

## Comprehensive Aspiration Risk Management Plan (CARMP) – 03/21/2019

**Person's Name:** \_\_\_\_\_ **Last 4 SS #:** \_\_\_\_\_ **Case Manager:** \_\_\_\_\_ **CM Agency:** \_\_\_\_\_  
**Date of ARST:** Click or tap to enter a date. **Risk level:** \_\_\_\_\_ **ISP Term:** \_\_\_\_\_ **CARMP**  **Initial**  **Annual - Date:** Click or tap to enter a date.  
**Revised:**  **Y**  **N** **Date (Revised):** Click or tap to enter a date.

*NOTE: Some CARMP Strategies may be optional for Persons at moderate risk for aspiration due to Risky Eating Behaviors (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*  |
|---|--|--|
| <b>A. Recognize and report individual specific signs and symptoms of aspiration</b> (required)  |  |  |
| The following is a list of those specific <b>signs and/or symptoms (S&amp;S)</b> of aspiration or aspiration associated illnesses that have been identified for this person. This should not be a generic listing of S&S of aspiration that applies to all people. <i>(If specific S&amp;S are not known the IDT may use generic until individual specific S&amp;S identified)</i><br>1.<br>2.<br>3.<br>4.<br>5.  |  | <ul style="list-style-type: none"> <li>• <b>Nurse</b></li> <li>• All IDT members may contribute.</li> <li>• All IDT members may reinforce and must monitor and report</li> </ul> |
| <b>All IDT members are required to monitor for individual specific signs and symptoms of aspiration.</b><br>When any of the identified signs and/or symptoms listed above is observed the following actions are required:<br>1. <u>The observer</u> calls the agency nurse to report the observation & make a note in the daily documentation at that site.<br>2. <u>The nurse</u> 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.<br>3. <u>The nurse</u> informs the <u>observer</u> of the actions taken and follow up as needed.<br>4. <u>DSP</u> will document all actions taken. |  | <ul style="list-style-type: none"> <li>• <b>Nurse</b></li> <li>• All IDT members are responsible to implement</li> </ul>   |
| <b>B. Health Monitoring and Reporting</b> (required)  |  |  |
| <b>Refer to the Medical Emergency Response Plan(s) (MERPs) for specific guidelines</b>  |  | <b>Nurse</b>   |
| <b>Observe and report, to the nurse, immediately:</b> choking that requires suctioning, abdominal thrusts (Heimlich maneuver) or 911.   |  | <b>Nurse</b>   |
| Use Pulse Oximeter  | (frequency) Notify (identify team member by role and condition for notification) | <b>Nurse</b>   |
| 1. <b>If vomiting or seizures occur:</b> Follow the MERP(s).<br>2. Identify positioning during vomiting and during seizures (Refer to Seizure Plan)<br>3. Call the nurse.<br>4. If vomiting occurred; check temperature, pulse and respirations three times a day, for three days. Document all results in Therap and notify nurse of each result.<br>5. 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.   |  | <b>Nurse</b>   |
| Nurse will monitor and document clinical and respiratory status and report to PCP as needed.  |  | <b>Nurse</b>   |

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| Staff will monitor weight (frequency):  | Nurse to notify PCP for weight loss/gain of 10 lbs. or 10% bodyweight within 6-month period. | Nurse         |
| Other Monitoring & Reporting:<br>1. Medical interventions related to aspiration/bronchial issues. Refer to respiratory care plan if needed. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>2. Medical interventions related to GERD, constipation, seizures, etc. Refer to other plans as needed. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A   |  | Nurse         |
| <b>C. Oral Mealtime Strategies (required, if the person eats or drinks anything orally) <input type="checkbox"/> Not applicable if 100% NPO (Delete sections below if checked.)</b>   |  |               |
| <b>Positioning for Mealtimes &amp; Snacks:</b>  |  | PT, OT        |
| <b>Position of person assisting with the meal/snack:</b>  |  | PT, OT        |
| <b>Nutritional Recommendation:</b><br>1. Nutrition goals:<br>2. Recommended weight range:<br>3. Diet order:<br>4. Supplements/snacks:<br>5. Caloric needs (For informational purposes; does not need to be tracked unless stated):<br>6. Protein needs (For informational purposes; does not need to be tracked unless stated):<br>7. Fluid needs (For informational purposes; does not need to be tracked unless stated):  |  | RD            |
| <b>Diet Texture:</b> (Check applicable – if using multiple textures, indicate type of food and/or situation for each. May delete examples below if using own descriptions)<br><input type="checkbox"/> Regular (no restrictions to diet texture)<br><input type="checkbox"/> Pureed (e.g. blended to smooth consistency) Examples & special instructions:<br><input type="checkbox"/> Minced (e.g. very small pieces 1/8 inch similar in size to sesame seeds) Examples & special instructions:<br><input type="checkbox"/> Ground (e.g. ground or diced into 1/4 inch pieces similar in size to rice) Examples & special instructions:<br><input type="checkbox"/> Chopped (e.g. cut into 1/2 inch pieces similar in size to uncooked elbow macaroni) Examples & special instructions:<br><input type="checkbox"/> Mechanical Soft (e.g. soft, moist foods with meats ground up) Examples & special instructions:<br><input type="checkbox"/> Other (describe):<br>Foods to Avoid: |  | SLP, OT       |
| <b>Liquid Consistency: (When liquids must be thickened, a commercial thickener or specific additive must be identified)</b><br><input type="checkbox"/> All liquid consistencies allowed<br><input type="checkbox"/> Thin (water like) Examples/special instructions:<br><input type="checkbox"/> Nectar (liquid coats & drips off spoon) Examples & special instructions:<br><input type="checkbox"/> Honey (flows off spoon in a ribbon just like honey) Examples & special instructions:   |  | SLP, OT       |

