Dysphagia

1. Purpose

This procedure describes the nature of dysphagia relevant to service users with learning disabilities with reference to the existing evidence base. The procedure for the identification of eating and drinking and swallowing difficulties is described using a screen for risk assessment.

The term dysphagia describes eating and drinking disorders which may occur in the oral and pharyngeal and oesophageal stages of deglutition. Subsumed in this definition are problems in positioning food in the mouth and in oral movements, including sucking and mastication and the process of swallowing. Difficulties in sensory perception may create sensitivities and may also lead to psycho-behavioural difficulties in relation to food and drink. (Communicating Quality 3, Royal College of Speech and Language Therapists [RCSLT 2006]).

Dysphagia has been identified as a key risk area for people with learning disabilities (NPSA 2004). Early identification of the symptoms of dysphagia and behavioural issues which impact on eating and drinking are essential to reduce the risk of asphyxiation (choking) and aspiration and is the responsibility of all healthcare staff (Chadwick & Samuels 2005).

1.1 Definition of Choking

A choking incident may be defined as an acute episode in which the service user coughed incessantly or experienced a colour change (with inability to speak or cough effectively) while ingesting food or drink. The solid or liquid had to be expelled to terminate the event (Fioritti, Giacotto, Mele 1997).

2. Signs and Symptoms of Dysphagia

All staff need be aware of the symptoms of dysphagia whether physical, medical or behavioural related.

Acute (immediate) symptoms of dysphagia may include (Stewart L, 2003, Leslie Carding & Wilson 2005):

- Coughing during or immediately after drinking and/or eating.
- Choking.
- Wet vocalisations after drinking.
- Change of skin colour.
- Watering eyes.
- Refusal of food before or during meal.
- Increased anxiety or distress at drink/meal times.
- Behavioural difficulties at drink/meal times.
➢ For some acute incidents service users may have minimal visible symptoms (i.e. they may become still or silent).

**Chronic (long term) symptoms of dysphagia may include:-**

➢ Repeated or prolonged chest infections.
➢ Watery vocalisations, repeated throat clearing during eating or drinking.
➢ Signs of malnutrition – weight loss, skin breakdown, hair loss.
➢ Signs of dehydration – constipation, strong urine, urinary tract infections, dry skin.

**There are a number of reasons why people with learning disabilities may be at more risk:-**

➢ Neurological causes of dysphagia including cerebral palsy and particular syndromes, for example, Retts Syndrome, Downs Syndrome.
➢ Profound and multiple/complex learning disability.
➢ High prevalence of epilepsy.
➢ Side effects from medication, in particular psycho tropic (commonly antipsychotic) medication.
➢ Prevalence rates of mental health problems are higher in adults with learning disabilities, in particular schizophrenia, dementia.
➢ Dependence on carer for feeding has been highlighted as increasing the level of risk.
➢ Behavioural issues which impact on eating and drinking.
➢ Communication difficulties which make it harder for the person to describe pain or symptoms and to understand medical intervention.

**Adults with learning disabilities can also acquire dysphagia (dual diagnosis with learning disabilities) as the result of various conditions including (Leslie et al 2005):-**

➢ CVA (stroke)
➢ Head injury
➢ Degenerative conditions such as Parkinson’s Disease, Motor Neurone Disease etc.
➢ Psychiatric illness
➢ Ageing
➢ Cancer (head and neck, oesophageal)
In addition eating and drinking difficulties can be affected by:-

- Anatomical problems
- Gastro-oesophageal reflux
- Medication use and complications (both short and long term)

Staff training

Operational Network Managers and Team Managers will be offered and expected to attend training in a ‘Risk of Choking’ Workshop covering normal eating, drinking and swallowing and how to identify risk of asphyxiation and also dysphagia. This training will be bought in and/or accessed via local services. The training will include how to implement the Care Pathway (see Appendix C) and how to use the Screening Tool (Appendix D). New staff in the above posts are expected to attend the full training workshop to develop competency before using the screening tool. Managers will ensure this training is accessed by applying to the Learning and Development Department. Update ‘follow up’ sessions will be available to promote retention of knowledge. Requests for this training should be made to the Learning and Development Department.

