# Document Control

| | | | |
|---|---|---|---|
| **Title**<br>**Oropharyngeal Dysphagia Guideline** | | | |
| **Author** | | | **Author's job title**<br>Speech and Language Therapist |
| **Directorate**<br>Therapies | | | **Department**<br>Speech and Language Therapy |
| **Version** | **Date Issued** | **Status** | **Comment / Changes / Approval** |
| 0.1 | Jan 2020 | Draft | Initial version for consultation |
| 1.0 | April 2021 | Final | Approved by Speech and Language Therapy and below stakeholders |
| **Main Contact**<br>NDDH SLT Acute Lead<br>SLT Department<br>Seamoor Offices<br>North Devon District Hospital<br>Raleigh Park<br>Barnstaple, EX31 4JB | | | **Tel: Direct Dial** –<br>**Tel: Internal** –<br>**Email**: |
| **Lead Director**<br>Director of Health and Social Care | | | |
| **Superseded Documents** | | | |
| **Issue Date**<br>April 2021 | **Review Date**<br>April 2024 | | **Review Cycle**<br>Three years |
| **Consulted with the following stakeholders:**<br>• Speech and Language Therapy Team<br>• Nutrition Steering Group (NSG)<br>• Stroke Steering Operation Group (SSOG)<br>• Relevant consultants, specialist nurses and Medicines Management /Pharmacy Team. | | | |
| **Approval and Review Process**<br>• Clinical Reference Committee | | | |
| **Local Archive Reference**<br>G:\North Devon Adult Speech and Language Therapy \ Dysphagia Guideline<br>**Local Path**<br>G:\North Devon Adult Speech and Language Therapy \ Dysphagia Guideline<br>**Filename**<br>Oropharyngeal Dysphagia Guideline | | | |
| **Policy categories for Trust's internal website (Bob)**<br>Dysphagia/swallowing/speech and language therapy | | | **Tags for Trust's internal website (Bob)**<br>Dysphagia<br>Swallowing<br>Aspiration<br>Choking |

# CONTENTS

# 1. Purpose

The purpose of this document is to detail the process for the identification, assessment and management of patients (over the age of 18) at risk of oropharyngeal dysphagia within the Trust. Management of oesophageal dysphagia is not covered by this document; please liaise with the medical team. For clarity, this document will use the term dysphagia in reference to oropharyngeal dysphagia.

Disruption of normal swallow function can have serious medical consequences, increasing the risk of malnutrition, dehydration, weight loss, pulmonary aspiration (food, fluid or saliva going into the lungs) and choking. It is associated with increased morbidity, mortality and a reduced quality of life due to emotional, psychological and social effects.

This guideline outlines the way in which health professionals should work as core members of a multi or interdisciplinary team to ensure best clinical practice for people with dysphagia. It is based on best professional practice and competency frameworks as related to the core dysphagia team, allied and nursing professionals.

This guideline will apply to all Trust staff, and covers all services within the Trust including inpatients, outpatients, community patients and adults with learning disabilities (ALD).

This document should be read in conjunction with other Trust policies, national and international guidelines. These may include:

- NDHT stroke water swallow screen http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/07/Swallow-Screening-assessment-V1.pdf
- Risk Feeding guideline https://www.northdevonhealth.nhs.uk/wp-content/uploads/2019/07/Risk-Feeding-Guidelines-v2.1.pdf
- Dysphagia overview as per the Royal College of Speech and Language Therapists https://www.rcslt.org/speech-and-language-therapy/clinical-information/dysphagia
- International Dysphagia Diet Standardisation Initiative https://iddsi.org/
- NICE guidelines relevant to patient groups, such as Stroke, Care of the Elderly https://www.nice.org.uk/guidance
- Royal College of Physicians documents such as Oral feeding difficulties and dilemmas (2010) and Stroke Guidelines (2016). https://www.strokeaudit.org/Guideline/Full-Guideline.aspx
- https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

# 2. Objectives

The principle aims of this guideline are to:

- Provide guidance on the key aspects of multi-disciplinary roles, assessment and intervention in dysphagia.

