Nutrition and Swallowing Checklist

What is the checklist for?

- The Nutrition and Swallowing Checklist is a way of screening people for problems related to nutrition and swallowing. It cannot make a diagnosis of a medical condition. A diagnosis can only be made by a specialist professional.

- The Checklist was developed as a means of **raising awareness of nutrition-related problems in people with disabilities. It has been developed to be used by people who care for people with disabilities.**

- By asking questions about a person's **health, weight and their ability to eat and drink,** the checklist will help you decide if further assessment and action is needed, **including advice or assessment by a dietitian, speech pathologist or other specialist.**

Who should complete it?

- If you are completing the checklist *you* should **know the person with a disability well**. For example, *you will* have been providing personal care to the person with a disability for at least 6 months. Otherwise ask someone who does know the person well to help you complete the checklist.

- Complete the checklist **with the assistance of the person with a disability** as much as possible.

How to complete it

Part 1- Preliminary Profile

- Gathers and evaluates information about the person's **weight and height**. In this section you have to write in the information requested for some questions and tick the relevant box for others.

Part 2 - Nutrition Risk and Swallowing Risk Checklist

- Assesses if the person has indications of **nutritional problems or swallowing problems** that may affect their nutrition and health.. Tick the relevant box for each question.

This marker + ***page x*** is used throughout the checklist. It indicates where you can find more information about a particular topic in the ***Nutrition in Practice Manual***.

Don't guess answers

- Try to obtain all the information you need to complete the checklist. For example, you may need to look at the person's weight records to work out if they have lost or gained weight over the past 3 months. If there are no records, and you are not able to measure height or weight, you should still complete as much of Section 1 as you can, and then complete Sections 2 to the best of your knowledge.

- **Be observant.** Don't guess answers. Use your powers of observation to answer those questions about how the person eats and drinks. If you are unsure or don't know the answer to a question,

you may need to seek another person's opinion or advice. If the answers are still uncertain, then tick the **Unsure/Don't know** box and refer to a health specialist for assistance.

Part 1 Preliminary Profile

The person with a disability

Name:…….. Male ☐ Female ☐

Date of birth: Age:

Residential address:…….. Postcode: ……

This address is: an independent residence…….. ☐
a family home …….. ☐
a group home …….. ☐
a residential centre …….. ☐
other (specify)…….. ☐

Has the Nutrition and Swallowing Checklist been used before for this person? Yes / No

If yes, when? Date ……/……../……

The person conducting the checklist

Date checklist is completed: ……/……/……

Your name (person completing the checklist):……

Your relationship to the person with a disability: case worker…….. ☐
case manager…….. ☐
residential care worker……..☐
nurse…….. ☐
parent…….. ☐
other…….. ☐

How long have you known the person? less than 6 months…….. ☐
6 months to 1year…….. ☐
1-2 years…….. ☐
2-5 years…….. ☐
more than 5 years…….. ☐

Where this Checklist is being completed? the person's home……..☐
the person's school……..☐
the person's work……☐
a Community Service Centre……☐
other (specify)……..☐

Who is the person providing the information so you can complete this checklist ? (tick more than one box if needed)
self…….. ☐
the person with a disability…….. ☐
parent (of the person with a disability)… ☐
close relative (of " " " " ")…… ☐
close friend (of " " " " ")…….. ☐
other (specify) …….. ☐

Weight information
Current weight without shoes (e.g. 69.5 kg): ……. kg. Date weighed: …….
If you have no information on the person's weight, why? ……..

Weight change over the past 3 months: ……. kg gained ☐ or, lost ☐
Do you have weight records for the past 3 months? Yes ☐ No ☐

Height information
Current height (measured standing and without shoes)
(e.g.164cm or 1.64 metres): ……. Date measured: ……

If you have no information on the person's height, or you are not able to measure their height, why?
……