General Awareness Workshops – Eating and Drinking Difficulties, for all staff

Staff who offer food and drink to service users will attend a carers’ workshop covering the normal eating, drinking and swallowing process, how to recognise signs of difficulty in eating and drinking, and practical experience of feeding. Staff will be encouraged to monitor the service users with whom they are regularly involved for any change/deterioration and will be enabled by the training to document and action any concerns they have. Staff may update their training annually either by attending further workshop sessions or by individual contact with local SLT. Managers should monitor staff compliance with SLT guidelines as a means of assessing their staff’s understanding of an individual’s eating and drinking difficulties. If any further training needs are suspected this should be discussed with the local SLT.

3. Risk Management –Service Users with Dysphagia

Mental Capacity Considerations
The Mental Capacity Act 2005 became law in April 2007. The Act requires that all service users are presumed to have the capacity to make decisions on their own behalf about all aspects of their life unless proven otherwise. Where there is reason to question an individual’s capacity to make decisions on their own behalf, e.g. where the individual has a learning disability, an assessment of capacity must be undertaken (refer to Mental Capacity Act Procedure).

Implementing the Screening Tool

All service users will be assessed to identify the risk of dysphagia using the Dysphagia Screening Tool. All Service Users supported within supported living, 24 hour
domiciliary care and/or where we are responsible for PCP & HAP will have a choking Risk Assessment and Screening completed within 14 days of the commencement of service being provided. This will be completed as specified in the Care Pathway by:-

Operational Network Managers, Behaviour Therapist or Team Managers who have attended full training by SLT. It is expected that where available regular support and advice should be sought from the local SLT and Psychology Services.

The screen should be reviewed annually and repeated also at any stage if:-

- A choking incident has occurred.
- A change in health status or general presentation is suspected.
- Any concerns are voiced by carers or staff.

4. **Risk Management of those Service Users Identified at Risk of Dysphagia or Choking**

Any service users identified as at risk of dysphagia either through the screening assessment process or as a result of a choking episode will immediately have an interim risk management plan developed to mitigate against the risk of asphyxiation (choking) using the guidance as outlined in Appendix B until medical assessment/specialist advice is received.

The person responsible for undertaking this task will be the person in charge of the home in consultation with the nominated Deputy/Operational Network Manager.

5. **Responding to Service Users Presenting with Signs/Symptoms of Dysphagia**

The Team Manager will liaise with the respective Primary Healthcare Team and Operational Network Manager to ensure that appropriate treatment and care planning is identified and that this information is clearly documented within the service user’s Health Action Plan, and reviewed as appropriate.

Where there are delays in service delivery or service deficits apparent this issue will be referred immediately via the weekly Network Management Meetings for the attention of the Operations Manager.

6. **Recording an Incident of Choking**

For any incident of choking *(including near miss)* in any service user an Incident Reporting System record should be entered.

Choking incidents should be recorded as a ‘clinical incident’. The Incident Reporting System entry should clearly specify the details of the incident using the additional information page *(Appendix B)* to allow individualised risk reduction strategies to be put in place and to ensure that any future incidents are recognised.
At the same time staff should ensure that the screening tool is redone *(within 14 days of the incident occurring)* and a referral made to appropriate healthcare professional *(e.g. Responsible Clinician, SLT, BT).*
Dysphagia Policy: Appendix A

Warning signs: eating, drinking and swallowing problems
Detecting increased risk of asphyxiation, aspiration, danger to health.

**Acute/Immediate**
- Coughing/Choking
- Facial colour change/pallor
- Eyes/Nose
- Stilling of movement or increased agitation
- Wet/gurgly voice
- Gasping for breath

**Chronic/long term**
- Repeated or prolonged chest infection
- Malnutrition,
- Dehydration.
- Coughing or spluttering at mealtimes
- Loss of weight
- Refusing to eat

**Behaviours which impact on physical health/mealtime safety**
- PICA
- Dementia
- Regurgitation
- Distractible
- Wandering
Dysphagia Policy: Appendix B

Risk Management Strategies for People at Risk of Asphyxiation *(Choking)*

(Reproduced with permission by Central Manchester PCT and Manchester Learning Disability Partnership)

The following common sense strategies may be useful for staff teams to consider while waiting for specialist assessment and advice.