- Deliver a safe, effective and efficient dysphagia service to all adult populations served by the Trust (evidence-based and/or accepted best practice).
- Ensure safe provision, administration, storage and disposal of modified oral intake, nutritional supplements and thickening agents to people with dysphagia.
- Ensure comprehensive dysphagia awareness and training amongst all staff.
- Adhere to Royal College of Speech and Language Therapists (RCSLT) dysphagia competencies, assessment and intervention guidelines.
- Adhere to relevant multi-disciplinary (allied health professional) guidance documentation where appropriate.

# 3. Responsibilities

## Head of Therapies/Senior Nursing

- Ensuring that this guideline is based on good practice and that its implementation is shared and supported throughout the Trust.
- Ensuring that staff members within their area of responsibility are able to recognise and manage patients who are at risk of dysphagia at a level appropriate to their clinical remit and competencies.
- Ensure that patient facing clinical and non-clinical staff receive appropriate training so they are able to identify patients who may be at risk of dysphagia, see training section below.
- Review, investigate and escalate any incidents relating to the management of dysphagia, using the Trusts Datix procedure.
- Supporting staff to attend required dysphagia-related training

## Speech & Language Therapists (SLTs)

- Completing and documenting a comprehensive assessment of an individual's eating, drinking and swallowing
- Advising on the patients dysphagia-specific requirements either in the short or long term, to maximise swallow safety and/or quality of life.
- Assessing the risk of cognitive factors that could compromise the safety of the swallowing process. The assessment and management will take into account an individual's preferences and beliefs, as well as best interest and quality of life issues.
- Ensuring the relevant competencies, knowledge and skills are up to date as dictated by the RCSLT and Health and Care Professionals Council (HCPC).
- Ensuring clear documentation is in place to make SLT input and recommendations clear
- Provide up to date dysphagia awareness training to patient facing clinical staff, see training section below.
- Optimising the patient's nutrition and hydration, taking into consideration the persons swallowing difficulties and SLT recommendations.

## Pharmacy

- To review the patients modification regimen, in line with the patents current swallow assessment and dysphagia recommendation, involving the patient and/or their carer wherever possible.
- To provide professional advice on any medications required (such as formulation, consistency, route of administration and interactions) to ensure that medications is administered safely and effectively.
- To ensure that professional advice is clearly documented in the patient's clinical record.

## Patient facing clinical Staff (inpatients, nursing/care homes, community teams)

- Ensuring inpatient referrals to SLT are appropriate. (See SLT Inpatient Referral page on BOB for guidance).
- Have an awareness of current patients who may be at risk of dysphagia, and take action to reduce the risk of aspiration and choking.
- Ensure all patients with modified diet and fluid have a yellow SLT advice sign placed above the bed space outlining SLT recommendations.
- Have an awareness of dysphagia, including knowledge regarding patients at risk of dysphagia, signs of aspiration, and sufficient knowledge of following eating, drinking and diet recommendations.
- Report any incidents relating to the management of dysphagia or choking, using the Trusts Datix procedure.
- Identify training needs to their immediate line manager in relation to the management of patients at risk of dysphagia.
- Monitor food or drink that may be ordered (eg.meal menus) / brought into hospital, care homes or other locations by the carers/relatives to ensure it is in line with SLT recommendations.
- Keep accurate records related to oral intake, swallow or risk of aspiration.
- Ensure thickening agents are stored safely and securely, out of the reach of patients, to ensure that patients are not at risk of accidental ingestion – see appendix 1.
- Raise any aspiration or choking concerns to the SLT team.
- Be aware of the safe storage, use and disposal of thickening agents and supplements for people with dysphagia.
- Have an awareness of and comply with Trust policies that may be related to dysphagia, such as completion of nutrition screening tools, e.g. Malnutrition Universal Screening Tool (MUST).
- Awareness and adherence to SLT referral processes, team depending – see section 5 and appendices.
- Follow SLT recommendations put in place.
- Ensure systems are in place to support mealtime services across inpatient wards through the implementation of an allocated mealtime monitor.

- Assisting with safe discharge process from the acute setting, e.g. alerting SLT to any discharge plans prior to discharge, sharing information with patient and representative, ensuring patient is discharged with required items (e.g. thickener) and paperwork.

