abc

|  |  |  |
| --- | --- | --- |
| **NAME:** | **D.O.B:** | **NHS NO:** |
|  |  |  |

**1. LONG TERM RISK FEEDING PATHWAY** Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_

**The above named patient is at high risk of aspiration, choking, malnutrition and dehydration as a result of poor swallowing.**

**Therefore, they are continuing with oral intake, as they are not appropriate for non-oral feeding due to** (tick all those applicable):

|  |  |  |
| --- | --- | --- |
|  |  | Go to section |
|[ ]  Patient has declined artificial nutrition and hydration | 2 |
|[ ]  Palliative Care (e.g. poor prognosis / short life expectancy) | 3 |
|[ ]  Procedure risks outweigh benefits e.g. PEG / RIG | 3 |
|[ ]  Unable to tolerate non-oral feeding attempts | 3 |
|[ ]  Quality of life best interest decision (lack of capacity already documented) | 3 |
|[ ]   Medical Team have deemed patient inappropriate for alternative nutrition and hydration | 3 |

**2. SUMMARY OF CAPACITY**

|  |  |  |
| --- | --- | --- |
| The patient is able to: | **Yes** | **No** |
| * Understand the information relevant to the decision
 |[ ] [ ]
| * Retain that information
 |[ ] [ ]
| * Use or weigh that information as part of the process in arriving at the decision
 |[ ] [ ]
| * Communicate the decision
 |[ ] [ ]

Results of the above assessment to determine if this patient has capacity in making decisions regarding nutritional management, indicate that this patient:-

 [ ]  does have capacity, or

 [ ]  does not have capacity.

Name of Assessor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| * If a patient lacks capacity a best interests discussion / decision meeting has been held and documented in the notes
 |[ ] [ ]
| * Feeding with the associated risk of possible aspiration pneumonia has been discussed with the patient/patients family/Lasting Power of attorney (LPA), Independent Mental Capacity Advocate(IMCA)
 |[ ] [ ]
| * Recommendations to reduce (but not eliminate) risk of aspiration have been discussed with patient/ LPA / patients family/IMCA :-
 |[ ] [ ]

**3. PATIENT’S OR ‘BEST INTEREST’ DECISION FOR ORAL INTAKE:**

**STRATEGIES**

* Optimal positioning
* 1:1 carer feeding
* Ensure as alert as possible
* Regular mouth care (minimum 3 x daily)
* Other:

**DIET**

* **Purée** (Texture C / Level 4 food)
* **Minced & Moist** (Texture D / Level 5 food)
* **Soft & Bite-size** (Texture E / Level 6 food)
* **Easy Chew options**

from the normal menu

* **Normal diet**

**FLUIDS**

* **Thin fluids** (normal)
* **Level 1 fluids**
* **Level 2 fluids**
* **Level 3 fluids**
* **Level 4 fluids**

See thickener instructions on the tin for how to thicken.

* **Medications needed in an appropriate form for patient to swallow**

**4. MEDICAL MANAGEMENT FOR PATIENTS WHO ARE FEEDING AT RISK**

**Checklist of patients on the Risk Feeding pathway:-**

**Please ensure all sections are completed.**

a. Patient will be treated for an aspiration induced infection Yes [ ]  No [ ]

Comments

b. If such infections recur patient will continue to be treated with antibiotics Yes [ ]  No [ ]

Comments

c. If patient has an aspiration induced infection they will be admitted to hospital Yes [ ]  No [ ]

Specify which hospital:

d. Medical team to ensure Risk Feeding management plan is handed over to discharge destination at time of discharge from hospital.

**5. DOCUMENTATION & DISSEMINATION OF RISK FEEDING:-**

|  |
| --- |
| [ ]  Electronic Discharge Summary Date: \_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Lorenzo “Swallow Alert” for Risk Feeding Date: \_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  **File this form in patient’s Medical Notes** |

|  |
| --- |
| Doctor’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_Doctor must discuss with senior medical colleague of ST3 or above**(If involved…)**Speech & Language Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ |

Please contact Speech & Language Therapy if the management plan or risk feeding decision changes.