<table>
<thead>
<tr>
<th>What is the Problem?</th>
<th>Risk Reduction Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easily distracted</td>
<td>Turn the TV off.</td>
</tr>
<tr>
<td></td>
<td>Have conversation time before or after meal, not during.</td>
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<tr>
<td></td>
<td>Sit in a quieter room.</td>
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<tr>
<td></td>
<td>Eat before or after others.</td>
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<tr>
<td></td>
<td>Do not have people sitting or talking behind the person.</td>
</tr>
<tr>
<td></td>
<td>Remove distraction on the table such as spare cutlery, or desserts.</td>
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<tr>
<td></td>
<td>Make sure staff are able to monitor without being a close physical presence.</td>
</tr>
<tr>
<td>Puts too much on the spoon, or takes too large a bite to be safely swallowed</td>
<td>Use a junior or sundae spoon.</td>
</tr>
<tr>
<td></td>
<td>Make sure the spoon has a full sized handle.</td>
</tr>
<tr>
<td></td>
<td>Use a larger plate with the food spread out more thinly.</td>
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<tr>
<td></td>
<td>Place only a small amount of food on the plate at a time.</td>
</tr>
<tr>
<td></td>
<td>Place another spoonful on the plate only when the first has been taken ready.</td>
</tr>
<tr>
<td></td>
<td>Offer the meal spread out in a range of small plates so they eat one plate at a time.</td>
</tr>
<tr>
<td></td>
<td>Show how much to put on the spoon.</td>
</tr>
<tr>
<td></td>
<td>Carer removes excess before the spoonful is taken.</td>
</tr>
<tr>
<td></td>
<td>Remind the person to swallow.</td>
</tr>
<tr>
<td></td>
<td>Ask if the person has swallowed.</td>
</tr>
<tr>
<td></td>
<td>Check his/her mouth is clear before offering more.</td>
</tr>
<tr>
<td>Problems chewing due to</td>
<td>Offer foods of an easy swallow consistency at first.</td>
</tr>
</tbody>
</table>
### What is the Problem? | Risk Reduction Strategies
---|---
**Eats very rapidly** | Remove the need to rush by allowing plenty of time to eat.  
Offer snacks in between meals to prevent the person becoming overly hungry.  
Eat together to model a slower pace.  
Agree a single word or phrase to prompt the person to slow down, e.g. steady, slowly or spoon down.  
Agree a physical prompt such as a hand on the arm, or hand on the table to prompt the person to put the utensil down.  
Establish a routine of putting the utensil down after each mouthful.  
Try prompting the person to place hands on knees in between spoons.  
Do not have the dessert on view.  
Use pacing cards or place mats to remind the person to slow down.  
Make sure the person knows that they will not miss out on an activity if they take their time, e.g. use visual planners.
---|---
**Likes to talk when eating** | Talk before the meal is served.  
Do not be tempted to start a conversation yourself.  
Do not give prompts that require an answer.  
Mealtimes can be social before, in between courses and after.
---|---
**Overloads the mouth** | Check utensils are not too large.  
Lots of small amounts taken consecutively without swallowing is just as dangerous.  
Tell the person to swallow.  
Offer only a small amount on the plate at a time.  
Offer an easy swallow consistency.  
**NB:** Overloading the mouth can be a sign of lack of oral sensation or a swallowing problem. 
---|---
**Moving around while eating** | Think about where the person sits in the dining room. Are they sitting next to the door?  
Is everybody sitting down when they eat?
Make sure the person knows that it is time to eat.
Visual planners can be used to show what is happening now and next.

MODIFYING FOODS TO AN EASY TO SWALLOW CONSISTENCY

This is described as – food that can be managed with minimal chewing, i.e. by service users with some lateral tongue and jaw movement. Food will be finely sliced or cut into swallow sized pieces, i.e. 1.5cm to facilitate safe management.

