very busy.

The patient was asked if she would like help with cleaning her teeth and denture and she was very grateful. She was provided with a toothbrush, toothpaste and named denture pot. The patient's denture, which was very dirty, was removed and cleaned using a toothbrush and some liquid soap. The patient's teeth were cleaned and a mouth care risk assessment and mouth care recording pack were completed. The patient was identified as having a dry mouth and dry mouth gel was applied to the patient's tongue and palate. The patient was advised to remove her denture at night and that this should be placed into a denture pot in clean water to allow her palate a chance to recover.

Daily recording sheet

Mouth Care Matters

NHS
Health Education England

Daily recording sheet

A Assessment completed
BP Bowl provided
DC Denture care
DMC Dry mouth care
TB Toothbrushing
PR Patient refused (>3 days explain actions)
R Referral (Explain actions)

Patient name	
D.O.B	
MRN Number	
NHS Number	

Date	Time	Action	Signature	Print name

21 Assisting patients with mouth care

Key messages

- Hospitalised patients will require a different level of assistance with their oral care
- A patient's independence and ability to perform everyday tasks may change throughout their hospital stay
- It is not always obvious that some patients need help

21.1 How to distinguish between independent and dependent patients?

Patients should be assessed as to their level of independence in terms of providing self-care, including toothbrushing. Hospitalised patients are often less independent than they would be at home, usually as a result of their illness; they may feel too unwell and lack the energy and desire to clean their teeth; or they may have reduced mobility and are unable to get to the bathroom to clean their teeth. It is therefore important to ask and not assume that a hospitalised patient is able to brush their teeth. Often, simply bringing the patient a bowl will allow them to carry out their normal oral hygiene routine at bedside.

It is important to assess the patient's ability to grip, hold and use a toothbrush. Electric toothbrushes that have a larger handle may be more beneficial for patients who have difficulties with their grip; adaptations can also be made to manual toothbrushes, which can increase the patient's independence in carrying out daily tasks. If necessary, seek help and advice from an occupational therapist or a dental professional.

