SOLENT RISK OF CHOKING SCREEN

RISK OF CHOKING SCREEN FOR ADULTS

Client Name: ……..Date of Birth: ……NHS Number:……
Has consent been gained to complete this screen? **Yes/No** *(give details)*……
Have the next of kin been informed where appropriate? **Yes/No** *(give details)*……

	COLUMN A	COLUMN B
1. Does the person frequently or continually cough before, during or after eating and/or drinking?	**Yes**	**No**
2. Has the person already got a known diagnosis of 'Dysphagia'? If **'Yes'**, when were they last assessed by a Speech & Language Therapist?.....	**Yes**	**No**
3. Has there been a choking (partial or complete obstruction affecting respiratory function) incident in the last 12 months? If **'Yes'**: Number of occasions …… On what? ……	**Yes**	**No**
4. Has the person had pneumonia or recurrent chest infections in the last 12 months? If **'Yes'**: Number of occasions …… Known respiratory conditions……	**Yes**	**No**
5. Has there been a significant change in the last 12 months in any of the following: (Please **provide details** for any **'Yes'** responses) a) Unplanned weight loss…… b) Fluid intake…… c) Time taken to complete meal/drink…… d) Self feeding skills…… e) Environment…… f) General health……	 **Yes** **Yes** **Yes** **Yes** **Yes** **Yes**	 **No** **No** **No** **No** **No** **No**
6. Oral skills: a) Are they able to chew a normal diet? If **'No'**, give details…… …… b) Is their food and/or drink currently modified? If **'Yes'**, how and why?..... ……	**No** **Yes**	**Yes** **No**
7. Oral Health: Does the person have good oral hygiene/healthy teeth? If **'No'**, please provide details……	**No**	**Yes**
8. Does the person have a diagnosis of Pica (a persistent craving & compulsive eating of non-food substances)**?**	**Yes**	**No**
9. Does the person have any other behaviours (including self harming) that may increase their risk of choking e.g. fast pace or food cramming? If **'Yes'**, please provide details…… ……	**Yes**	**No**
10. Is the person currently experiencing any of the following side effects from their medication: relaxed muscle tone; drowsiness; dryness of the mouth; increased saliva? If **'Yes'**, please provide details…… ……	**Yes**	**No**

If you have circled an answer in Column A – further action is required. A new care plan, adopting a common sense approach, maybe required to manage the risk of choking.

For additional advice - questions 1-6 liaise with Speech & Language Therapy, questions 7-10 liaise with an appropriate health professional or GP.

Agreed action/outcome of liaison: