

## SWALLOWING DISORDERS CHECKLIST

### Instructions for Completion

The Swallowing Disorders Checklist must be completed:

- Within 30 days of admission,
- Annually,
- Following an incident of choking, and
- Anytime a consistent change, concern, or problem is noted in any area identified on the Checklist.

It must be completed with input from someone who has, on several occasions, assisted or observed the person during meals. Additionally, it must include responses based on a discrete observation of the person dining. When completed following an incident of choking, when possible, input must be obtained from someone who witnessed the incident.

To complete, identify the person by **first and last name** with **middle initial**. Include the person's **sex**, **date of birth**, the **name of residence** in which the person lives, the name of the **residential provider** and indicate by checking the **type of residence**.

This form is designed to compare reviews and therefore is designed to accommodate three (3) consecutive reviews (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup>). The Checklist must be completed within 30 days of admission, annually, following an incident of choking, and anytime a change, concern or problem is noted. The **year** the checklist is completed must be entered. The **month/day** on which the person was observed or a problem was identified should be noted under the year. The person's **weight** during the month the Checklist is being completed must be entered.

Each statement (1-17) on the checklist requires a “**YES**” or “**NO**” response. For each statement, it must be noted whether the person does (“**YES**”) or does not (“**NO**”) exhibit the signs/symptoms listed. Yes/No responses should be entered in the column that corresponds to the year, month and day the checklist is being completed. When indicated, as part of a statement to which a “**YES**” response is given, check all boxes that apply to provide more specific details.

When all statements have been scored and specific information or responses provided, the person (staff member) completing the Checklist must **sign** and **date** the form on the line that corresponds to the review being completed (1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup>) and include a **phone number** and **email address** at which he/she can be reached should additional questions arise.

Scoring the statements:

1. Enter “**YES**” if the person had a **choking incident with airway obstruction** (a specific incident where a food/liquid item or an object obstructed their airway, prevented breathing, and required intervention to dislodge the item). If “**YES**” is entered, also note the **date** of the incident, whether the **Heimlich or back thrusts** were performed and the specific **item** ingested during the incident. **NOTE:** The occurrence of choking with airway obstruction is considered a **critical incident** and must be reported in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting. The “Dysphagia/GERD Protocol” is the completed Swallowing Disorders Checklist and the completed Swallowing Disorders Follow-Up Assessment.

2. Enter “YES” if the person experienced a **choking incident without obstruction** (during an isolated incident, an ingested item caused significant disturbance in the swallowing process; but, the person was able to cough and continued to breathe until the incident resolved without intervention). If “YES”, also enter **date** of the incident and **food item** ingested during the incident.
3. Enter “YES” if the person **coughs consistently before, during or after meals** (coughs prior to meals, while eating, or when the meal is finished). If “YES” check all of the circumstances (i.e., before, during and/or after) that are true for the person.
4. Enter “YES” if the person experiences **coughing at night when sleeping or when lying down** (coughs when in bed at night or when in a reclined position) and/or if the person experiences **morning hoarseness** (on a consistent basis after awakening). If “YES” is entered, check the box or boxes that correspond to the correct circumstances.
5. Enter “YES” if the person “**gets choked**” (forcefully coughs frequently during meals) and/or if the person **gags during meals**. If “YES”, list specific meals, foods, or situations, etc., that appear to elicit the coughing/gagging.
6. Enter “YES” if the person **has had documented progressive weight loss (planned or unplanned)** (lost weight overall in the past 12 months or since the last review) or if the person is **noticeably underweight** (noticeably thin). If “YES” is entered due to weight loss, identify if the weight loss was “**planned**” (calorie reduction, increased activity, etc.) or “**unplanned**” (medical illness, unknown etiology, etc.).
7. Enter “YES” if the person **refuses or has difficulty with certain textures (liquids, grainy foods, chopped meats, etc.)**. If “YES”, list specific **textures** (liquids, grainy, chopped, etc.) with which the person has difficulty or refuses. If “YES”, indicate if the person will accept liquids, but not solid foods.
8. Enter “YES” if the person **sounds wet or gurgly, when breathing or talking before, during or after eating/drinking** (when at rest, speaking or making noises, the person has a wet /gurgly voice quality and/or if the person clears their throat excessively after meals or routinely throughout the day). If “YES” is entered, check the box or boxes that correspond to the correct circumstances.
9. Enter “YES” if the person has **frequent colds/respiratory illnesses** (is routinely treated with over the counter medications for cold symptoms or respiratory illnesses) and/or **has consistent/ongoing congestion** (exhibits signs/symptoms of being congested on an ongoing basis) and/or **has recurrent upper respiratory infections** (medically confirmed upper respiratory infections) and/or **has been diagnosed with pneumonia in the last 12 months** (has had a confirmed diagnosis of pneumonia in the past 12 months). If “YES” is entered, check the box or boxes that correspond to the correct circumstances.
10. Enter “YES” if **multiple swallows are needed to clear mouth of food/liquid** (more than one swallow to completely clear their mouth of a food/liquid) when the person is eating and/or **holds food in mouth** (consistently holds food in their mouth and/or requires cueing to swallow, requires liquid to initiate swallowing of the food, and/or is known to have food in their mouth after meals) and/or **pockets food in cheeks** (holds food in their cheeks or food is found between their cheeks and gums after the meal has been

