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.