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| <input type="checkbox"/> Spoon-Thick ( <i>pudding consistency</i> ) Examples & special instructions:<br><input type="checkbox"/> Other (describe):<br><input type="checkbox"/> Fluid Restrictions ( <i>describe in detail as per PCP orders</i> )<br>Liquids to Avoid:   |                   |                                 |
| <b>Adaptive Eating Equipment</b> ( <i>identify by name; photos may be helpful. Attach page with ordering/purchasing information</i> )<br>1. Utensils:<br>2. Dishes:<br>3. Cup:<br>4. Mat:<br>5. Other:   |                   | <b>OT, SLP,</b>                 |
| <b>Level of Supervision:</b> When eating and/or drinking ( <i>describe</i> ):  |                   | <b>SLP, OT, BSC, PT, Nurse,</b> |
| <b>Assisted Eating Techniques:</b><br>1. Meal Preparation ( <i>include description of the person's role, if any</i> ):<br>2. Presentation of Food ( <i>describe</i> ):<br>3. Presentation of Liquid ( <i>describe</i> ):   |                   | <b>SLP, OT</b>                  |
| <b>Self-Feeding Techniques</b> ( <i>describe set-up &amp; cueing strategies</i> ):   |                   | <b>OT, SLP</b>                  |
| <b>Sensory Support:</b>  |                   | <b>OT, SLP</b>                  |
| <b>Behavioral Support</b> ( <i>Strategies to address risky eating behaviors</i> ):   |                   | <b>BSC</b>                      |
| <b>Positioning after meals and how long:</b>   |                   | <b>PT, OT</b>                   |
| <b>D. ORAL MEDICATION DELIVERY STRATEGIES</b> <input type="checkbox"/> Not applicable – 100% NPO or <input type="checkbox"/> *** Optional for REB Only ( <i>Delete sections below if NPO or REB only</i> )   |                   |                                 |
| <b>Altered form of Medication:</b><br>1. Refer to MAR for current medications & appropriate times for medication delivery. <b>DO NOT LIST MEDICATIONS HERE.</b><br>2. Describe the altered form of medications as needed due to sensory and/or dysphagia limitations ( <i>check all that apply, if using multiple altered forms of medication specify type for each</i> )<br><input type="checkbox"/> Liquid ( <i>special instructions</i> ):<br><input type="checkbox"/> Crushed ( <i>special instructions</i> ):<br><input type="checkbox"/> Cut into pieces no larger than _____, ( <i>special instructions</i> ):<br><input type="checkbox"/> Whole ( <i>special instructions</i> ): | <b>Nurse, SLP</b> |                                 |