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Modification Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potatoes</td>
<td>Make sure mashed potato is not too sticky. Moisten chips with gravy, chop in half, and remove hard edges. Moisten roast potatoes with a sauce.</td>
</tr>
<tr>
<td>Pasta</td>
<td>Chop spaghetti as long strips can escape into the throat. Chop ravioli in half. Always serve in a sauce.</td>
</tr>
<tr>
<td>White Meat</td>
<td>Chop/shred into small strips. Better served with gravy.</td>
</tr>
<tr>
<td>Red Meat</td>
<td>Chop into 2cm pieces. Stew or slow cook in the oven <em>(burgers will need to be chopped small use fresh rather than frozen, do not serve in a bun. Avoid lettuce and tomato slices)</em>.</td>
</tr>
<tr>
<td>Sausages</td>
<td>Shred or use chopped skinless sausages.</td>
</tr>
<tr>
<td>Pies</td>
<td>Avoid hard crusts, moisten pastry with sauces. Pastry goes very claggy when it has been mashed in the mouth.</td>
</tr>
<tr>
<td>Sandwiches</td>
<td>Avoid crusts. Baps are easier. Always use a soft, moist filling such as egg or tuna mayonnaise. Cut into small pieces, no more than 2cm. Open topped sandwiches would be less dense and easier to manage.</td>
</tr>
<tr>
<td>Salad</td>
<td>Avoid strips of lettuce that could hang into the throat.</td>
</tr>
<tr>
<td>Vegetables</td>
<td>Chop into 2cm pieces; remove very fibrous stalks such as broccoli stumps.</td>
</tr>
<tr>
<td>Fish</td>
<td>Double check for bones. Avoid hard batter. Serve with a sauce if possible.</td>
</tr>
<tr>
<td>Biscuits</td>
<td>Opt for softer biscuits such as fig rolls or cake bars.</td>
</tr>
<tr>
<td>Cakes</td>
<td>Go for softer, lighter sponges rather than dense fruitcakes.</td>
</tr>
<tr>
<td>Fruit</td>
<td>Avoid hard fruit pieces such as apples unless chopped very small indeed. Opt for tinned Satsumas, half grapes and strawberries. Blend soft fruits together to make a fruit smoothie. Dried fruit should be avoided.</td>
</tr>
<tr>
<td>Snacks</td>
<td>Avoid hard sweets, such as jelly babies, toffee, wine gums. Opt for softer crisps such as skips where possible.</td>
</tr>
</tbody>
</table>
Dysphagia Policy: Appendix C

CARE PATHWAY
Risk of Choking Screening Assessment

Only to be used by trained staff – for use by Future Directions CIC
Screening Assessment: Indicators for risk of choking (asphyxiation)

**Name:**

**DOB:**

Screening tool completed by (The person completing this screening assessment must have attended the training session, through PDC, in its use prior to completing the screen):

**Designation:** Enter information

**Date completed:** Click here to enter a date.

**Introduction**

This screen is aimed at identifying people at risk of choking or aspirating as a result of poorly functioning swallow, oral problems, or aspects of their behaviour or condition.

All questions in the screen should be completed by the Case Manager, BNT, Team Manager/Ward Manager, Deputy or Ward Based Co-ordinator. The questions relate to how the person has been in the previous twelve months. Therefore, the person carrying out the screen must have had regular contact with the person in that time.

Any queries please ring Speech and Language Therapists on 01254 821502 or Behaviour Therapy

**Summary of Actions:**

<table>
<thead>
<tr>
<th>Referral to:</th>
<th>Enter name</th>
<th>Date referral submitted:</th>
<th>Click here to enter a date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour Therapy</td>
<td>Enter information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>Enter information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology</td>
<td>Enter information</td>
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<tr>
<td>GP</td>
<td>Enter information</td>
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<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Enter information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td>Enter information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Please state</td>
<td>Enter information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This document to be stored in CareNotes, under the Reports Tab and a copy to be sent to Line Manager

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**Part A Non Dysphagia**

1. **Is there anything about this person’s behaviour at mealtimes that puts them at risk of choking?**
Guidance Notes

- Do they rush their food?
- Do they eat non food items?
- Do they grab food from other’s plates?
- Do they overfill their mouth?
- Do they leave the table during the meal?
- Do they try to lie down or recline during or soon after the meal?

No Concerns
No action needed

2. Is there anything about this person’s **behaviour outside mealtimes** that puts them at risk of choking?

Guidance Notes

- Do they eat non food items?
- Do they have PICA or copy this behaviour from others?
- Do they put non-food items in their mouths for any reason?
- Do they chew their own clothing, buttons, etc.

No Concerns
No action needed

3. Is this person ever **left alone to eat or drink** either at home or when out and does this make you concerned for their safety?
Guidance Notes

- Do they attend a day placement where they may be unsupported at meal-times?
- Do they take food from fridges or cupboards or elsewhere and eat unsupervised?
- Do they visit relatives and friends and eat unsupervised?
- Is the eating environment overly noisy/busy or have other distractions that could lead to the person being unsupported whilst eating (even for a short period of time)?
- Do visitors bring food or treats which the person eats on their own?
- Does the person leave the table during/after the meal with food in their mouth?