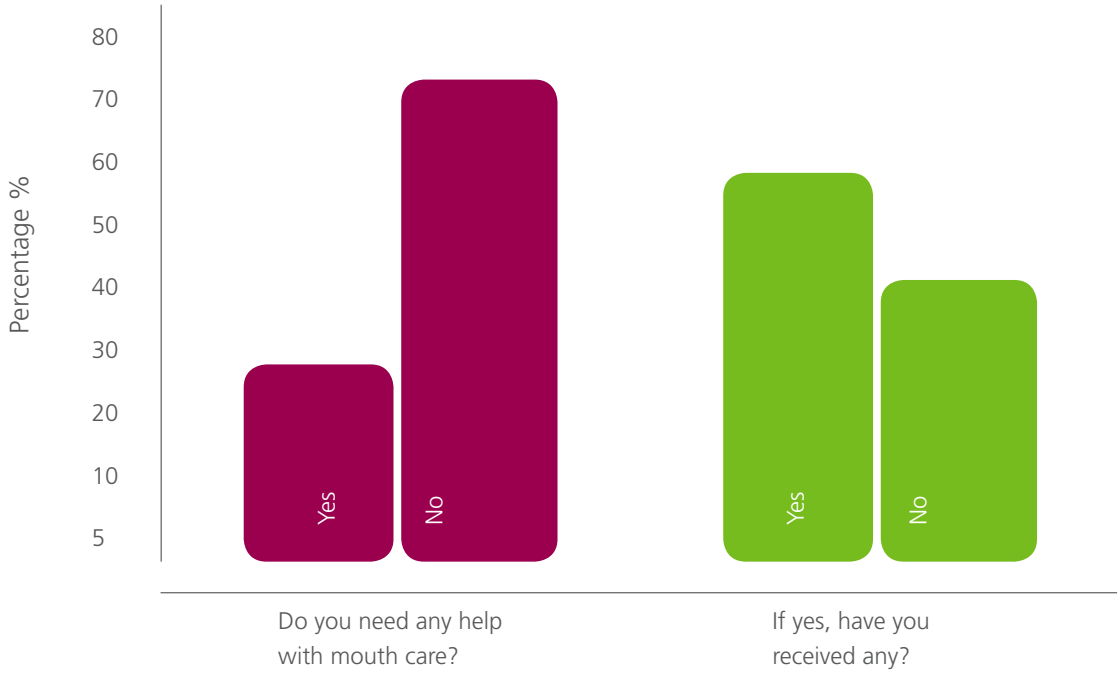
21.2 Different types of assistance

Patients may require different levels of assistance; it could be as simple as prompting and reminding them to brush their teeth or using the hand-over-hand technique as discussed (see section 18). It is important to assist patients with their mouth care in a way that maintains their independence as it provides them with a sense of achievement and worth. This in turn impacts on a patient's sense of wellbeing, helping a person to remain independent also ensures patient dignity in care.

For some patients, particularly those who lack cooperation with mouth care or those with learning disabilities, assistance from visiting family members or carers may help to gain compliance with oral hygiene. It may be necessary to find out how mouth care is ordinarily provided for the patient.

We asked some patients on the wards about their oral care and oral health whilst in hospital and found that:

- 20% were currently experiencing problems with their mouths
- 12% did not have a toothbrush and toothpaste with them in hospital
- Almost 1 in 3 required help with their oral care (see below)



21.3 Cross infection control

Personal Protective Equipment (PPE) should be worn by nursing staff/healthcare assistants when providing or supporting a patient with mouth care.

Hand hygiene should be carried out and the following PPE used:

Plastic apron

Disposable gloves

Face mask and protective glasses (if desired)

Hand washing technique

21.4 Key messages in steps

Dry mouth care

- Hydration with frequent sips of plain water (unless patient is nil by mouth or on fluid restriction).
- Application of dry mouth moisturising gels. These can be applied as necessary and for severe dry mouths recommended two hourly. The gels can be applied with a gloved finger, toothbrush or MouthEze cleanser to all areas of the mouth including the cheeks, the tongue and the palate.

Toothbrushing

- Where possible patients should be encouraged to sit up.
- Toothbrushing should be carried out twice daily.
- A toothbrush with a small head is recommended for patients in hospital.
- A pea sized amount of toothpaste should be used for patients with no swallowing problems.
- A smear of non-foaming SLS free toothpaste should be used for patients with swallowing problems (dysphagia) and paste should be pressed into the bristles of the brush.
- Patients should be encouraged to spit out but do not rinse the mouth out afterwards to maximise the contact of fluoride on teeth.

Toothbrushing on a patient

Using the MouthEze stick with dry mouth gel

22 Denture care

Key messages

- Dentures should be cleaned at least once daily with a denture brush or toothbrush and soap
- Dentures should be removed at night and stored in water, in a labelled denture pot
- An incident reporting form must be completed by the ward for every lost denture

22.1 Changes in denture demographics

The oral health of the nation has greatly improved over the last 50 years and as a result, we are keeping our teeth for longer. This means that dentures are far less common than they used to be, with only 6% of the population having no teeth at all (edentulous) in 2012 compared to 37% in 1968 (ADHS, 2009). It is far more common now to see patients who have some natural teeth with missing teeth replaced with a partial denture.

22.2 Types of dentures

There are two main types of dentures:

Complete/full or partial

Acrylic/plastic or metal

A complete denture is one that replaces all the teeth in one arch as there are no teeth remaining. A partial denture is made when only some of the teeth are missing and the patient still has some natural teeth remaining.

Full acrylic denture

Partial acrylic denture

Partial metal denture

Some dentures may be retained in the mouth via implants that are placed in the jaw bone (see picture below). These implants will need to be cleaned in the same way that teeth are cleaned and the dentures will need to be removed and cleaned in the same way as any other denture.

22.3 Importance of denture hygiene

Denture hygiene is important to ensure good oral health. Food debris and plaque can easily accumulate on dentures and needs to be removed daily. In the case of partial dentures, plaque left on dentures can lead to an increased risk of decay in the remaining teeth. Dentures, in particular acrylic dentures, can harbour microorganisms such as candida, which can cause oral thrush that is commonly referred to as denture stomatitis when under a denture.