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| <input type="checkbox"/> Sprinkled on food ( <i>special instructions</i> ):<br><input type="checkbox"/> Dissolved in liquid ( <i>special instructions</i> ):<br><input type="checkbox"/> Other (describe):   |                   |               |
| <b>Oral Medication Delivery Method:</b> ( <i>Level of Assistance with Medication Delivery is based on the MAAT. This section indicates additional delivery techniques intended to minimize aspiration risk; check all that apply</i> )<br><input type="checkbox"/> Drink using (specify cup type, straw, etc.)<br><input type="checkbox"/> Mix with (e.g. water, puree food, soft foods, etc.)<br><input type="checkbox"/> Present using (e.g. syringe, specific spoon, med cup, fingers, etc.)<br><input type="checkbox"/> Number of pills/tablets/capsules in mouth at one time<br><input type="checkbox"/> Follow each oral presentation medication dose with (drink, puree food etc.)<br><input type="checkbox"/> Visually examine the mouth ( <i>cheeks, under tongue, area between lips and teeth</i> ) to assure medication has been swallowed.<br><input type="checkbox"/> Sweep the mouth with a (gloved finger, toothette) to assure medication has been swallowed.<br><input type="checkbox"/> Other: |                   | SLP           |
| <b>E. TUBE (Enteral) FEEDING STRATEGIES</b> via <input type="checkbox"/> G; <input type="checkbox"/> J; <input type="checkbox"/> G/J; or <input type="checkbox"/> NG tube<br><input type="checkbox"/> Not applicable, no feeding tube ( <i>may delete tube feeding sections below if checked</i> )   |                   |               |
| <b>Nutritional Content of tube feeding</b>   |                   |               |
| 1. Refer to MAR for the most current orders for enteral feeding and hydration schedules.<br>2. Nutrition goals:<br>3. Recommended weight range:<br>4. Caloric needs (For informational purposes; does not need to be tracked unless stated):<br>5. Protein needs (For informational purposes; does not need to be tracked unless stated):<br>6. Fluid needs (For informational purposes; does not need to be tracked unless stated):   |                   | RD            |
| <b>Tube Feeding Protocol (required).</b> <input checked="" type="checkbox"/> = Indicates required content  |                   |               |
| 1. List steps for checking tube placement ( <i>describe, i.e., by checking mark on tube at exit site or n/a</i> ):<br>2. List steps for checking residual, if ordered by PCP or specialist ( <i>describe or n/a</i> ):<br>3. List steps for setting up and/or connecting/disconnecting tube feeding including:<br>a. <input checked="" type="checkbox"/> Aseptic/Clean technique for flushes ( <i>describe</i> ):<br>b. <input checked="" type="checkbox"/> Total time allowed to hang:<br>c. <input type="checkbox"/> Bolus vs. <input type="checkbox"/> Continuous ( <i>describe</i> )<br>d. <input type="checkbox"/> Other instructions:<br>4. Instructions for routine site care ( <i>describe</i> ):<br>5. Instructions regarding potential complications, <i>describe</i> :<br>a. <input checked="" type="checkbox"/> When to discontinue feedings;<br>b. <input checked="" type="checkbox"/> Notify nurse of vomiting.  |                   | Nurse         |

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| c. <input type="checkbox"/> Nurse will notify the PCP.<br>d. <input checked="" type="checkbox"/> Instructions for what to do in case of change in tube length/displacement or dislodgement;<br>e. <input checked="" type="checkbox"/> Instructions for abdominal pain, swelling or tenderness;<br>f. <input checked="" type="checkbox"/> Instructions for redness/infections/erosion/drainage at site;<br>g. <input type="checkbox"/> Other: |                   |                |
| <b>Positioning DURING and AFTER tube feeding, water flushes, and medication administration</b>   |                   |                |
| Describe general places the person may receive tube feeding, water flushes and medication administrations? (e.g. regular chair, wheelchair, bed, etc.)<br>1.                      2.                      3.   |                   | <b>PT, OT</b>  |
| Positioning <b>during</b> tube feeding, water flushes & medication administration:   |                   | <b>PT, OT</b>  |
| Positioning <b>after</b> tube feeding, water flushes and medication administration:<br><b>Minimum</b> length of time this position must be maintained:   |                   | <b>PT, OT</b>  |
| <b>Activity or behavioral strategies during tube feedings</b>  |                   |                |
| 1. Activity strategies:  |                   | <b>OT, PT,</b> |
| 2. Behavioral strategies (examples: distraction, use of abdominal binder to minimize risk of pulling tube, etc.):  |                   | <b>BSC</b>     |
| <b>MEDICATION DELIVERY VIA TUBE FEEDING</b> <input type="checkbox"/> <b>Not applicable</b> (may delete sections below if checked)  |                   |                |
| <b>Medication Delivery Method: Refer to MAR for Physician orders; including crush and flush orders</b><br>1. <u>Medications must never be added to formula.</u><br>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).<br>3. Flush with water as ordered after each medication administration.<br>4. Other:   |                   | <b>Nurse</b>   |
| <b>F. POSITION FOR ROUTINE ACTIVITIES</b> <input type="checkbox"/> <b>Determined not applicable based on assessment &amp; IDT consensus</b> (may delete sections below if checked).  |                   |                |
| Positioning for:<br>1. Bed:<br>2. Showering or bathing:<br>3. Personal care (e.g. Attends changes, dressing etc.):<br>4. Swimming:<br>5. Rest or leisure:<br>6. Other:   |                   | <b>PT, OT</b>  |
| <b>G. ORAL HYGIENE STRATEGIES</b> (required) or <input type="checkbox"/> <b>Determined N/A based on assessment &amp; IDT consensus for *** REB only</b> (may delete sections below if checked)   |                   |                |

