

PHYSICAL AND NUTRITIONAL MANAGEMENT MONITORING

Instructions:

- 1) Select the population to be monitored
- 2) Answer each question
- 3) In Section III., ONLY answer questions for A. Nourishment by mouth, or for B. Nourishment by tube

I. ACTIVITY MONITORED: (Check all that apply or note on the side of the monitoring tool.)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> BREAKFAST | <input type="checkbox"/> CHANGING/DRESSING |
| <input type="checkbox"/> LUNCH | <input type="checkbox"/> ORAL CARE |
| <input type="checkbox"/> DINNER | <input type="checkbox"/> BATHING |
| <input type="checkbox"/> SNACK | <input type="checkbox"/> DENTAL APPT |
| <input type="checkbox"/> MED PASS | <input type="checkbox"/> TUBE FEEDING |

II. GENERAL INFORMATION REVIEW:

- 1) Can staff define dysphagia? YES NO
- 2) Can staff articulate what risks are associated with dysphagia? YES NO
- 3) Can staff describe the symptoms associated with dysphagia? YES NO

III. CLIENT SPECIFIC INFORMATION: (Choose ONLY one – either A. Nourishment by mouth or B. Nourishment by tube.)

A. CLIENT SPECIFIC: NOURISHMENT BY MOUTH

- 1) Does the staff know the choking risk level for the client? YES NO
- 2) Does the staff know what client specific signs and symptoms to report to the nurse? YES NO
- 3) Is the Physical and Nutritional Management Plan for the client at the area? YES NO
- 4) Is the adaptive equipment identified on the Physical and Nutritional Management Plan? YES NO
- 5) If so, is the adaptive equipment being used in accordance with the Physical and Nutritional Management Plan? YES NO
- 6) Is the client in the correct position? YES NO
- 7) Is the client's intake provided in a manner consistent with the PNM plan – e.g., small bites, slower pace? YES NO
- 8) Is the client's intake provided in a manner consistent with the Physical and Nutritional Management Plan e.g. consistency of food and liquids? YES NO
- 9) Is the Physical and Nutritional Management Plan effective in keeping the client safe? YES NO
- 10) Does the staff know the intended outcome of the Physical and Nutritional Management Plan? YES NO
- 11) If the client is being physically moved and/or lifted, is it being done in manner that is consistent with the PNM plan? YES NO

B. CLIENT SPECIFIC: NOURISHMENT BY TUBE

- 1) Does the staff know that the client is at a SEVERE risk due to having a tube for nourishment? YES NO
- 2) Does the staff know what client specific signs and symptoms to report to the nurse? YES NO
- 3) Is there a feeding/Physical and Nutritional Management Plan in place for the client? YES NO
- 4) Is the necessary equipment identified on the feeding/Physical and Nutritional Management Plan? YES NO
- 5) If so, is the equipment being used in accordance with the plan? YES NO

- 6) Is the client in the correct position while being fed? YES NO
- 7) Is the volume of formula given as ordered? YES NO
- 8) Is the client's intake provided in manner consistent with the PNM plan e.g. type of tube feedings type, check of tube placement? YES NO
- 9) Is the feeding/Physical and Nutritional Management Plan effective in keeping the client safe? YES NO
- 10) Does the staff know the intended outcome of the feeding/Physical and Nutritional Management Plan? YES NO
- 11) If the client is being physically moved and/or lifted, is it being done in manner that is consistent with the PNM plan? YES NO

IV. PHYSICAL AND NUTRITIONAL MANAGEMENT

- 1) During the observation, has the client experienced any of the following that were unable to be corrected?
 - a) Coughing with S/S of struggle.
 - b) Wet vocal quality and/or breath sounds.
 - c) S/S of discomfort and improper position.
 - d) Inoperable or unavailable wheelchair.
 - 2) How many choking/dysphagia S&S occurred since the last review
 - a) 0
 - b) 1-5
 - c) 6-10
 - d) 10 or more
 - 3) If uncorrected S&S were documented, was the nurse and appropriate therapist notified? YES NO
 - 4) Is the individual free from any reddened areas and/or skin breakdown? YES NO
 - 5) If NO, was the nurse/therapist notified? YES NO
 - 6) Is the client's weight with-in their goal range? YES NO
 - 7) If NO, is there documentation that the nurse/dietician was notified? YES NO
 - 8) Did the IDT meet to address the identified risk and an addendum to the IP made? YES NO
 - 9) Issues corrected on site? YES NO
 - 10) Additional action required? YES NO
 - 11) Additional action completed? YES NO
- Describe additional action needed/completed:

Signature

Date and Time