Denture stomatitis

22.4 Denture fixative

Denture fixative is often used to help increase the retention and comfort of dentures. It is available to buy over the counter and should be removed daily from both the denture as well as the patient's mouth using a denture brush and toothbrush respectively.

22.5 Removing and replacing dentures in the mouth

Dentures should be removed at night, cleaned and stored in water in a labelled denture pot. Not all patients will be willing to follow this advice and it is important to respect the patient's decision if this is the case. Keeping the denture out overnight will help to reduce the patient's risk of oral candida.

Patients are often able to remove their own dentures - just ask. Some patients might have difficulty, so to assist them, remove dentures by sliding a gloved finger by the side of the dentures to help break the seal between the mouth and the denture.

22.6 Lost dentures

Dentures can unfortunately get lost during a patient's hospital stay, often whilst a patient is in transit between wards. They may also be left on dinner trays or thrown away as patients sometimes wrap them in tissue, which can be easily mistaken for rubbish. To keep dentures safe, patients sometimes keep them under their pillow or in their pyjamas and they can accidently be disposed of when the linen is changed. For this reason, it is important that patients are encouraged to use their denture pots to store their dentures when they are not in their mouth.

Dentures take approximately 6-8 weeks to make with the patient needing to attend the dentist for five appointments. An NHS denture costs the patient £237 and private dentures can cost considerably more. A lost denture can therefore impact the patient in a number of different ways, including their ability to eat, speak and socialise.

If dentures are lost, an incident reporting form (DATIX) should be completed by the nursing staff on the wards.

22.7 Cleaning dentures

Dentures should be cleaned at least once daily but ideally after every meal. If the patient is unable to do this themselves, care staff should complete denture cleaning as follows:

- Carry out hand hygiene and use patient protective equipment (PPE) including disposable gloves and apron
- Fill a disposable bowl with water
- Remove the dentures from the patient's mouth
- Use a denture brush or a soft toothbrush. If the patient has natural teeth, this should not be the patient's toothbrush but a different brush
- Use a specially formulated denture cleaning paste or a fragrance-free liquid soap applied to the brush to remove plaque and food debris, ensuring to brush all surfaces of the denture and paying particular attention to any clasps. Toothpaste should not be used as this can be abrasive and can wear the denture away
- Rinse the denture well with cold water
- Either return to the patient or store overnight in a labelled denture pot filled with fresh, cold water
- Remove PPE and carry out hand hygiene

If the patient has partial dentures, they will also have their own natural teeth that will need to be cleaned twice daily.

If the patient has both upper and lower complete dentures, the patient should be encouraged to rinse out their mouth with either water or mouthwash to remove any remaining food debris.

For patients with oral thrush under a denture (denture stomatitis) the denture should be soaked in Chlorhexidine 0.2% for 15 minutes and rinsed thoroughly before being placed in a named denture pot or back in the mouth.

Regardless of whether the patient has partial or complete dentures the rest of the mouth needs to be cleaned twice daily with a small-headed toothbrush.

An older male patient was recovering from pneumonia in hospital. He had a lower denture with clips, that replaced his back teeth. He was very weak and was unable to remove his denture during his stay. This had not been identified by the nursing staff. He was reviewed by the mouth care team as he had a sore mouth. When the denture was removed it was covered in food debris and mould. The denture was cleaned and the staff were shown how to assist the patient remove, clean and replace the denture on a daily basis. The denture was quite tricky to remove and this highlighted the importance of ward based training for hospital staff.

22.7.1 Cleaning dentures flow diagram

(optional)

22.8 The denture sunflower

The denture sunflower

To try and reduce the number of dentures being lost in hospital, Mouth Care Matters have devised a simple solution. When a patient is hospitalised and has a denture(s), the nursing staff asks them if a sunflower sign can be placed above their bed. This symbolises to staff, without affecting the patient's dignity, that they have a denture. The symbol will act as a visual aid for nursing and hostess staff to check for dentures wrapped up in tissues on a meal tray or hidden in bed linen to reduce the risk of them being accidently disposed of.

23 Dental referrals

Key messages

- Hospitals should have a pathway for urgent dental referrals for inpatients
- Patients with non urgent problems that are not impacting on their every day life should be advised to see a dentist on discharge
- If a patient does not have a dentist they (or their carer) should be advised to call 111

23.1 Urgent and non-urgent referrals

During a hospital stay it may be necessary for a patient to be referred for dental advice/treatment.