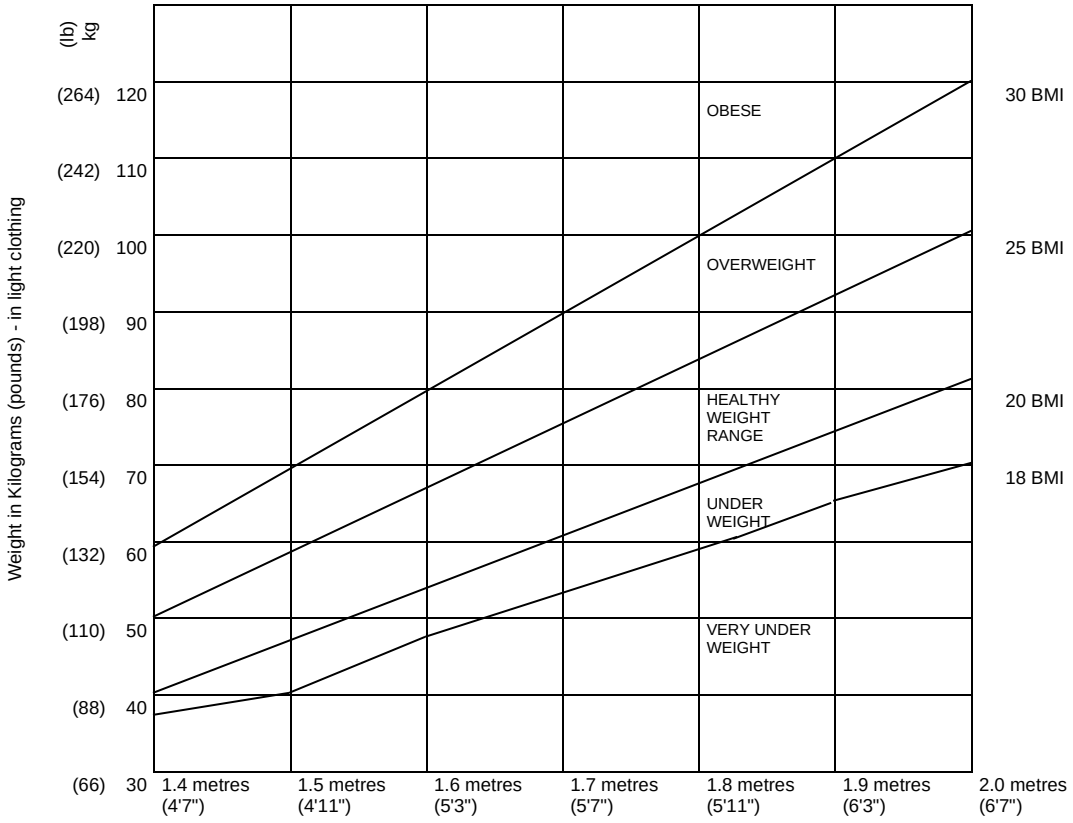
Note: For children and young people under 18 years, their growth rate should be assessed by a GP, paediatrician, early childhood nurse or dietitian every year? Has this happened? Yes ☐ No ☐

Using the weight and height information
If the person is an adult, mark the spot on the chart (below) where their height and weight meet.

Weight for Height Chart

(FOR MEN AND WOMEN FROM 18 YEARS ONWARD)

Based on Body Mass Index (BMI) in Range of 18, 20, 25, 30.



Height in metres (feet and inches) – without shoes.

Part 2 - Nutrition and Swallowing Risk Checklist

Tick an answer box for each question. The explanations beneath each question will help you complete the checklist.

	Yes	No	Unsure/Don't know
Question 1. **If the person is a child** (i.e. under 18 years) have they lost weight or failed to gain weight over the last 3 months?	❑	❑	❑

You will need weight records to answer this question accurately.

	Yes	No	Unsure/Don't know
Question 2. Is the person underweight?	❑	❑	❑

Tick the **Yes** box if *either* of the following:
- they are an adult and their weight on the *Weight for Height Chart* is in the very underweight range
- when you look carefully at the person (adult or child), their bone structure is easily defined under their skin. This can indicate significant loss of fat tissue and is easily checked by looking around the eyes and cheeks. Other areas to check include the shoulders, ribs and hips.

	Yes	No	Unsure/Don't know
Question 3. Has the person had unplanned weight loss or have they lost too much weight?	❑	❑	❑

Tick the **Yes** box if *any* of the following:
- their weight loss is undesirable or has been unexpected
- they are under 18 years and there is **any** weight loss in two or more consecutive months
- they have lost weight on two or more consecutive months and are not on a monitored weight loss program.

