**Choking and Aspiration Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB here |
| --- | --- | --- | --- |
| **These are my diagnoses related to choking and aspiration:** | List all diagnoses related to choking and aspiration |
| **I am allergic to these things:** | List all known allergies and sensitivities, or note if there are none |
| **The goal of this Healthcare Plan is:** | [ ]  I will remain free of signs/symptoms of aspiration for the duration of the ISP year.[ ]  I will not experience any aspiration pneumonia for the duration of the ISP year.[ ]  I will eat meals and snacks safely to avoid choking and aspiration for the duration of the ISP year.[ ]  Describe any other goal related to managing my choking/aspiration. |
| **Progress in the past year:** | What has my choking/aspiration status for the past year been as compared with the year prior? |
| **My choking and aspiration risk is:** | [ ]  Low | [ ]  Moderate | [ ]  High |
| **These are the things you might see me do that make it more likely I will choke or aspirate:** | [ ]  I eat too quickly.[ ]  I shovel food into my mouth.[ ]  I hold food in my mouth without swallowing it (pocketing or cheeking).[ ]  I talk or vocalize when I am eating.[ ]  I have a hard time chewing.[ ]  Other Describe any other things I do that put me at risk, or indicate NONE OF THE ABOVE |
| **In an EMERGENCY****Call 911 IMMEDIATELY and begin CPR if I:****🡪 Have difficulty breathing or stop breathing****🡪 Turn blue****🡪 Lose consciousness (becomes unresponsive)****🡪 When instructed by nurse****🡪 Describe any additional instructions here** |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL** **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **These are some things you should know about me that make it more likely I will choke or aspirate.** | [ ]  I have difficulty swallowing (dysphagia).[ ]  I have aspirated in the past and/or been diagnosed with aspiration pneumonia.[ ]  I have a feeding tube.[ ]  I have no teeth. (I am edentulous.)[ ]  I have GERD (reflux).[ ]  I have seizures.[ ]  Other Describe any other conditions I have that put me at risk, or indicate NONE OF THE ABOVE |
| **If you see any of these signs and symptoms, I might be choking or aspirating:** | [ ]  Coughing/gagging during meal and up to 2 hours after meal[ ]  Drooling a lot[ ]  Vomiting after meals[ ]  Food is falling out of my mouth | [ ]  Watery eyes[ ]  Wheezing/chest congestion[ ]  Other Describe any other signs that might mean I am choking or aspirating, or indicate NONE OF THE ABOVE |
| **These are the supports I need reduce my risk of choking and aspiration during meals and snacks.** |
| **Positioning:** Describe how I should be sitting during meals and snacks, including positioning equipment used, such as wheelchair, and how long I should remain upright after eating, or note if there are no specific requirements.  | **Mealtime Equipment:**[ ]  Utensils Describe[ ]  Cup Describe[ ]  Plate Describe[ ]  Bowl Describe[ ]  Mat Describe[ ]  Other Describe, or indicate NONE OF THE ABOVE | **Food Texture:** Describe texture of food it is safe for me to eat, e.g., whole, chopped, ground, pureed, or note if there are no restrictions**Liquid Consistency:** Describe the consistency of liquids that are safe for me to drink e.g., thin, nectar, honey, pudding, or note if there are no restrictions |
| **These are foods I should not eat:** List any foods identified as unsafe for me, or note if there are no restrictions  | **These are beverages I should not drink:** List any liquids identified as unsafe for me, or note if there are no restrictions |
| **This is how you support me during meals and snacks:** Describe how people support me to safely eat and drink. Include a description of where my supporter should be while I am eating and what my supporter should be doing. If I should wait a certain time between bites, note that here. If I should take a drink after a certain number of bites, note that here as well, or note if there are no specific requirements.  |
| **These are the supports I need reduce my risk of choking and aspiration when I take my medication.** |
| **Positioning:** Describe how I should be sitting when I take my medication, including positioning equipment used, such as wheelchair, or note if there are no specific requirements | **Form of Medication:** Describe how my medications are given to me, e.g., whole pills, liquids, crushed, or indicate if I do not take medications  |
| **This is how you support me when I am taking my medication:** Describe how people support me while safely to take my medication. Include who is allowed to give me medications and what they should be doing to help me, or note if there are no specific requirements.  |
| **These are the supports I need reduce my risk of choking and aspiration when I complete my oral care routine:** |
| **Positioning:** Describe how I should be sitting when I complete my oral hygiene, including positioning equipment used, such as wheelchair, or note if there are no specific requirements.  | **Equipment and supplies:** Describe any special equipment and supplies I should use during oral care, e.g., type of toothbrush, oral rinse, suction equipment, etc., or note if there are no specific requirements.  |
| **This is how you support me when I complete my oral care:** Describe how people support me to safely complete my oral care. Include where my supporter should be and what they should be doing to help me, or note if there are no specific requirements.  |
| **Documentation:**  | Describe the things that supporters should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to choking and aspiration, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

 RN Typed Name and Agency

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