| Person’s Name | Date of Birth | ProviderOne Number |
| --- | --- | --- |
|  |  Developmental Disabilities Administration (DDA) **Aspiration / Choking Plan** **You do not need permission to call 911.** |
| Call 911 and [**START FIRST AID**](https://www.redcross.org/take-a-class/resources/learn-first-aid/adult-child-choking) as trained if:1. The person is not breathing or is blue / gray in color.
2. The person is having difficulties breathing or making abnormal noises while breathing.
3. The person appears ill; and you are concerned about their immediate health and safety.
4. Other:

**After 911 has been notified, follow instructions from the dispatcher. Notify the dispatcher if there is a POLST DNR/I in place.**After calling 911 and stabilizing the person:* Contact your supervisor.
* Document per agency protocol in the person’s chart.
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| **Immediate Interventions if you suspect aspiration (see signs and symptoms below)** |
| 1. **STOP food or fluids immediately. Do not resume until instructed by       to continue.**
2. Encourage the person to sit upright.
3. Encourage the person to cough.
4. Provide first aid, as trained (when necessary).
5. Call 911 if person’s symptoms change and are thought to be life threatening.
6. Notify supervisor, medical provider / nurse when safe to do so.
7. If no response from above persons within  minutes follow instructions listed below.

**Person specific instructions:**  |
| After the person is safe and without concerns for health or safety, document incident in:[ ]  Progress notes [ ]  Incident Report [ ]  Other:  |
| **Signs and Symptoms of Aspiration** |
| 1. Rapid breathing or difficulties breathing while eating, drinking, or tube feeding.
2. Gagging, gurgling, choking, coughing or vomiting during eating, drinking, or tube feeding.
3. Changes to level of consciousness (overly tired or agitated).
4. Low oxygen levels (typical oxygen levels are **95-100%**).
5. Abnormal temperature (typically temperature between **97.8oF to 99.1oF degrees** Fahrenheit).
6. Other (specific to individual):
 |
| **Diet History** |
| History of choking: [ ]  Yes [ ]  NoHistory of aspiration: [ ]  Yes [ ]  NoDescribe risk factors related to aspiration (including diagnoses, history, and diagnostic exams): Specialized diet orders: [ ]  Yes [ ]  No; if yes, explain: Specialized diet texture: [ ]  Yes [ ]  NoI’m fed through a feeding tube: [ ]  Yes [ ]  No  |
| **Food texture** | **Fluid consistency** |
| [ ]  Regular [ ]  Ground[ ]  Chopped [ ]  Pureed | [ ]  Thin / regular [ ]  Nectar thick (tomato juice texture)[ ]  Honey thick (yogurt or honey texture) [ ]  Pudding |
| **Instructions** |
| **Staff require specialized training prior to assisting with my hydration or nutrition:** [ ]  Yes [ ]  No**I have an Exception to Policy in place related to nutrition / hydration:** [ ]  Yes [ ]  NoIf yes, describe: When I eat, I need the following assistance: When I drink, I need the following assistance:I use adaptive equipment when I eat or drink: [ ]  Yes [ ]  NoIf yes, describe: I need small portions when I eat or drink, so I don’t choke: [ ]  Yes [ ]  NoIf yes, describe: I need supervision when I’m eating or drinking: [ ]  Yes [ ]  NoIf yes, describe: I need staff to feed me: [ ]  Yes [ ]  NoIf yes, describe: I need to remain upright for  minutes after eating or drinking. **If tube fed, I must be kept at       degrees during and after my feedings and fluids, to prevent aspiration.** |
| Additional Information |
| Plan Completed by: | Date Plan Completed |
| Health Care Provider’s Signature | Date Signed |
| Health Care Provider’s Printed Name | Phone |
| **Date of last review (enter signature and date):** |
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