No action needed

4. Do you think this person’s behaviour has changed at all in any way in the last 12 months?

Guidance Notes

- Is there any disturbed or agitated behaviour?
- Does he/she ever refuse food or drink?
- Is there any short term or temporary change?

No Concerns

Click here to enter comments.
5. Has this person’s mental well-being changed in the past twelve months?

Guidance Notes

- Does he/she seem as alert as they used to be?
- Has there been a change in mood?
- Any change in level of cooperation or participation in activities?
- Do you ever think they seem depressed?
- Are there any short term or temporary changes which need different management?
- Has this person a formal diagnosis of schizophrenia, depression, affective disorder, dementia or any other mental health; or are there concerns about their mental health?

No action needed

6. Are there any issues or change in the person’s physical health in the past twelve months?

Guidance Notes

- Are you concerned about any medical issues?
- Is the position or posture at mealtimes a problem?
- Can you see any physical change (deterioration) in this person?
- Is there a progressive condition? (e.g. Motor Neurone Disease, Parkinson's Disease, etc)
- Do they just seem to be getting more ‘elderly’ physically – compared to 12 months ago?
- Has there been any weight loss?
- Is reflux a problem for this problem?
- Does the person suffer from any other neurological condition?
- Does the person have epilepsy?
- Any short-term or temporary changes?
- Is position or posture at mealtimes a problem?

Click here to enter comments.
7. Does the person take *medication* which may affect their movement, physical abilities, levels of consciousness, mood or concentration?

**Guidance Notes**

- Movement? Physical capability?
- Level of consciousness? Concentration? Mood?
- Has there been a change in the person’s condition since their last medication review?
- Dry mouth
- Are there any temporary or short term effects which require different management (for example as required medications, sedation, rapid tranquillisation etc.)?

8. Does this person appear to stimulate him/herself by regurgitating or vomiting?

**Guidance Notes**

- Can they be distracted from this behaviour?
- Has this behaviour changed in any way?
- Has this behaviour become more frequent? More intense?
- Does the regurgitated food appear unchewed?
- Are there any long term digestive problems such as reflux?
- Has there been any gastro-enterology involvement?

**No Concerns**

Click here to enter comments.

**Low/medium risk identified**

Strategies in place within document

Or Referral placed to: Behaviour Therapy on
Or to: Psychology on

Click here to enter strategies.

Or to enter a date.

Or to enter a date.

**High risk identified**

Referral placed to: Behaviour Therapy on
Or to: Psychology on

Click here to enter a date.

Click here to enter a date.
9. Does this person have any sensory impairment?

Guidance Notes

- Does this person have any visual impairment?
- Does the person have a hearing impairment?
- Does this person have any impairments regards their ability to taste or smell?
- Does this person notice when any food is left on the tongue or lips after a mouthful has been swallowed?
- Can this person detect/sense hot temperatures (i.e. do they avoid food or drinks that are too hot?)

No Concerns
No action needed Click here to enter comments.

Low/medium risk identified
Strategies in place within document Click here to enter strategies.
Or Referral placed to: Behaviour Therapy on Click here to enter a date.
Or to: Psychology on Click here to enter a date.

High risk identified
Referral placed to: Behaviour Therapy on Click here to enter a date.
Or to: Psychology on Click here to enter a date.
10. Do you think this person ever has any difficulty in eating or drinking?

**Guidance Notes**

- Do they ever complain verbally or show nonverbally any pain or discomfort while eating or drinking?
- Do they ever have repeated coughing or throat clearing after food or drink?
- Have you ever seen the person appearing to ‘choke’ on anything?
- Does their voice sound wet or gargly after food or drink?

**No Concerns**

No action needed

**Low/medium risk identified**

Strategies in place within document

Or Referral placed to: S&L on

Or to: Psychotherapy on

**High risk identified**

Referral placed to: S&L on

Or to: Psychotherapy on

11. Is this person receiving non-oral/tube/PEG feeds? If yes do they also have food or drink by mouth?

**No Concerns**

No action needed

**Low/medium risk identified**

Strategies in place within document

Or Referral placed to: S&L on

Or to: Psychotherapy on

**High risk identified**

Referral placed to: S&L on

Or to: Psychotherapy on
12. Has he or she had any repeated or prolonged chest infections in the last 12 months?

