Comprehensive Aspiration Risk Management Plan (CARMP)

Name: Patrick Drake Date of Birth: 4/6/1979 Last 4 SS#: 0820

CARMP: ☐ **Initial** ☒ **Annual** **Date:** 3/17/2021 **Revised:** ☒ **Y** **Revision Date:** 6/26/2021 **Risk level:** High

Date of ARST: 6/20/2021 **ISP Term:** 4/15/21-4/14/22 **Case Manager:** Lola Devine **CM Agency:** Finley Case Management

NOTE**: Some CARMP Strategies may be optional for persons at moderate risk for aspiration due to Risky Eating Behavior (REB), when that is the ONLY criteria met on the Aspiration Risk Screening Tool (ARST). The optional REB strategy sections are labeled as "*Optional for REB Only". Other required CARMP sections continue to be required or may be determined "not applicable (n/a)" based on assessment & IDT consensus.*

☐ **REB ONLY criteria**

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
A. RECOGNIZE AND REPORT INDIVIDUAL SPECIFIC SIGNS AND SYMPTOMS OF ASPIRATION (required)		
The following is a list of those specific **signs and/or symptoms (S&S)** of aspiration or aspiration associated illnesses (including dehydration) that have been identified for this person. This should not be a generic listing of S&S of aspiration that applies to all people. *(If specific S&S are not known the IDT may use generic until individual specific S&S identified)* 1. Coughing during or after eating 2. Gurgling or "wet sounding" voice during or after eating 3. Dry lips/smacking lips 4. Tires easily and leans to one side		**Nurse** All IDT members should: • Provide input • Monitor and report
All IDT members are required to monitor for individual specific signs and symptoms of aspiration When any of the identified signs and/or symptoms listed above is observed the following actions are required: 1. The observer calls the agency nurse to report the observation & make a note in the daily documentation at that site. 2. The nurse determines the appropriate follow up action, coordinates this with the direct support personnel (DSP) and documents in nursing notes. Nursing actions may include, but are not limited to, contacting the PCP, monitoring temperature, pulse, and respirations for next 72 hours, sending the person to urgent care or the emergency room. 3. The nurse informs the observer of the actions taken and follow up as needed. 4. DSP will document all actions taken.		**Nurse** • All IDT members are responsible to monitor, report, and implement strategies
B. HEALTH MONITORING AND REPORTING (required)		
Refer to the Medical Emergency Response Plan(s) (MERPs) for specific guidelines		**Nurse**
Observe and report to the nurse immediately: choking that requires suctioning, abdominal thrusts (Heimlich maneuver) or 911.		**Nurse**
Use Pulse Oximeter 4 times a day (frequency) Notify Nursing: if below 95 *(insert range)*		**Nurse**
If vomiting or seizures occur: Follow the MERP(s). 1. Identify positioning during vomiting: laying on the left side to allow drainage Identify positioning during seizures: N/A (Refer to Seizure Plan) 2. Call the nurse. 3. If vomiting occurred; check temperature, pulse, respirations, and O2 saturation level (pulse oximeter) three times a day, for three days. Document all results in Therap and notify nurse of each result.		**Nurse**

