

“.....w/ acute respiratory compromise, recent intubation/extubation, and generalized weakness/deconditioning, pt. remains at increased risk for aspiration and it’s complication (and/or exacerbation of dysphagia s/s)...risk can be reduced with dysphagia mechanically altered diet, aggressive/frequent oral care, increased mealtime supervision/assist for cueing, and general swallow/reflux precautions (outlined below). SLP will continue to follow pt for dysphagia management, pt. education, and diet toleration/management as clinically warranted...”

‘Consider VFSS pending pt. pulmonary status and diet tolerance over next few days.’

Hold PO w/ +s/s aspiration or medical/cognitive/respiratory decline.

‘Pt. p/w suspected moderate oropharyngeal dysphagia characterized by reduced oral access/ability to self-feed d/t UEs weakness, characterized by reduced orolingual control/coordination, suspected premature spillage, inconsistent swallow elay, and marginal reduced hyolaryngeal elevation, resulting in +s/s aspiration and pharyngeal residue w/ large bites of puree as described above.’

Patient referred to ST due to new onset of cognitive impairment, decreased safety awareness, decreased ability to sequence ADL's, decreased ability to manage medications independently and increased need for assistance from others indicating need for ST to improve cognitive skills/function, develop & instruct in strategies, and facilitate increased independence during ADL's to ensure safe discharge @ PLOF.

“May cap trach with therapy only. Keep pulse ox above 92. Apply 2 liters via nasal cannula PRN. Remove cap for any s/s of distress.”

“In order to decrease risk of falls, pt will utilize and recall toileting schedule x5 consecutive sessions given mod verbal/visual ST cues.”