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| 1. Complete Oral Care _____ times per day.  |                   | <b>Nurse</b>                   |
| 2. Identify when oral care should occur:  |                   | <b>OT</b>                      |
| 3. Recommended Location(s) for oral care:   |                   |                                |
| 4. Identify <u>prescribed/recommended</u> dental treatment per the Dentist/Oral hygienist including:<br>4.1. Mouthwash/solutions: see MAR ( <i>describe when and how to use</i> )<br>4.2. Toothpaste<br>4.3. Toothbrushes<br>4.4. Other:              |                   | <b>Nurse</b>                   |
| 5. List and describe ALL needed materials ( <i>including any identified in #4 above</i> )<br>5.1. Type of toothbrush:<br>5.2. Type of toothpaste:<br>5.3. Mouthwash or other prescribed solutions ( <i>refer to MAR</i> ):<br>5.4. Other:             |                   | <b>OT, SLP, Nurse, PT, BSC</b> |
| 6. Utilize good oral hygiene techniques as <i>identified by Dentist/Oral Hygienist or Team consensus</i> :<br>6.1. Brushing technique (required if using suctioning toothbrush):<br>6.2. Brushing time:<br>6.3. Flossing instructions:<br>6.4. Other: |                   | <b>Nurse</b>                   |
| 7. Positioning of person during oral care:  |                   | <b>PT, OT</b>                  |
| 8. Positioning of person assisting with oral care:  |                   | <b>PT, OT</b>                  |
| 9. Specific Oral Care Procedures not covered above, in sequential order, including Sensory, Behavioral, Cognitive and Self-brushing strategies:<br>9.1.   |                   | <b>OT, SLP, Nurse, PT, BSC</b> |
| 10. Saliva management techniques during oral care not previously stated ( <i>e.g. suctioning, etc.</i> ):   |                   | <b>Nurse, SLP, PT, OT,</b>     |
| 11. Observe for and report to nurse any:  |                   | <b>Nurse</b>                   |

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| 11.1. Change in appearance of gums or tongue; (e.g. dark, broken, loose or missing teeth; bad breath; swelling, lesion).<br>11.2. Presence of oral pain, refusal to eat or drink hot/cold food or liquids etc.<br>12. Stop oral care immediately and contact nurse if:   |                   |                       |
| 13. Positioning <b>AFTER</b> oral care and how long:   |                   | <b>PT, OT</b>         |
| <b>H. SALIVA MANAGEMENT STRATEGIES</b> <input type="checkbox"/> <b>Determined not applicable based on IDT assessment &amp; consensus</b> (may delete sections below if checked)  |                   |                       |
| Positioning:<br>1. Lying down:<br>2. Sitting:<br>3. Other: (may consider position of persons who interact with the person to minimize risk, i.e., do not stand above the person seated)  |                   | <b>PT, SLP, OT</b>    |
| Skin/clothing Protection:  |                   | <b>Nurse, SLP, OT</b> |
| Medical strategies:<br><input type="checkbox"/> Medication (routine or PRN medications used to control oral secretions)<br><input type="checkbox"/> Suction:<br>1. Type of suction catheter:<br>2. Size of suction catheter:<br>3. <input type="checkbox"/> Oral or <input type="checkbox"/> Tracheal suctioning,<br>4. Frequency to apply suction:<br><input type="checkbox"/> Other instructions:<br><input type="checkbox"/> Contact nurse for:<br>Nurse will contact PCP when indicated. |                   | <b>Nurse</b>          |
| Other Strategies (if any):   |                   | <b>BSC</b>            |
| <b>I. STRATEGIES TO MINIMIZE RUMINATION</b> <input type="checkbox"/> <b>Determined not applicable based on assessment &amp; IDT consensus</b> (may delete sections below if checked)   |                   |                       |
| Sensory Strategies:  |                   | <b>OT</b>             |
| Positioning Strategies:  |                   | <b>PT, OT</b>         |
| Behavioral Strategies:   |                   | <b>BSC</b>            |
| <b>J. PERSONALIZED OUTCOMES</b> (required)<br>(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  |                   | <b>IDT: develops</b>  |

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|---|-------|-------------------|----------------|---------------------------------|
| 1.<br>2.<br>3.<br>4.  |       |                   |                | CM: assures IDT tracks outcomes |
| K. LEAD CONTACT (TRAINER) INFORMATION (required for ALL)      |       |                   |                |                                 |
| Name  | Phone | Fax               | E-Mail Address |                                 |
| Primary Nurse:<br>RD:<br>SLP:<br>PT:<br>OT:<br>BSC:<br>Other: |       |                   |                |                                 |

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