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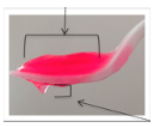
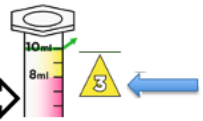
STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
4. If any S&S of aspiration or aspiration associated illness are present after vomiting, immediately have the person seen by the PCP, urgent care, or in the ER.		
Nurse will monitor and document clinical and respiratory status and report to PCP as needed.		**Nurse**
Staff will monitor weight (frequency): Twice per month Nurse to notify PCP for weight loss/gain of 10 lbs. or 10% bodyweight within 6-month period.		**Nurse**
All IDT members are required to monitor for signs and symptoms of dehydration as listed in section A (some examples are dry mouth, poor skin turgor, low or dark urine output, etc.). Notify nurse and RD with concerns.		**Nurse**
Other Monitoring & Reporting Related to: 1. Respiratory/bronchial issues. Refer to respiratory care plan if needed. ☐ Yes ☒ N/A 2. Other: GERD, constipation, seizures, etc. Refer to other plans as needed. ☒ Yes ☐ N/A 3. Hydration/Dehydration due to other complex medical/behavioral needs. Refer to plan as needed. ☐ Yes ☒ N/A		**Nurse**
C. ORAL INTAKE STRATEGIES (**required if** the person eats, drinks, or takes medications orally) ☐ Not applicable - 100% NPO *(if checked, delete all areas in section below)*		
Positioning *of person* when eating or drinking anything**:** • Patrick should be sitting at the dining table in his wheelchair • Prior to eating, check to be sure his hips are all the way back on the cushion, the seatbelt is snug, chest strap is on, and his feet are on the footrests • Be sure he is close to the table and not 'twisted' in his chair		**PT**
Positioning *of person assisting* with all food or fluids**:** sitting on Patrick's right side at or below his eye level		**PT**
Nutrition Recommendations: ☒ Refer to more detailed Nutrition Plan, as needed. 1. Nutrition goals: 1) Tolerate enteral feeding as ordered by physician. 2) Maintain adequate hydration. 3) Tolerate oral feeding for pleasure. 4) Gradual weight gain of 2-3 pounds each month until a weight is reached within the recommended weight range of 117-143 pounds. 5) No signs or symptoms of aspiration. 6) Soft BM every 1-2 days. 7) No signs or symptoms of reflux. 2. Recommended weight range: 117-143 3. Diet order: Avoid tomato products and caffeine due to causing reflux for Patrick. Add high calorie condiments to food to boost caloric intakes, such as melted cheese, butter, gravy, sour cream, mayonnaise, salad dressing, cream cheese, jelly, honey, whip topping, cream sauces, olive oil, canola oil, half and half, Greek yogurt, etc. 8oz prune juice twice daily. Provide high calorie beverages, such as juice, smoothies, milk, lemonade, sweetened tea rather than water and flavored water packets that contain no calories to help with weight maintenance. 4. Food allergies, if known: None 5. Supplements/snacks *(do not list vitamins*): None 6. Caloric needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 1800 calories		**RD**

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
7. Protein needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 60 grams 8. Fluids: a. Fluid intake needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 1800 ml b. Fluid intake restrictions (per PCP orders): None Ordered I&O must be tracked. c. Additional strategies to minimize risk of dehydration *(such as offer beverages with regular intervals, variety of beverages, offer small amounts frequently, etc.)*: Oral fluid intake is for pleasure and 100% of fluid needs are being met by G-tube H_2O flushes		
Diet Texture: Choose **one** appropriate IDDSI Level; delete all other levels. ***Note:*** Refer to CARMP Instructions if DCP has occurred.		**SLP**
IDDSI Level	*IDDSI Description* - ***do not alter***	*Testing Methods* – ***see Appendix: IDDSI Reference***
Level 4 – Pureed Food	• usually eaten with a spoon • not sticky • does not require chewing • liquid must not separate from solid • no lumps *** must pass both *Fork Drip* and *Spoon Tilt* test**	 Holds shape, not firm or sticky 
Instructions/Guidance for *preparation of food* for person *(describe blender/speed being used, fluids to add, etc.)*: N/A		
Liquid Consistency: Choose **one** IDDSI Level; delete all other levels. ***Note:*** Refer to CARMP Instructions if DCP has occurred.		**SLP**
IDDSI Level	*IDDSI Description* - ***do not alter***	*IDDSI Flow Test/Test Methods* - ***see Appendix: IDDSI Reference***
Level 3 Moderately Thick Liquid	• can be drunk with a cup or taken with a spoon • smooth texture with no 'bits' • can be poured *** must pass both *Flow* test and *Fork Drip* test**	 **at least 8mL** left in the syringe Drips slowly through fork slots 
When liquids must be thickened, a commercial thickener or specific additive must be identified: Simply Thick Packets (Level 3: Moderately Thick) ☐ **N/A** **Instructions/Guidance for *preparation of liquid* for person:** N/A		
Adaptive Eating Equipment *(identify by name; photos are helpful. Include web links or attach page with ordering/purchasing information)* 1. Utensils: Munchkin spoon**;** ~~brown nylon teaspoon for liquids~~ **Per DCF 6/26/21: Nosey Cup allowed with 1oz fluid at a time** 2. Dishes: N/A	 	**OT**