	Yes	No	Unsure/Don't know
Question 4. Is the person overweight?	❑	❑	❑

Tick the **Yes** box if *either* of the following:
- they are an adult (over 18 years) and their weight on the W*eight for Height Chart* is in the overweight or obese range
- they (adult or child) appear to have rolls of body fat, for example around the abdomen.

	Yes	No	Unsure/Don't know
Question 5. Has the person had unplanned weight gain or have they gained too much weight?	❑	❑	❑

Tick the **Yes** box if *either* of the following:
- their weight gain is undesirable or has been unexpected
- they are not on a weight gain program and their clothes no longer fit.

	Yes	No	Unsure/Don't know
Question 6. Is the person receiving tube feeds?	❑	❑	❑

Tick the **Yes** box if the person is receiving naso-gastric, naso-duodenal or gastrostomy feeding.

	Yes	No	Unsure/Don't know
Question 6a. If you answered Yes to question 6, does the person also receive food or drink through the mouth?	❑	❑	❑

Tick the **Yes** box if they receive any food or drink by mouth, in addition to tube feeding.

If the person is receiving tube feeds and no other food by mouth, then answer only questions 10,13,14,16, 18 and 19.

Question 7. Is the person physically dependent on others in order to eat or drink?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if:
- the person cannot put food or drink into their own mouth and someone else is needed to feed them.

Question 8. Has the person had a reduction in appetite or food or fluid intake?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if *either* of the following:
- they are not eating or drinking as much as they usually do and this is unintentional
- they appear unwilling to take most food offered to them and the equivalent of 6 large glasses of fluid each day.

Question 9. Does the person follow, or are they supposed to follow, a special diet?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if they are on, or are supposed to be on, any of the following dietary plans:
- puree, minced, chopped or soft foods
- thickened fluids
- weight reduction or weight-increasing
- low fat
- vegetarian
- low cholesterol or cholesterol-lowering
- diabetic
- any other diet which modifies or restricts foods or food choices

Question 10. Does the person take multiple medications?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if:
- they are usually on more than one type of medication

Question 11. Does the person select inappropriate foods or behave inappropriately with food?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if *any* of the following apply:
- they are a 'picky' eater or refuse to eat some food groups, making a balanced diet impossible
- they over-consume alcohol or coffee, tea and cola drinks
- they eat non-food items such as dirt, grass or faeces
- they drink excessive amounts of fluid
- they steal or hide food.

Question 12. Does the person usually exclude foods from any food group?	Yes ❑	No ❑	Unsure/Don't know ❑

Tick the **Yes** box if the person usually excludes **all foods** from one or more of the following groups of food:
- bread, cereals, rice, pasta, noodles
- vegetables, legumes
- fruit
- milk, yogurt, cheese
- meat, fish, poultry, eggs, nuts, legumes

	Yes	No	Unsure/Don't know
Question 13. Does the person get constipated?	❑	❑	❑

Tick the **Yes** box *either* of the following:
- their bowel movements are irregular, painful and sometimes infrequent
- laxatives, suppositories or enemas are required to maintain regular bowel movements

	Yes	No	Unsure/Don't know
Question 14. Does the person have frequent fluid-type bowel movements?	❑	❑	❑

	Yes	No	Unsure/Don't know
Question 15. Does the person have mouth or teeth problems that affect their eating?	❑	❑	❑

Tick the **Yes** box if *any* of the following:
- teeth are loose, broken or missing
- the lips, tongue, throat or gums are red and inflamed or ulcerated
- they have a malocclusion (upper and lower teeth do not meet) and this affects their ability to chew.

