WHITING FORENSIC HOSPITAL
Nursing Policy and Procedure Manual

SECTION D: PHYSIOLOGICAL ADAPTATION
CHAPTER 13: BASIC NEEDS

POLICY & PROCEDURE: 13.1.6 Aspiration Risk Precautions

Standard of Practice
The Registered Nurse will ensure that patients who are clinically at risk for aspiration are continuously assessed and ensure that preventive measures and precautions are implemented and documented in the Nursing Plan of Care.

Standard of Care

Patients predisposed to actual or potential aspiration can expect to be continuously assessed for signs and symptoms of aspiration risk.

Policy:
WFH Universal Aspiration Precautions will be implemented as ordered by an Ambulatory Care Services (ACS) Provider or as an independent nursing order for all patients at risk.

Procedure:
Initiate WFH Universal Aspiration Precautions when ordered by an ACS Provider or as an independent nursing order when clinically indicated:

WFH Universal Aspiration Precautions:

1. Feed only if awake and alert
2. Sit patient fully upright (90 degrees) when drinking or eating
3. Provide the diet as ordered for solids and liquids
4. Encourage small bites and sips
5. Encourage alteration of liquids/solids every (2-3 bites)
6. Provide oral care and check for food left in mouth after eating
7. Retain patient in upright position for 30 minutes after meals
8. Do not use straws

Procedure:
On Admission:

1. During the Admission Nursing Assessment, the RN will evaluate patient risk for aspiration. Any positive findings will be communicated to the ACS Provider, the Dietician, and the Speech Language Pathologist, and documented on the ACS Medical Rounds Board and in the Progress Notes.
2. Upon admission, the ACS Provider will order Aspiration Precautions in tandem with dietary consistency on the Physician Order Sheet, which will then be transcribed by the nurse. If a higher level of observation is deemed necessary for a patient at mealtime, then the ACS Provider will specify either 1:1 or Continuous Observation (CO) at mealtime only on the

Physician's Order Sheet. Nursing will inform the Dietician, Speech Language Pathologist, and Nursing Supervisor of this recommendation.

3. The order is then documented in the Progress Notes and reflected in the Nursing Plan of Care.
4. The night shift nurse will place the patient's name, indicating Aspiration Precautions, on the *Nursing Dietary/Aspiration Risk Tracking Form*. This Tracking Form is initiated daily and posted in the unit kitchen and nursing station. The night shift head nurse will maintain the *Nursing Dietary/Aspiration Risk Tacking Forms* on the unit for 90 days.

Meals:

All patients will be afforded the opportunity to have their meals in off –unit dining rooms unless clinically contraindicated.

A. **Off-Unit Dining**:
   1. Nursing Staff are assigned to escort patients to the Dining Room based on appropriate ratios and patient levels.
   2. A copy of the *Nursing Dietary/Aspiration Risk Tracking Form*, which lists all patients by name, their respective diet, food allergies, and dietary risk issues, including Aspiration Risk, is brought to the Dining Room.
   3. Upon reaching the food distribution area, staff will:
      a) Identify each patient to dietary staff using appropriate patient identification procedures.
      b) Check the meal ticket on the patient's tray to ensure that the diet specified matches with what is on the *Nursing Dietary/Aspiration Risk Tracking Form* and that meal items provided are as ordered. Any discrepancies shall be clarified as appropriate prior to issuing the meal.
      c) After the patient receives his/her meal, the assigned staff is to position themselves in the Dining Room, and circulate among tables at various intervals to monitor eating habits, safety considerations, and Aspiration Precautions to ensure maximum visibility of patients.
      d) Staff shall pay particular attention to patient's eating habits, safety considerations, and Aspiration Precautions. Dietary high risk behaviors are noted on the *Nursing Dietary/Aspiration Risk Tracking Form*. The MHA/FTS will document any additional concerns noted during meal time and communicate these to the Nurse in Charge and document as appropriate in the patient's record.
      e) The nurse will convey any dietary risk concerns to the **Team and ACS Provider, as needed,** for further evaluation by a Dietician and/or the Speech Language Pathologist, if indicated.

B. On-Unit Dining:
   1. A staff member shall continually be assigned to the on-unit Dining Room while patients are eating to ensure visibility of patients, safety considerations, and Aspiration Precautions.
   2. The staff member assigned to distribute trays will check the meal ticket against the unit's *Nursing Dietary/Aspiration Risk Tracking Form* to ensure the correct diet **and consistency** is given and that all food and liquids provided match the ticket description and prescribed order.

3. If there is a question concerning the diet, the staff member distributing the tray is to ask the nurse to verify the order.
4. Staff shall pay attention to patients eating habits, safety considerations, and Aspiration Precautions such as food left in mouth after swallowing, frequent coughing or sputtering, taking large bites of food, eating rapidly or shoveling food into mouth, etc. Any concerns will be noted on the *Nursing Dietary/Aspiration Risk Tracking Form*, reported to the nurse and documented in the patient's medical record.
5. Staff who are assigned to circulate in the Dining Room will check trays when returned, noting what the patient ate and that utensils are returned.
6. Dietary risk concerns shall be communicated as noted in Section A4e, above.