AGENCY
DYSPHAGIA CARE PLAN

_____*Client's Name*_____
Date
Level ___ Risk

_____

_____

Diagnoses related to Dysphagia (i.e., GERD, Oral, Pharyngeal, Esophageal Dysphagia, Aspiration or Choking risk etc…)

TRIGGERS:

In this section you will include specific triggers (aka signs or symptoms) that are related to the individual having increased difficulty swallowing, tolerating tube feedings, tolerating their own secretions or positioning triggers during mealtme)

- **IF YOU NOTICE ONE OR MORE OF THE ABOVE TRIGGERS, ATTEMPT TO SELF CORRECT (make sure dysphagia plan is being followed correctly) IF TRIGGER IS OBSERVED AGAIN, DOCUMENT ON FLOW CHART AND NOTIFY NURSE.**

NUTRITION AND MEALTIME

This section includes information on the client's food textures, fluid textures and supplements. If NPO, this should be listed here as well as the client's rate and frequency of feedings. Any adaptive equipment, positioning information (during and after meals) and dining strategies (small bites, alternating liquids/solids etc…) should be included.

ORAL CARE and MEDICATION

Oral Care Guidelines (suctioning or non-suctioning), positioning, and fluid texture information are included in this section

GENERAL POSITIONING

Positioning as it relates to bathing, attends changes, and showering are included in this section. ***Remember*** *that an individual should be positioned in an upright manner when performing these activities.* ***Refer to Positioning Plan for specifics.***

Quarterly Review:

1st Quarter	2nd Quarter	3rd Quarter

- **IT IS HELPFUL TO USE A BULLET FORMAT FOR EASY REFERENCE**
- **ASPIRATION CAN OCCUR AT ANY TIME**