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
3. Cup *(specify style, lid, spout, straw, etc.)*: ~~N/A~~ **Per DCF 6/26/21: Nosey Cup allowed with 1oz fluid at a time** 4. Cup for hydration outside of mealtime: ~~N/A~~ **Per DCF 6/26/21: Nosey Cup allowed with 1oz fluid at a time** 5. Mat: N/A 6. Other (*blender/food processor, etc.*): N/A	Nosey Cups https://www.amazon.com/dp/B009R2EH3I/ref=cm_sw_em_r_mt_dp_77CYNG33P833HD7TXZ8Q Munchkin Soft Tip Spoon 6 Pack https://www.amazon.com/dp/B003WUGR6G/ref=cm_sw_em_r_mt_dp_GCKTCHGX3A4ASTKMY60Z	
Level of Supervision when eating and/or drinking (*describe*): Caregiver should be seated at the table with Patrick		**SLP**
Assisted Eating Techniques: how to assist the person with eating **when another person** is bringing the food and/or liquid to their mouth 1. Presentation of Food (*describe placement on lips or tongue, types of cues given, pacing, amount on spoon, alternating food and liquid sips, alertness strategies, etc.*): • Scoop the food onto the spoon • Tell Patrick, "here comes a bite" • Wait for him to bring his head up and open his mouth • Place spoon in his mouth and apply slight downward pressure to mid-third of tongue • Wait for him to close his lips around the spoon and then pull it out • Look to make sure he has swallowed the food in his mouth before giving him another bite 2. Presentation of Liquid (*describe placement on lips or in mouth, types of cues given, pacing, amount of liquid in cup or per sip, etc.*): • Fill his cup to the 1oz mark. • Tell Patrick, "here comes a drink" • Wait for him to bring his head up and open his mouth • Place the cup on his lips and wait for him to close them around the rim. • DO NOT pour the liquid into his mouth. • Slightly tip the cup and give him no more than two small consecutive drinks • Remove the cup and allow him to take breath before giving him more		**SLP**
Self-Feeding Techniques: assistance needed **for the person** to safely bring the food and/or liquid to their own mouth 1. Adaptive Equipment: 2. Communication Aid(s):		**N/A**

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
3. Presentation of Food: 4. Presentation of Liquid: 5. Cues needed:		
Sensory Support *(describe strategies to support sensory needs and ensure safety during mealtime):* Turn off background noise such as tv or radio. Close dining room blinds partway so Patrick doesn't have to squint in the sunlight. In the community/at a restaurant, have Patrick sit facing 'away' from the activity and away from the aisle or walkway, whenever possible.		**OT**
Behavioral Support *(include strategies to address risky eating behavior, prompts to address distraction, provide reassurance, combat food insecurity related to trauma, confusion, overstimulation, anxiety, motivation, etc.):* • When assisting Patrick during pleasure feeding/drinking, remind him that you are doing it this way to keep him safe. • Use a reassuring tone. Know Patrick might need some extra time during pleasure feeding. • Be sure to give him a break between spoonfuls/drinks to breathe and manage saliva. • It works really well if you and Patrick take deep breaths together. It helps to keep your voice level even and stay calm. • Eating alone in a quiet place may be useful. • If Patrick is unable to relax, stop, take a break, and try again if he demonstrates interest.		**BSC**
Positioning after oral intake: upright or tilted to 30° or less in his wheelchair **Minimum** length of time this position must be maintained: 45 minutes after each pleasure feeding		**PT**
D. ORAL MEDICATION DELIVERY STRATEGIES ☐ Not applicable – 100% NPO or ☐ ****** Optional for REB Only (*if checked, delete both rows in section*)		
Altered form of Medication: 1. Refer to MAR for current medications & appropriate times for medication delivery. DO NOT LIST MEDICATIONS HERE. 2. Describe the altered form of medications as needed due to sensory and/or dysphagia limitations (*check all that apply, **if using multiple altered forms of medication specify type for each**)* ☐ Liquid (*special instructions*): ☐ Crushed [assure medication is crushable] *(special instructions*): ☐ Cut into pieces no larger than , (*special instructions*): ☐ Whole (*special instructions*): ☐ Sprinkled on food (*special instructions*): ☐ Dissolved in liquid (*special instructions*): ☐ Other (describe):		**N/A**
Oral Medication Delivery Method: *Indicate additional delivery techniques intended to minimize aspiration risk; check all that apply. Note: Level of Assistance with Medication Delivery is based on the MAAT: contact nurse with any questions.*		**N/A**

