**Nutrition and Swallowing Risk Checklist**

**What is the purpose of the Checklist?**

* The Nutrition and Swallowing Risk Checklist (the Risk Checklist) is a way of screening participants for difficulties related to nutrition and swallowing. It cannot make a diagnosis of a medical condition. A diagnosis can only be made by a health specialist.
* The Risk Checklist was developed as a means of raising awareness of nutrition related problems in participants with disability. It has been developed to be used by people who care for people with disability.
* By asking questions about a participant’s health, weight and their ability to eat and drink, the checklist will determine if further assessment and action is needed, including advice or assessment by a dietician, speech pathologist or other health professional.

**Who should complete it?**

* If you are completing the Risk Checklist, you should know the participant with a disability well. Collaboration with a parent or family member may be helpful in achieving the most accurate result.
* It is important to include the person with disability when completing the Risk Checklist as much as possible.

**How to complete it**

**Part 1 – Preliminary Profile –** Gathers information about the participant and who is involved in completing this checklist.

**Part 2 – Nutrition and Swallowing Risk Checklist –** Assesses any indications of nutritional problems or swallowing difficulties that may affect the participants nutrition and health.

**Part 3 – Summary of Results –** **This section is to be completed by an MDNSW staff member.** Records descriptions of the risks or issues of concern relating to questions answered with a ‘Yes’ or ‘Unsure / Do not know’.

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| **Part 1 – Preliminary Profile** | | |
| **The Participant** | Name: | |
| Gender: Male  Female | Date of birth: | Age: |
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| Address: | | |
| Parent/Guardian name: | | |
| Has the Risk Checklist been used before for this participant?  Yes  No | | |
|  If ‘Yes’, enter date when last Risk Checklist completed: | | |
| **Person completing the Risk Checklist** | Name: | |
| Date Checklist completed: |  | |
| Who is involved in completing this checklist? | Participant | |
| Parent / Carer | |
| MDNSW Client Services Team | |
| Support Worker | |
| Other (Specify): | |
| If not being completed by participant or family member, how long have you known the participant? | Less than 6 months | |
| 6 months – 1 year | |
| 1-2 years | |
| 2-5 years | |
| more than 5 years | |

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| Questions | Yes  ✓ | No  ✓ | Unsure/Don’t Know  ✓ |
| 1. Is the participant receiving tube feeds?   * Naso-gastric * Naso-duodenal * Gastronomy feeding   If ‘Yes’, we require a detailed feeding plan including quantity of feeds, timing and care requirements. |  |  |  |
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| 1a. If you answered ‘Yes’ to question 1, does the participant also receive food or drink through the mouth in addition to tube feeding? Details: |  |  |  |
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| 2. Is the participant physically dependent on others in order to eat or drink?   * The participant cannot put food or drink into their own mouth and someone else is needed to feed them * The participant is dependent on assistance during the meal e.g. guidance with utensils |  |  |  |
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| 3. Has the participant had a reduction in appetite or food or fluid intake?   * The participant is not eating or drinking as much as they usually do and this is unintentional * The participant appears unwilling to take most food offered to them and the equivalent of 6 large glasses of fluid each day |  |  |  |
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| 4. What diet does the participant follow, or supposed to follow?   * Normal * Mince or chopped * Soft or pureed foods * Thickened fluids * Vegetarian * Halal * Dairy free * Gluten free * Weight reduction or weight increasing * Low fat * Diabetic * Any other diet which modifies or restricts foods or food choices. Please provide details:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Unsure |
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| 5. Does the participant have food allergies?  Please provide details: |  |  |  |
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| 6. Does the participant usually exclude foods from any food group?  Tick any that are applicable:   * Bread, cereals, rice, pasta, noodles * Vegetables, legumes * Fruit * Milk, yoghurt, cheese * Meat, fish, poultry, eggs, nuts | Yes | No | Unsure |
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| 7. Camp can have limited options at meal times. Please provide instructions if the participant refuses to eat their meal. |  |  | N/A |
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| 8. Does the participant have mouth or teeth problems that may affect their eating?   * Loose, broken or missing teeth * Lips, tongue, throat or gums red and inflamed or ulcerated * Upper & lower teeth do not meet which affects the ability to chew | Yes |  |  |
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| 9. Does the participant cough, gag, choke or breathe noisily during or after eating food, drinking or taking medication?   * Sometimes coughs or chokes during or several minutes after eating, drinking or taking medication * Breathing becomes noisy after eating, drinking or taking medication * Gags during eating, drinking or taking medication. How long after? 🞏 10 mins 🞏 30 mins 🞏 over 1 hour |  |  |  |
| 10. Does the participant drool or dribble saliva when resting, eating or drinking?   * Drools or dribbles saliva at rest or mealtimes * Clothes or protective napkins/bibs frequently need changing because of drooling |  |  |  |
| 11. Does food or drink fall out of the participant’s mouth during eating or drinking?   * Unable to close their mouth which causes food, drink or medication to fall out of their mouth * Cannot keep their head upright and food, drink or medication falls out of their mouth * Their tongue pushes out food, drink or medication * Their mouth continuously needs to be wiped or they need to wear a cloth to protect clothes during mealtime |  |  |  |
| 12. If the participant eats independently, do they overfill their mouth or try to eat very quickly?   * Tries to cram or stuff their mouth before attempting to chew or swallow * Tries to swallow too much food before chewing it properly * Usually finishes all of their main meal in less than 5 minutes |  |  |  |
| 13. Does the participant appear to eat without chewing?   * Food is sucked rather than chewed * Food remains in their mouth for a long period of time before being swallowed * Swallows their food whole without chewing |  |  |  |
| 14. Does the participant take a long time to eat their meals?   * Eats independently but takes more than 30 minutes * Is dependent on someone to feed them but it takes a long time to feed the whole meal * Appears to tire as the meal progresses and may not finish their meal |  |  |  |
| 15. Does the participant show distress during or after eating or drinking?   * They appear distressed while eating or drinking * They appear distressed immediately or shortly after eating and drinking * Sometimes while distressed, they refuse food or spits out food |  |  |  |
| 16. Does the participant take multiple medications? |  |  |  |
| 17. Does the participant suffer from frequent chest infections, pneumonia, asthma or wheezing?   * Frequent chest infections or pneumonia * Often ‘chesty’ or has difficulty in clearing phlegm * Asthma or wheezing |  |  |  |

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| **Part 3 – Summary of Results - To be completed by an MDNSW staff member** | |
| Name of the person: | Date: |
| MDNSW staff member to complete the table below for any questions answered with a ‘Yes’ or ‘Unsure do not know’ response by describing the risk identified or issue of concern in the ‘Comments’ column and any further action required.  File the completed checklist and summary in the participants record. A copy should also be saved in current Camp folder. | |

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| **Question**  **No.** | **Comments** | **Further Action Required** |
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| **Question**  **No.** | **Comments** | **Further Action Required**  **(GP to complete)** |
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| **Part 4 – Risk Checklist Verification** |

Note: MDNSW workers completing this section are verifying that:

* The Risk Checklist has been completed
* All relevant referrals have been actioned
* The participant has been updated if required
* The Nutrition and Swallowing Risk Checklist is filed in the participant’s record.

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing the Checklist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Assisting to Complete the Checklist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **REMEMBER, IF ANYTHING CHANGES, RE-DO THE NUTRITION AND SWALLOWING RISK CHECKLIST -**