NHS
Cannock Chase
Clinical Commissioning Group

NHS
Stafford and Surrounds
Clinical Commissioning Group

Aspiration Risk assessment for Residents in Residential/Nursing Homes

Who may have swallowing problems? √

- Stroke
- Dementia
- Acute Medical Condition – UTI
- Multiple sclerosis
- Motor neurone disease
- Myasthenia Gravis
- Parkinson's Disease
- Head and Neck cancer
- Generally unwell (frail elderly)

Behaviours that could lead to choking or aspiration: √

- Eating too fast
- Too slow
- Overloading mouth
- Storing food/drink in mouth
- Not chewing food
- Gulping liquids,
- Moving around whilst eating

Acute signs of aspiration: √

- Coughing and choking when eating and drinking
- Signs of chest infection or pneumonia e.g. ↑ temp
- Changes in colour
- Sounds of respiratory difficulty – wheezy
- Wet or gurgly voice
- Gasping

Chronic Signs of aspiration √

- Loss of weight
- Recurrent chest infections
- Refusal to eat/drink
- Reduced quality of life
- Reduced enjoyment of eating
- Pressure sores – poor wound healing
- Hunger
- Dehydration/malnutrition
- Choking
- Death – choking, aspiration pneumonia

Refer to Speech and Language Therapy (SLT) for swallowing assessment

- SLT assessment including: -
  - information gathering from client/carer
  - mealtime observation – if appropriate
- Verbal and written advice on texture modification for food and fluid intake provided

Residential/Nursing Home Staff's responsibilities

- Follow any recommendations from professions involved e.g. SLT, Dieticians
- Positioning during meals – sit as upright as possible
- Ensure correct modified diet and fluid consistency is provided
- Food and fluid charts to monitor oral intake
- Level of assistance required to feed safely
- Procedures for reporting changes
- Ensure good oral hygeine

Risk level reduced

Risk level remains high → Re-refer to GP/SLT

Monitor

- Monitor over time and report any concerns to qualified staff