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
Liquid Medication/Medication Dissolved in Liquid: ☐ Drink using (*specify cup type, straw, etc.)* Other Forms of Medication: ☐ Mix with (*e.g. water, puree food, soft foods, etc*.) ☐ Present using (*e.g. syringe, specific spoon, med cup, fingers, etc*.) ☐ Number of pills/tablets/capsules in mouth at one time ☐ Follow each oral presentation medication dose with (*drink, puree food etc.)* ☐ Visually examine the mouth (*cheeks, under tongue, area between lips and teeth*) to assure medication has been swallowed. ☐ Sweep the mouth with a (*gloved finger, toothette*) to assure medication has been swallowed. ☐ Other:		
E. TUBE (Enteral) FEEDING STRATEGIES via ☒ G; ☐ J; ☐ G/J; or ☐ NG tube ☐ Not applicable, no feeding tube *(if checked, delete all areas in tube feeding section below)*		
Nutritional Recommendations for Tube Feeding		
Do not list enteral feeding or water flush orders. Refer to MAR for the most current enteral feeding and water flush orders. **☒ Refer to more detailed Nutrition Plan, as needed.** 1. Nutrition goals: 1) Tolerate enteral feeding as ordered by physician. 2) Maintain adequate hydration. 3) Tolerate oral feeding for pleasure. 4) Gradual weight gain of 2-3 pounds each month until a weight is reached within the recommended weight range of 117-143 pounds. 5) No signs or symptoms of aspiration. 6) Soft BM every 1-2 days. 7) No signs or symptoms of reflux. 2. Recommended weight range: 117-143 3. Caloric needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 1800 calories 4. Protein needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 60 grams 5. Fluid needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 1800 ml		**RD**
Tube Feeding Protocol (required) ☒ **= Indicates required content**		
1. List steps for checking tube placement (*describe, i.e., by checking mark on tube at exit site or n/a):* Observe tube length each time before starting tube feeding, giving water flushes, or medication. Use the measuring tape and report the tube length on the I&O form. If the tube is one inch shorter or longer call the nurse. 2. List steps for checking residual, if ordered by PCP or specialist (*describe or n/a*): N/A 3. List steps for setting up and/or connecting/disconnecting tube feeding including: i. Wash hands in the kitchen sink with the antibacterial soap. ii. Gather all supplies, bring it to the person, place on a clean area. iii. Supplies needed include the feeding bag, formula water, gloves, measuring container, clean hand towel iv. Explain to the person what you are going to do and ensure they are comfortable.		**Nurse**

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
v. Ensure the person is in the correct position as described by the PT. vi. Expose the feeding tube. vii. Cleanse hands with the Alcohol-based Hand Sanitize. Put enough sanitizer on your hands to cover all surfaces. Rub your hands together until they feel dry (this should take around 20 seconds). viii. Make sure the tubing is clamped before attaching the feeding bag ix. Attach the feeding bag to the feeding tube. Cover Patrick with the clean towel. x. Fill the bag with 250 ml formula. xi. Hang the bag on the hanger that is not higher the person's shoulder. xii. Allow Formula to run in freely over 30 minutes. xiii. Do not leave Patrick alone during this time. xiv. Patrick may watch tv or read his book. xv. When the bag is empty clamp the tubing. xvi. Add 100 ml water in the bag. xvii. Hang the bag on the hanger that is not higher the person's shoulder. xviii. When the bag is empty clamp the tubing. xix. Cleanse hands with the Alcohol-based Hand Sanitize. Put enough sanitizer on your hands to cover all surfaces. Rub your hands together until they feel dry (this should take around 20 seconds). xx. Unhook the feeding bag from the feeding tube and cover the feeding tube. xxi. Observe the skin and dressing for signs of leakage. xxii. Cover Patrick, ensure he is comfortable, and in the correct position as described by PT. xxiii. Rinse the feeding bag and hang to dry. Clean and store container. xxiv. Document intake. a. ☒ Aseptic/Clean technique for flushes (*describe*): i. Wash hands in the kitchen sink with the antibacterial soap. ii. Gather all supplies, bring it to the person, place on a clean area. iii. Supplies needed include the feeding bag, water, gloves, measuring container, clean hand towel iv. Explain to the person what you are going to do and ensure they are comfortable. v. Ensure the person is in the correct position as described by the PT. vi. Expose the feeding tube. vii. Cleanse hands with the Alcohol-based Hand Sanitize. Put enough sanitizer on your hands to cover all surfaces. Rub your hands together until they feel dry (this should take around 20 seconds). viii. Make sure the tubing is clamped before attaching the feeding bag ix. Attach the feeding bag to the feeding tube. Cover Patrick with the clean towel. x. Fill the bag with 250 ml of water. xi. Hang the bag on the hanger that is not higher the person's shoulder. xii. Allow water to run in freely over 15 minutes.		