completed). If “YES” is entered, check the box or boxes that correspond to the correct circumstances.

11. Enter “YES” if the person **requires extended time to complete meals** (requires more than 30 minutes for reasons other than socialization; but may be due to holding food in their mouth, delayed initiation of the swallow, distractions, food spillage, etc.). If “YES”, describe.
12. Enter “YES” if the person **eats at a fast pace** (eats at a rapid pace and/or requires cueing to slow their pace during meals) and/or **over packs mouth** (over packs their mouth with food by taking large bites or by taking consecutive bites prior to swallowing what is in their mouth) and/or **swallows without adequate chewing** (swallows solid foods without adequately chewing or has a history of this behavior) and/or **takes large bites off of whole food items (e.g., sandwiches, breads, cookies, etc.)** (takes large bites off of solid food items such as sandwiches, hamburgers, chicken drumstick, etc. or as been observed to put an entire food item in their mouth without biting off an appropriate sized bolus). If “YES” is entered, check the box or boxes that correspond to the correct circumstances.
13. Enter “YES” if the person **takes food/liquid from other consumers or has a history of taking food/liquid from other consumers** (takes foods/liquids that may or may not be within their recommended dietary guidelines).
14. Enter “YES” if the person **refuses to eat or is eating less than they normally would** (is refusing to eat on a consistent basis, eating limited amounts, routinely refusing the same meal during the day or is refusing certain foods) If “YES”, describe.
15. Enter “YES” if the person **vomits** (after meals) and/or **regurgitates** (return of partly digested food from the stomach to the mouth) during/after meals and/or **belches/burps during or after a meal** (belches consistently and/or excessively during/after meals). If “YES” is entered, check the box or boxes that correspond to the correct circumstances and note **how often** (every meal, every day, etc.) any of these have been observed.
16. Enter “YES” if the person **engages in hand-mouthing behavior** (frequently puts their hands in their mouth, bites their fingers/hand, “sticks finger down their throat”, etc.). If “YES”, check the box that best describes when the behavior occurs, **during/after meals or throughout day**.
17. Enter “YES” if **neck extension is observed during meals when eating/swallowing** (the person consistently extends their neck backwards during meals and swallows food/liquid in this position). If “YES” describe what is observed.

Additional actions:

If the response to **any** statement (1-17) above is “YES”, the **Swallowing Disorders Follow-up Assessment** must be completed (unless the provider or DDSN Regional Center has a therapist who can evaluate the Checklist and the therapist conducts an assessment and documents the results of this assessment or unless otherwise noted on previous Consultation Summary).

If the responses to **all** statements (1-17) above are “NO”, no additional action is required. The Checklist should be maintained as part of the person’s residential services or medical record.