

**COMPETENCY FOR PHYSICAL AND NUTRITIONAL MANAGEMENT
MEALTIME**

NAME _____ **DATE** _____

WORK UNIT _____

TASK/CRITERIA: <i>Should be able to verbalize, demonstrate and/or document knowledge of the following:</i>	MET	*N/I	*N/A	PLAN OF CORRECTION
Dysphagia				
A Physical and Nutritional Management Plan and the intent of the plan.				
An individual's level of choke risk as indicated on the Physical and Nutritional Management Plan				
Signs/symptoms of difficulty swallowing (dysphagia) as listed on an individual's Physical and Nutritional Management Plan				
An individual's position, alignment and/or elevation during mealtime in accordance with instruction on the Physical and Nutritional Management Plan.				
An individual's adaptive equipment and its use as specified in the Physical and Nutritional Management Plan.				
Appropriate diet for an individual as specified in the Physical and Nutritional Management Plan.				
Appropriate liquid consistency as specified in the Physical and Nutritional Management Plan.				
What actions to take if identified signs/symptoms of difficulty swallowing are observed.				
Who and when to notify if signs/symptoms of difficulty swallowing are observed.				

INSTRUCTOR'S SIGNATURE _____ **DATE** _____

*N/I = Needs Improvement
*N/A = Not Applicable