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
xiii. Do not leave Patrick alone during this time. xiv. Patrick may watch tv or read his book. xv. When the bag is empty clamp the tubing. xvi. Cleanse hands with the Alcohol-based Hand Sanitize. Put enough sanitizer on your hands to cover all surfaces. Rub your hands together until they feel dry (this should take around 20 seconds). xvii. Unhook the feeding bag from the feeding tube and cover the feeding tube. xviii. Observe the skin and dressing for signs of leakage. xix. Cover Patrick, ensure he is comfortable, and in the correct position as described by PT. xx. Rinse the feeding bag and hang to dry. Clean and store container. xxi. Document intake. b. ☒ Total time allowed to hang: The feeding bag should be changed every 24 hours. c. ☒ Bolus vs. ☐ Continuous (*describe*): Refer to MAR for current order and formula d. ☐ Other instructions: N/A 4. Instructions for routine site care (*describe*): Gently clean with warm water & gauze pad daily/PRN. Report redness/drainage to nurse ASAP 5. Instructions regarding potential complications (*describe)*: a. ☒ When to discontinue feedings: If coughing, gurling, or vomiting b. ☒ Notify nurse of vomiting: ASAP c. ☒Nurse will notify the PCP: For signs of infection or dislocation as needed d. ☒ Instructions for what to do in case of change in tube length/displacement or dislodgement: Stop feeding. Call nurse ASAP e. ☒ Instructions for abdominal pain, swelling or tenderness: Call nurse ASAP and discontinue feeding. Take temperature f. ☒ Instructions for redness/infections/erosion/drainage at site: Take temperature. Call nurse ASAP g. ☒ Monitor for signs of dehydration: Watch for dry lips/tongue, dry skin, amber colored urine, urinating less than once every three hours h. ☐ Other: N/A		
Medication Delivery via Tube ☐ **Not applicable** *(if checked, delete row below)*		
Medication Delivery Method: Refer to MAR for Physician orders; including crush and flush orders 1. Medications must never be added to formula. 2. Medications must be given one at a time (*e.g., dissolved or crushed and mixed with water or other liquid as ordered by PCP*): dissolved in water 3. Assure medication is crushable. 4. Flush with water as ordered after each medication administration. 5. Other: N/A		**Nurse**

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
Positioning DURING and AFTER tube feeding, water flushes, and medication administration		
Describe general places the person may receive tube feeding, water flushes and medication administrations (*e.g. regular chair, wheelchair, bed, etc.*): 1. Wheelchair 2. Bed 3.		**PT**
Positioning **during** tube feeding, water flushes & medication administration: • upright or tilted to 30° or less in his wheelchair • laying down with the head of his bed elevated to 45°		**PT**
Positioning **after** tube feeding, water flushes and medication administration: • upright or tilted to 30° or less in his wheelchair • laying down with the head of his bed elevated to 45° **Minimum** length of time this position must be maintained: 45 minutes after each feeding		**PT**
Activity or behavioral strategies during tube feedings		
1. Activity strategies: Patrick likes to listen to music on his headphones or books on tape. These are great to do during tube feeding.		**OT**
2. Behavioral strategies (*e.g., distraction, redirection prompts, use of abdominal binder to minimize risk of pulling tube, etc.*): • If Patrick gets agitated during tube feeding, remind him that "we're not done yet, it's safer to hang out for a little longer". • Patrick is good at deep breathing with others. It works really well if you and Patrick take deep breaths together.		**BSC**
F. POSITION FOR ROUTINE ACTIVITIES ☐ **Determined not applicable based on assessment & IDT consensus** *(if checked, delete row below)*		
Positioning for (*photos are helpful):* ☒ Refer to more detailed WDSI, as needed. 1. Bed: laying down with the head of his bed elevated to 45°, blanket roll under his knees, pillows alongside each upper leg and hips, towel rolls on each side of his head in his pillowcase 2. Showering or bathing: upright or tilted to 30° or less in his rolling shower chair with feet on footrests, chest strap and seat belt secured 3. Personal care (e.g., *Attends changes, dressing etc*.): in bed laying flat for less than 10 minutes 4. Swimming: N/A 5. Rest or leisure: in his recliner, tilted back to 30° or more, with pillow props under each arm and footrest extended 6. Other: N/A		**PT**

