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| **Name:**  Appendix B to Risk Feeding Policy  **Risk Feeding Proforma**  **D.O.B**  **Hosp no:** | | |
|  |  |  |

**1. Long Term Risk Feeding Pathway**

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

**However, they are continuing with oral intake at risk, for the following reasons** (tick all that apply):

**Patient has expressed wish** to:

* decline Artificial Nutrition & Hydration (ANH)..…………………..…………….*go to section* ***2***
* decline SaLT safe swallow recommendations……………………...…..……..*go to section* ***2***
* choose to continue to eat & drink at risk alongside ANH…………...…..……*go to section* ***2***

**Medical team** have deemed ANH is not appropriate for this patient due to:

* palliative care (e.g. poor prognosis, end of life)……………………...……..…*go to section* ***3***
* procedure risks of ANH outweigh benefits……………..…….……...……..….*go to section* ***3***
* patient has not tolerated non-oral feeding attempts……………………….….*go to section* ***3***

**‘Best Interest’ decision** has been made (lack of capacity already documented)

* for oral intake/feeding at risk (for quality of life)……………………………...….*go to section* ***3***

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**2. Capacity Status** Is there a reason to **doubt** this patient has capacity? **Yes**, **No** *go to section* ***3***

|  |  |  |
| --- | --- | --- |
| Is the patient is able : | **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 above assessment (to determine if this patient has capacity in making decisions regarding nutritional management) indicate that this patient:  **has capacity**,  does **not** have capacity.

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

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

**3. Oral Intake Decision: Patient’s choice, or Best Interest & least restrictive option for oral intake**

**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.

**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**

**STRATEGIES**

* Position:
* 1:1 carer feeding
* Alert & not distracted
* Regular mouth care (minimum 3 x daily)
* Other:
* **Medications needed in an appropriate form for patient to swallow**

**4. Medical Management for Patients who are Risk Feeding**

**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 Decision:-**

|  |
| --- |
| 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: \_\_\_\_\_\_\_\_\_ |

Contact Speech & Language Therapy (ext 3571) if the management plan or risk feeding decision changes.