## Sodexo Staff

- Ensure meals are correctly prepared, served at the recommended temperature and well presented
- Ensure the correct meals are given to the patient in accordance with the recommendations made on yellow SLT advice signs (SLT advice signage that provides eating and drinking recommendations) above the patient's bed
- Be aware of the safe storage, use and disposal of thickening agents and supplements for people with dysphagia or
- If they have received the relevant training and feel competent to do so, to thicken drinks to the correct consistency as outlined on the patient's yellow SLT advice sign.
- Ensure that thickening agents are stored safely and securely out of the reach of patients if indicated, to ensure that patients are not at risk of accidental ingestion, see appendix.

## Doctors

- Ensuring inpatient referrals to SLT are appropriate. (See SLT Inpatient Referral page on BOB for guidance).
- For making decisions re: long term feeding, e.g. alternative feeding vs feeding with accepted risk.
- Working with SLTs to consider appropriate medical investigations and onward referrals indicated to help investigate cause and/or progression of dysphagia.
- Contribution to/completion of Advanced Care Plans or Treatment Escalation Plan (TEP) forms.
- For patients placed NBM, ensure that a medication review is carried out promptly (with advice from the ward pharmacist as needed), to ensure that medications are not inadvertently omitted (see the Trust Omitted and Delayed Medicines Standard Operating Procedure for more information).
- Ensure that modifications made to the patient's medication regimen are clearly annotated on the patients discharge summary, and communicated to the patients GP on discharge or transfer of care.
- Assisting with safe discharge process from the acute setting, e.g. alerting SLT to any discharge plans prior to discharge, sharing information with patient and representative, ensuring patient is discharged with required items (e.g. thickener) and paperwork.

## Volunteers

- To attend SLT led training session on swallowing and feeding patients.
- To complete the appropriate volunteer competency framework on feeding patients.

- To follow the Volunteer guideline which includes guidance for volunteers assisting at mealtimes. The guideline highlights that volunteers must not feed any people with identified dysphagia (https://www.northdevonhealth.nhs.uk/2018/02/volunteer-policy)

## 4. Dysphagia

Dysphagia is the medical term for difficulty with swallowing. These difficulties can occur in the oral, pharyngeal and oesophageal stages of the swallow.

Dysphagia can result in, or contribute to negative health conditions such as chest infections, choking, weight loss, malnutrition and dehydration, sometimes with serious and fatal results.

In addition to impacting on physical health, difficulty with swallowing may have a negative impact on quality of life. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences for both the person and family members.

Dysphagia can present as acute or chronic, and be transient, static or progressive in presentation.

Dysphagia in adults can occur as a result of a number of factors. The following list includes some of them but is not exhaustive:

- Neurological disorders such as stroke, Parkinson's Disease (PD), Motor Neurone Disease (MND), Multiple Sclerosis (MS), Progressive Supranuclear Palsy (PSP), Guillian-Barre (GB), brain tumour, subarachnoid haemorrhage, dementia, head injury, Cerebral Palsy (CP).
- Head and Neck cancer
- Oncology, e.g. lung cancer, oesophageal cancer
- Cardiopulmonary disorders, e.g. Chronic obstructive pulmonary disease (COPD)
- General medical disorders, e.g. Urinary tract infection (UTI)
- Disorders associated with the elderly, e.g. cervical osteophytes, presbyphagia
- Swallowing difficulties as a result of surgery
- Tracheostomy
- Ventilator dependant individuals, e.g. post-extubation related dysphagia
- Drug or medication related difficulties
- Learning disability
- Psychogenic causes
- Treatments, e.g. radiotherapy.
- Cognitive and/or behavioural problems
- Structural changes, e.g. pharyngeal pouch

Speech and Language Therapists trained in clinical and instrumental assessment and management of oropharyngeal dysphagia, manage swallowing difficulties as part of the multidisciplinary team. The primary aim

in most cases is to assess the risk of aspiration – when food, drink or saliva enters the airway. Aspiration can lead to a serious lung infection known as aspiration pneumonia.