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
G. ORAL HYGIENE STRATEGIES (required) **** if REB only ☐ Determined not applicable based on assessment & IDT consensus** *(if checked, delete all areas in oral hygiene section below)*		
Please check all that apply *(for team information only):* ☐ own teeth (all present) ☒ own teeth (some missing) ☐ no teeth ☐ partial plate/dentures used ☐ partial plate/dentures refused		
1. Complete Oral Care 2 times per day.		**Nurse**
2. Identify when oral care should occur: after breakfast and after dinner 3. Recommended Location(s) for oral care: in bathroom, near sink		**OT**
4. List and describe ALL needed oral hygiene supplies (including those identified by the team and prescribed/recommended per the Dentist/Oral Hygienist): 4.1. Mouthwash/solutions (*refer to MAR if ordered*): N/A 4.2. Toothpaste (*refer to MAR if ordered*): fluoride, gel (not paste) 4.3. Toothbrush(es): manual, small head, soft bristles 4.4. Other *(include partial/denture care as needed):* washcloth, floss pics		**OT**
5. Utilize good oral hygiene practices as recommended by Dentist/Oral Hygienist or identified by the team *(include detailed instructions in sections 8 and 9)*: 5.1. Brushing time: 30 seconds per quadrant 5.2. Flossing: Once per day, after dinner 5.3. Partial/Denture care:		**OT**
6. **Positioning *of person*** during oral care: upright or tilted to 30° or less in his rolling shower chair or wheelchair with feet on footrests, chest strap and seat belt secured, headrest in marked position		**OT**
7. **Positioning *of person assisting*** with oral care: • The person assisting Patrick should be positioned at his eye level • Squatting or kneeling at eye level with Patrick, to side or front – whichever is easiest for reaching and observing his oral area • There is a stool at the house for staff to sit on while assisting Patrick		**OT**
8. Brushing Routine Assistance and Instructions recommended by Dentist/Oral Hygienist or as identified by team.		**OT**

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
Choose One (*and describe set up, supervision, placement in mouth, time per mouth quadrant, types of verbal/gestural/physical cues or assist, pacing, sensory strategies, etc.)* ☐ Self-Brushing for complete oral hygiene routine: ☐ Self-Brushing and Assisted Brushing for oral hygiene routine: ☒ Assisted Brushing for complete oral hygiene routine: *Brushing:* • Place clothing protector around Patrick's neck, put on gloves. • Wet toothbrush and shake off excess water. • Use a very small dab of toothpaste/about the size of a grain of rice • Gently brush all teeth surfaces and gums with the brush. • Brush one small area at a time and then remove brush ("count 1, 2, 3 and out"). • Give Patrick a break and allow saliva to flow out of his mouth. • Repeat brushing small sections and giving breaks until all areas have been cleaned. • Do not brush if Patrick is laughing or verbalizing, wait until he has stopped. *Flossing:* • Let Patrick know you are going to help him with the flossing. Touch his cheek to let him know where you are going to start (upper/lower, left/right side) • Ask him to open his mouth. Gently slide the floss back and forth between each tooth in the area/quadrant. Stop and give Patrick a 20-30 sec break. Repeat for the other 3 areas/quadrants.		
9. Specific Oral Care Procedures not covered above, in sequential order, including Sensory, Behavioral, and Cognitive strategies: 9.1.		**N/A**
10. Saliva management techniques *during oral care* not previously stated (*e.g. suctioning, etc.*): Patrick does not have an active spit. He needs to be positioned upright to allow saliva to flow forward out of his mouth.		**OT**
11. Observe for and report to nurse any: 11.1. Change in appearance of gums or tongue; (e.g. dark, broken, loose or missing teeth; bad breath; swelling, lesion).		**Nurse**