Guidance Notes

- Can these infections be easily explained by an existing medical condition?
- Do you have any reason to suspect there is aspiration?

**No Concerns**
No action needed

**Low/medium risk identified**
Strategies in place within document
Or Referral placed to: S&L on
Or to: Psychotherapy on

**High risk identified**
Referral placed to: S&L on
Or to: Psychotherapy on

13. Is this person ever fed food or drink by someone else? (I.e. instead of feeding themselves)?

Guidance Notes

- Are there any concerns regarding the feeder’s approach or methods?
- Does the person react differently to unfamiliar people helping or feeding at mealtimes?
- Does the person indicate clearly and consistently when they want the feeder to pause or stop in feeding?

**No Concerns**
No action needed

**Low/medium risk identified**
Strategies in place within document
Or Referral placed to: S&L on

**High risk identified**
Referral placed to: S&L on
14. Does this person seem to need several swallows to clear each mouthful?

 Guidance Notes

- Does this depend on what he or she is eating or drinking (i.e. the consistency or texture of the food or drink)?
- Does this person have difficulty with particular foods or drink?
- Do they seem to eat very slowly?
- Have you observed a tendency to cramming (overfilling the mouth) or bolting food (eating too fast)?
- Has this person started to avoid certain foods?

No Concerns
No action needed Click here to enter comments.

Low/medium risk identified
Strategies in place within document Click here to enter strategies.
Or Referral placed to: S&L on Click here to enter a date.

High risk identified
Referral placed to: S&L on Click here to enter a date.

15. Does this person have thickener in his/her drinks or meals?

 Guidance Notes

- Has this been specified by the SLT?
- Has this been reviewed in the last 12 months?
- Do you feel the guidelines are still appropriate?

No Concerns
No action needed Click here to enter comments.

Low/medium risk identified
Strategies in place within document Click here to enter strategies.
Or Referral placed to: S&L on Click here to enter a date.

High risk identified
Referral placed to: S&L on Click here to enter a date.
16. Is there food left in the person's mouth at the end of the meal?

Guidance Notes
- Food visible inside the cheeks?
- Are there lumps of food visible on the lips/tongue (but service user not aware)?
- Cramming behaviour leading to food being packed into the cheeks?
- Food stuck up in roof of the mouth?
- Ask the person to swallow again, does this clear the mouth?
- Do you think the person is relying on a drink to get the swallow going/clear the mouthful?

No Concerns
No action needed to enter comments.

Low/medium risk identified
Strategies in place within document to enter strategies.
Or Referral placed to: S&L on click here to enter a date.

High risk identified
Referral placed to: S&L on click here to enter a date.

17. Does this person have problems with their teeth?

Guidance Notes
- Do they have sore or infected teeth?
- Problems with dentures?
- Poor oral hygiene?
- Does the person suffer from infections or have halitosis (bad breath)?
- Is the person missing some or all of their teeth?
- Do you suspect this person is avoiding food which needs chewing?

No Concerns
No action needed to enter comments.

Low/medium risk identified
Strategies in place within document to enter strategies.
Or Referral placed to: Dentist on click here to enter a date.

High risk identified
Referral placed to: Dentist on click here to enter a date.
18. Does this person have any unexplained weight loss?

Guidance Notes

- Do you have any concerns about the person’s nutrition?
- Has the weight/BMI been accurately and consistently measured?

**No Concerns**
No action needed Click here to enter comments.

**Low/medium risk identified**
Strategies in place within document Click here to enter strategies.
Or Referral placed to: Dietician on Click here to enter a date.

**High risk identified**
Referral placed to: Dietician on Click here to enter a date.

19. Do you think this person may be dehydrated?

Guidance Notes

- Do they appear to have difficulty with drinking?
- Do you have any concerns about the person’s nutrition?
- Has the weight/BMI been accurately and consistently measured?
- Observe them with hot and cold drinks, do they cough or splutter?
- Does the sound of breath or voice change during or soon after drink?

**No Concerns**
No action needed Click here to enter comments.

**Low/medium risk identified**
Strategies in place within document Click here to enter strategies.
Or Referral placed to: Dietician on Click here to enter a date.

**High risk identified**
Referral placed to: Dietician on Click here to enter a date.