Aspiration can be acute or chronic.

| Possible signs of acute aspiration | Possible signs of chronic aspiration |
|---|---|
| Pyrexia | Loss of weight |
| Coughing and choking | Repeated chest infections |
| Change of patient's facial colour | Dehydration and malnutrition |
| Sounds of respiratory distress | Excess/changes in oral secretions |
| Loss of voice or changes in voice quality | Respiratory problems |
| Gasping | Coughing and choking history |
| Rapid heart rate | Refusal to eat |
| Decrease in oxygen saturations / Increase in oxygen requirements | Sticking sensation in throat |

### 4.1. Identifying Dysphagia

The severity of dysphagia can vary from individuals having difficulties with certain consistencies of food and/or fluid, to an individual being unable to swallow. Some people may also complain of pain or discomfort on swallowing.

The following are signs and symptoms which may be indicative of a dysphagia:

- Individual's inability to recognise food
- Prolonged chewing time/taking a long time to finish meals
- Difficulties with chewing and manipulating food in the mouth
- Food or fluids residue remaining in the patient's mouth
- Poor lip closure/difficulties in controlling or retaining fluid or saliva in the mouth
- 'Dribbling' or 'drooling' after eating and/or drinking
- Wet voice or breathing

- Increased wheeze when eating and drinking
- Inability to cough or a weak ineffective cough
- Coughing during or after eating or drinking
- History of chest infections
- Regurgitation of food/nasal regurgitation
- Poor oral hygiene
- Slurred speech and/or facial weakness
- Malnutrition/dehydration
- Weight loss

The following are examples of possible behaviours that may indicate or cause disorganised eating and drinking. These factors may therefore increase the risk of aspiration and choking and need to be identified:

- Lack of interest or attention to food and drink and the feeding environment
- Cramming/overloading of food into the mouth
- Attempting to eat/cram food from around the environment
- Holding food/drink in the mouth
- Attempts to eat non-food items, known as Pica
- Swallowing food without chewing
- Increased difficulties around eating and drinking with others, e.g. getting distracted or anxiety
- Pace of eating or drinking – too fast or too slow
- Pacing and agitation whilst eating
- Levels of alertness

It should be noted that some patients may present with aspiration pneumonia, without any of the above signs. This could be silent aspiration. If this is suspected, please discuss with the medical team and consider a referral to SLT.

## 5. Referring to SLT

SLT services within North Devon have their own referral pathway. They include Adult Learning Disabilities (see appendix 2), Community (see appendix 3) and Acute Inpatient and Stroke (see appendix 4).

- For Acute SLT and community SLT, referral forms can be found on Bob, the Trust's intranet (https://ndht.ndevon.swest.nhs.uk/speech-and-language-therapy/referral-forms/)
- Stroke patients can be referred to SLT via bleep 581, through Staples Ward or through Stroke Early Supported Discharge.
- Head and Neck SLT referrals will be received via the MDT.
- ALD referrals will be received by the specialist learning disability service and triaged by a professional advisor to determine level of urgency. Dysphagia & Choking Pre-screen/Dysphagia Screen may be completed if appropriate

Once referrals are received, they will be triaged based on clinical priority. See appendix

Inappropriate reasons for a referral for a swallow assessment can be found on the referral forms. These include:

- Vomiting and sickness unrelated to dysphagia
- Problems with taking medication/tablets only – liaise with pharmacy
- Problems with small appetite or refusing to eat and drink
- Enquiries for tube feeding. Please refer to dietitians.

## 6. Assessment of Dysphagia

It is the role of the SLT to collect and collate all information deemed relevant to the assessment and management of the person with dysphagia. This may include:

- Reviewing relevant medical documentation, including information regarding current and past medical history (PMH), current food/fluid intake, presenting condition, relevant medical investigations etc.
- Reviewing current medications and method of administration
- Discussion with relevant staff, such as Doctors, Nurses, Healthcare Assistants, Discharge Coordinators, Dietician, Physiotherapist and Occupational Therapists
- Patient observations completed by nurses or healthcare assistants which may provide information regarding oxygen, SATs range or alertness levels
- Information from the patient
- Information from family, friends or carers. If a person holds Lasting Power of Attorney for Health and Care (which must be registered with the Office of Public Guardian) and have provided evidence of this so that

a copy can be held in the medical notes, they are legally entitled to information and to be involved in decision making.
- Identification of any dietary restrictions including allergy and/or cultural and religious practices.