	Yes	No	Unsure/Don't know
Question 16. Does the person suffer from frequent chest infections, pneumonia, asthma or wheezing?	❑	❑	❑

Tick the **Yes** box if *any* of the following:
- they have had frequent chest infections or pneumonia
- they are usually 'chesty' or have difficulty clearing phlegm
- they have asthma or wheeze

	Yes	No	Unsure/Don't know
Question 17. Does the person cough, gag and choke or breathe noisily during or after eating food, drinking, or taking medication?	❑	❑	❑

Tick the **Yes** box if any of the following:
- they sometimes cough or choke during or several minutes after eating, drinking or taking medication
- their breathing becomes noisy after eating or drinking or while talking
- they gag on eating, drinking or taking medication

	Yes	No	Unsure/Don't know
Question 18. Does the person vomit or regurgitate on a regular basis?	❑	❑	❑

(Note: This question is not applicable to infants under 12 months of age)

the **Yes** box if either
- they vomit or regurgitate (ie. bring up) food, drink or medication more than once per day, or, on a regular basis.
- they take anti-reflux medication
- they clear their throat often or burp often

	Yes	No	Unsure/Don't know
Question 19. Does the person drool or dribble saliva when resting or eating or drinking?	❑	❑	❑

Tick the **Yes** box if either of the following :
- the person drools or dribbles saliva at rest or mealtimes
- their clothes or protective napkins/bibs frequently need changing because of drooling.

	Yes	No	Unsure/Don't know
Question 20. Does food or drink fall out of the person's mouth during eating or drinking?	❑	❑	❑

Tick the **Yes** box if any of the following:

- they are unable to close their mouth and this causes food, drink or medication to fall out of their mouth
- they cannot keep their head upright and food, drink or medication falls out of their mouth
- their tongue pushes food, drink or medication out of their mouth
- their mouth continuously needs to be wiped or they need to wear a cloth to protect their clothes during mealtime.

Note that this question does not relate to the person's manual dexterity or ability to place food in their mouth.

	Yes	No	Unsure/Don't know
Question 21. If the person eats independently, do they overfill their mouth or try to eat very quickly?	❑	❑	❑

Tick the **Yes** box if they eat independently and any of the following:

- they try to cram or "stuff' their mouth before attempting to chew or swallow
- they try to swallow too much food before they have chewed it properly

they usually finish all of their main meal in less than 5 minutes

	Yes	No	Unsure/Don't know
Question 22. Does the person appear to eat without chewing?	❑	❑	❑

(Note: This question does not apply to people on a puree diet)

Tick the yes box if any of the following:

- they suck their food instead of chewing
- the food remains in the mouth for a long period of time before swallowing
- they swallow their food whole without chewing.

	Yes	No	Unsure/Don't know
Question 23. Does the person take a long time to eat their meals?	❑	❑	❑

Tick the **Yes** box if either of the following:

- they eat independently and they take more than 30 minutes to eat meals
- they are dependent on someone to feed them and it takes a longtime to feed them the whole meal
- they appear to tire as the meal progresses and may not finish their meal

	Yes	No	Unsure/Don't know
Question 24. Does the person show distress during or after eating or drinking?	❑	❑	❑

Tick the **Yes** box if any of the following:

- they appear distressed while they eat or drink
- they appear distressed immediately after or shortly after eating or drinking
- sometimes while distressed they refuse food or spit out food

YES to any question?

If you answered YES to one or more questions, the person may have a nutrition risk or risk to safe swallowing.

Does the person have any food allergies? Yes No Unsure/Don't Know (please circle)

If yes – please state allergy and reaction _____

_____

_____

Please state food likes _____

_____

Please state food dislikes _____

_____

Part 3 - Summary of results for …….. on date of…….

*Refer to the relevant question in the Nutrition in Practice Manual. The Nutrition in Practice Manual outlines **things to consider** and some simple safe **things you can do** to manage the problem or risks you have identified. It also helps you decide if the person needs to be referred to a specialist, such as a speech pathologist, dietitian, doctor etc..*

If you decide that a specialist referral is the best action take this completed Checklist to the appointment.

A copy of this completed Checklist should be kept in the person's person files.

Q.#	Nutrition and Swallowing Risks Identified	Comments	Action decided
	Reminder: *Children or young people under 18 years of age an annual growth assessment should be completed by a GP, paediatrician, early childhood nurse or dietitian.* Has this occurred?		
	Reminder: *Weigh regularly and record changes. Does this happen?*	*If you are not able to measure height and weight, refer to a specialist professional for measurement of height and weight and an estimate of the person's healthy weight range.* + *page XX*	
Q2	***Example*** *The person is overweight*	***Example*** *Weight gain over the last year. Difficulty walking because of excess weight.*	***Example*** *Make appointment with dietitian*