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Dysphagia risk assessment

The NPSA dysphagia risk assessment seeks to answer the following questions:

1. What is the current situation?
2. What could go wrong?
3. How serious is the harm to the person?
4. How likely is the harm to occur?
5. What actions are needed to prevent harm?
6. How and when will the situation be reviewed?

Assessment Group Members (Group should include health practitioners, family members, the person with learning disabilities if appropriate, social worker, home manager and carers from day and residential provision. (Tick box for those involved))	
☐**Person with learning disabilities**	**Name:……** **Date of birth:……** **Address:……...** **……** **……**
☐**Family member/caregiver**	**Name:……**
☐**Key worker**	**Name:……**
☐**Day centre staff**	**Name:……**
☐**Speech and language therapist**	**Name:……**
☐**Dietician**	**Name:……**
☐**Physiotherapist**	**Name:……**
☐**Occupational therapist**	**Name:……**
☐**GP**	**Name:……**
☐**Other (give details)**	**Name:……**
Notes (including any additional members of the group):	

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DYSPHAGIA RISK ASSESSMENT DATE……..

NAME ……. DOB …….. Room No ……..

Nature of problem

(for example, risk of choking, risk of chest infection, risk of nutritional comprise and risk of dehydration

Is this a new problem ☐or an existing problem that has worsened☐? (Please tick)

Other existing needs

(include details of current medication)

Current eating and drinking situation

(include where meals are taken and level of support needed)

Previous health and risk issues

(include any previous factors which have the potential to affect the swallow)

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Service Users Name: : ……..……..Date: ……..

Dysphagia risk management plan

What could go wrong (risk area)	Impact of problem			Likelihood of harm occurring			Severity (impact x likelihood)	What needs to be done	Agreed actions	Named person responsible for actions	Timescale (date by which action is to be completed)
	low	med	high	low	med	high					

Completed by Name::……..... Date: ……..…

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Client's Name: : ……..……..Date: ……..

Dysphagia risk management plan review

What could go wrong (risk area)	Impact of problem			Likelihood of harm			Agreed actions	Named person	Agreed timescale	Progress to date	Revised problem impact			Revised harm likelihood			Revised agreed actions
	low	med	high	low	med	high					low	med	high	low	med	High	

Date of next review:……

Completed by Name::……..... Date: ……..…….....

Tick this box if review will be conducted by the assessment group ☐