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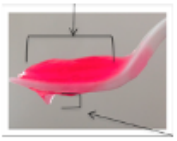
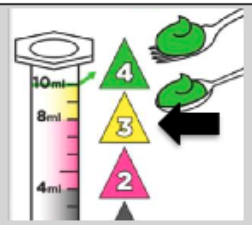
STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
11.2. Presence of oral pain, refusal to eat or drink hot/cold food or liquids etc. 11.3. Stop oral care immediately and contact nurse if: the person is coughing, gagging, or choking and cannot catch his breath, or turning blue		
12. Positioning **AFTER** oral care: upright in his rolling shower chair or wheelchair, tilted to 30° or less **Minimum** length of time this position must be maintained: 10 minutes		**PT**
H. SALIVA MANAGEMENT STRATEGIES ☐ **Determined not applicable based on assessment & IDT consensus** (*if checked, delete areas below)*		
Positioning: 1. Lying down: 2. Sitting: 3. Other:		**N/A**
Skin/Clothing Protection: Use clothing protector, as need for drooling		**Nurse**
Medical strategies: ☐ Medication (routine or PRN medications used to control oral secretions): ☐ Suction: 1. Type of suction catheter: 2. Size of suction catheter: 3. ☐ Oral or ☐ Tracheal suctioning 4. Frequency to apply suction: ☐ Other instructions: ☐ Contact nurse for: Nurse will contact PCP when indicated.		**N/A**
Other Strategies (if any):		**N/A**
I. STRATEGIES TO MINIMIZE RUMINATION ☒ **Determined not applicable based on assessment & IDT consensus** (*if checked, delete areas below*)		
J. PERSONALIZED OUTCOMES (required) *Note: Outcomes must be measurable. Timeline for each outcome will be through the ISP term. If timeline is different than this, PLEASE SPECIFY!*		
The IDT will track the following outcomes to determine the effectiveness of the CARMP 1. Patrick will not have any incidents of aspiration or aspiration associated illnesses 2.		**IDT:** develops **CM:** assures IDT tracks outcomes

STRATEGIES	**PHOTOS (optional)**	**LEAD CONTACT***

K. LEAD CONTACT (TRAINER) INFORMATION (required for ALL) **Use SCOMM only for all communication and scheduling**

Name	**Agency**	**Phone**	**Fax**
Primary Provider Nurse: Betsy RN: Nettie RD: Jennifer SLP: Demarre PT/PTA: Mary Beth OT/COTA: Robin BSC: Lynn			

APPENDIX: IDDSI REFERENCE PAGE - DIET TEXTURE - DO NOT EDIT - DO NOT DELETE

IDDSI Descriptors and Characteristics	IDDSI Testing Methods
Level 7 Regular Food	• everyday foods of various textures • no texture/size restrictions at this level
Level 7 Regular, Easy to Chew Food: • does not include: hard, tough, chewy, fibrous, stringy, crunchy or crumbly bits, pips, seeds, fibrous parts of fruit, husks, or bones * must break apart easily and pass fork pressure test	• everyday foods of soft/tender textures • must **break apart easily** with the side of a fork/spoon • doesn't regain shape when squashed • may include 'dual consistency' or 'mixed consistency' per lead contact
Level 6 Soft and Bite-Sized Food • knife not required to cut this food • soft, tender and moist throughout but with no separate thin liquid * must pass both food piece size and softness tests	• can be mashed/broken down with pressure from fork or spoon • does not return to original shape when squashed    Food pieces no bigger than 1.5cm x 1.5cm
Level 5 Minced and Moist Food • can be scooped & shaped (e.g. into a ball shape) on a plate • soft and moist with no separate thin liquid * must pass all 3 tests: fork, squash, spoon tilt	 Food pieces no bigger than 4mm x 15mm  • soft enough to squash easily with fork or spoon  • small lumps visible within the food • holds shape, **not** firm or sticky, little food may stay on spoon 
Level 4 Pureed Food • can be piped, layered, or molded because it retains its shape • should not require chewing • very slow movement under gravity but cannot be poured • cannot be sucked through a straw * must pass both Fork Drip and Spoon Tilt tests	 • sits in a mound or pile above the fork • small amount may flow through and form a tail • does *not* drip continuously through fork slots • falls off in a single 'plop' when spoon tilted or flicked • not firm or sticky  • thin film may stay on spoon 
Level 3 Liquidized Food • can't be piped, layered, or molded; will not keep its shape • can be swallowed directly; no chewing required • smooth texture with no 'bits' (lumps, fibers, bits of shell or skin, husk, particles of gristle or bone) * must pass both Flow Test and Fork Drip tests	 • Can be eaten with a spoon • Can't be eaten with a fork because it drips slowly or in dollops/ strands through the slots of a fork 
Transitional Foods: ***Used only with Levels 5, 6, and 7*** • food that starts as one texture (e.g. firm solid) and changes into another texture specifically when moisture (e.g. water or saliva) is applied or when a change in temperature occurs (e.g. heating) • food squashes and does not return to original shape * must pass Fork Pressure test	