Referrals will either be urgent (needs to be treated whilst in hospital) or non urgent (should be advised to see a dentist on discharge).

It is important that all hospitals have a pathway for patients that require urgent advice/treatment that might impact on their overall condition and hospital stay.

An urgent referral for a hospitalised patient includes:

- **Severe dental pain affecting sleep, eating and drinking**
- **Dental infection (facial swellings, pus adjacent to teeth)**
- **Trauma to teeth (might be after a fall)**
- **Teeth that are so mobile they may be an aspiration risk**
- **Broken/lost dentures**
- **Ulcers caused by trauma from broken teeth/ dentures**

A non-urgent problem that does not need a referral includes:

- **Broken teeth/filling/dentures that are not painful (for some groups of patients such as people with severe dementia or severe learning disabilities, it may not be possible to know if they are in pain and they should be referred to appropriate services such as special care dental service)**
- **Loose dentures**
- **Cosmetic dentistry**

Patients with non-urgent problems should be advised to see their dentist. If they do not have a dentist they should call 111 who will be able to advise them on how to find a local dentist.

Some hospitals will have on site dental or maxillofacial units that can provide urgent treatment for inpatients. Others will not but there should be a pathway in place to get dental advice on the phone or for domiciliary care in hospital.

24

Drugs that cause dry mouth (xerostomia)

Analgesic
Morphine
Antianxieaty
Doxepin
Hydroxyzine
Antidepressant/Anxiolytic
Amitriptyline
Citalopram
Clomipramine
Doxepin
Fluvoxamine
Fluoxetine
Imipramine
Mirtazapine
Nortriptyline
Paroxetine
Sertraline
Trazodone
Trimipramine
Venlafaxine
Antidiarrheal
Co-phenotrope
Loperamide
Antiemetics
Cyclizine
Prochlorperazine
Hyoscine
Antiepileptics
Carbamazepine
Gabapentin
Lamotrigine
Antihistamine
Cetirizine
Chlorphenamine
Clemastine
Cyproheptadine
Diphenhydramine
Hydroxyzine
Loratadine
Promethazine
Triprolidine with pseudoephedrine
Antipsychotic
Chlorpromazine
Clozapine
Fluphenazine
Haloperidol
Lithium
Olanzapine
Perphenazine
Pimozide
Prochlorperazine
Trifluoperazine
Antispasmodic
Flavoxate
Hyoscine
Oxybutynin
Propantheline
Tolterodine
Bronchodilator
Ipratropium
Ipratropium/Salbutamol
Cardiovascular
Amlodipine
Atenolol
Captopril
Carvedilol
Doxazosin
Enalapril
Fosinopril
Lisinopril
Methyldopa
Metoprolol
Moexipril
Nadolol
Perindopril
Prazosin
Quinapril
Ramipril
Terazosin
Trandolapril
Decongestant
Pseudoephedrine
Antiparkinsonian
Amantadine
Bromocriptine
Co-careldopa
Entacapone
Orphenadrine
Procyclidine
Selegiline
Tolcapone
Trihexyphenidyl
Muscle Relaxant
Baclofen
Proton Pump Inhibitor
Omeprazole
Lansoprazole
Smoking Control
Bupropion
Diuretic
Amiloride
Indapamide
Triamterene
Hypnotic/Sedative
Temazepam

*There are over 400 drugs that can cause a dry mouth

25 MOUTHS

Key messages

- An acronym designed to help remember the six key points for carrying out good mouth care

25.1 What is MOUTHS?

By using MOUTHS in patients daily mouth care routine, their overall dignity and wellbeing will be greatly improved.

Mouth Care Pack after 24 hours of admission

Oral assessment

Unhealthy mouth & the affects on nutrition, hydration & dignity

Tools & products

Help & level of support

Sunflower & denture care

26 Contact

Contact

Email: mouthcarematters@ncel.hee.nhs.uk
Twitter: @MCM_HEKSS

Surrey and Sussex Healthcare NHS Trust
www.surreyandsussex.nhs.uk

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www mouthcarematters.hee.nhs.uk

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