APPENDIX: IDDSI REFERENCE PAGE - LIQUID CONSISTENCY — DO NOT EDIT – DO NOT DELETE

IDDSI Descriptors and Characteristics

Level 4 Extremely Thick Liquid
- Cannot be poured
- Cannot be drunk from a cup

Level 3 Moderately Thick Liquid
- Can be poured
- Can be drunk with a cup or taken with a spoon

Level 2 Mildly Thick Liquid
- 'sippable'
- Pours quickly from a cup or spoon, but more slowly than thin drinks

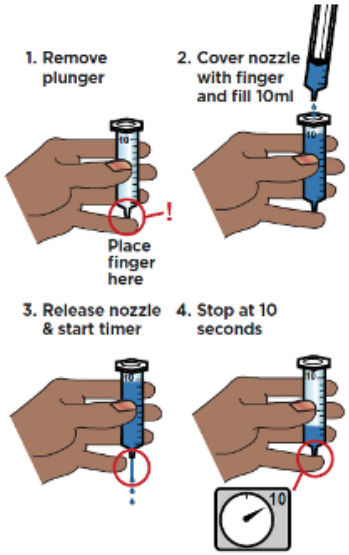
Level 1 Slightly Thick Liquid
- Thicker than water
- Requires a little more effort to drink than thin liquids

Level 0 Thin Liquid
- No liquid restrictions; fast flow
- Flows like water

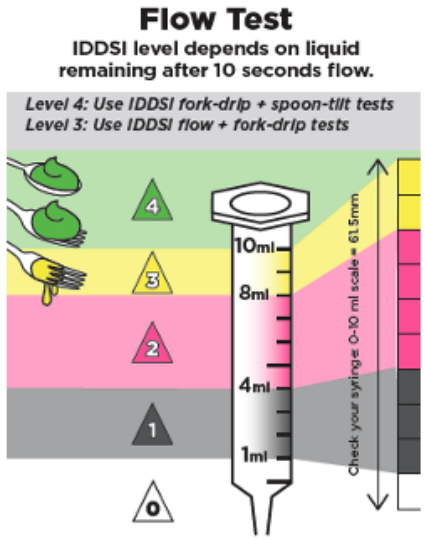
IDDSI Flow Test/Testing Methods

*** Use Flow Test after mixing and wait time ***

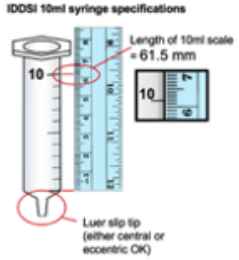
www.iddsi.org

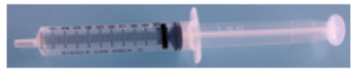


The amount of liquid in the syringe after 10 seconds determines the IDDSI Level



Always use this syringe for IDDSI Flow Testing





BD 10ml Slip Tip syringe - code 303134
BD 10ml Luer Lock syringe - code 300912

OR

Any 10ml syringe measuring 61.5 mm in length from the zero line to the 10 mL line

Additional Considerations and Guidance

Wait Time:
- Typically test liquid after it sits for 5-10 minutes
- Varies by brand and product – check the package

Temperature:
- Both the room temperature and food/liquid temperatures make a big difference
- Please test and retest as needed

Carbonated Drinks:
- Thickener makes carbonated drinks fizz
- Mix until the fizz goes down
- WAIT at least 3 minutes after the fizz goes down before testing these drinks

Smoothies, Shakes, & other 'already thick' drinks
- Test drink first
- Thin or thicken as required for level needed
- These drinks melt as they sit
- Please retest

Need to Thicken or Thin?
- See CARMP Liquid Consistency Instructions Box for what to use
- See CARMP Nutrition Recommendations section for specifics about use of broth, purees, etc.