## 6.1. Consent

Clinical staff have a duty to ensure they gain consent for all care provided. If a patient's ability to provide consent is questioned, actions should be taken to review their capacity. Please see Trust Mental Capacity Act Policy.

Consent may take different forms including written, verbal or implied consent if there is passive acceptance from the patient for the action of the clinician, e.g. the patient complies with a swallow assessment.

If the patient refuses assessment or does not cooperate, this should be documented.

## 6.2. Assessment

For an initial assessment, it is expected that the SLT will complete a clinical swallow evaluation of the patients swallow function.

During an assessment, a SLT will:

- Introduce self and explain role and reason for assessment
- Ensure patient is sufficiently alert and able to maintain alertness for the session
- Ensure patient positioned appropriately
- Comply with Trust infection control requirements such as hand hygiene and PPE
- Conduct an Oro-motor assessment (OMA) if clinically indicated, to ascertain muscle strength, cranial nerve involvement and voice quality. Oral structures and cavity should also be visualised.
- Review current dentition
- Trial differing volumes, methods of delivery and consistencies/textures of diet and fluid as clinically indicated
- Use tools to assist with assessment such as pulse oximetry, auscultation, laryngeal palpation etc.
- Consider the need for and, if appropriate, trial compensatory measures or strategies that may be effective in improving swallow safety
- SLTs can perform Oral Yankauer suction as indicated once competencies have been completed. Please refer to SLT Oral Yankauer Competencies on BOB.

Contraindications to completing a clinical swallow evaluation may include:

- Patients who do not give consent or willingly participate and are therefore not perceived to give implied consent
- If assessment would cause physical or mental distress

- Respiratory problems:
  - Where supplementary oxygen is required and cannot be safely removed/tolerated for the duration of the assessment
  - Where a tracheostomy is in situ with a cuff up (unless further appropriate instrumental assessment is available )
  - Where a patient is intubated and ventilated
  - Where a patient is unable to tolerate cuff deflation for clinical bedside assessment.
- Where a patient is unable to rouse for an assessment, or unable to sustain alertness for the duration of an assessment
- Where a patient is unable to maintain adequate positioning for assessment/eating and drinking, either independently or supported.

**Note**: This is not an exhaustive list and the absence of contraindications does not automatically infer that a patient will be appropriate for assessment. Clinical decision making should override guidelines in instances where patients could be excluded from SLT/dysphagia intervention if a therapist deems appropriate. Rationale not to assess will be discussed with the referring clinician so a suitable management plan can be made.

Post assessment, the SLT will:

- Formulate a hypothesis as to the severity of the dysphagia and risk of aspiration
- Consider and put in place a management plan, whether this be short or long term
- Document all findings, recommendations and plans in the patients' medical/care records and relevant SLT notes.
- Liaise with patient, healthcare professionals and family/carers

### 6.3. Videofluoroscopy Swallow Study (VFS)

It is expected that SLT will complete a clinical bedside assessment as an initial course of action, however for some patients instrumental assessment, such as a videofluoroscopy, may be required to further assess the swallow mechanism, aspiration risk and/or to help guide quality of life decisions.

VFS is a modification of the standard barium swallow X-ray examination, completed by SLT. During a VFS the oropharyngeal swallowing physiology and anatomy is evaluated as the patient eats and drinks a radiopaque substance such as barium sulphate. The radiopaque substance may be mixed with food or drink to replicated modified intake; in line with IDDSI levels (see modified oral intake section). The moving images of the oropharyngeal swallow are recorded for interpretation.

VFS referrals are triaged and completed by the SLT team in the Trust. Post procedure, images are further reviewed by a Consultant Radiologist.

See the Trusts VFS SOP for further information (https://ndht.ndevon.swest.nhs.uk/videofluoroscopy-procedure-for-speech-and-language-therapists-and-radiographers-standard-operating-procedure/).

### 6.4. Stroke Patients

If the patient has had a suspected or confirmed stroke the Trust's Stroke Swallow Screen should be used within four hours of the patient arriving at the North Devon District hospital (See Appendix 4). There are trained members of staff in ED, Staples Ward and Clinical Site Management who are trained to carry out this screen. The Stroke Swallow Screen Guideline can be found at: http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/07/Swallow-Screening-assessment-V1.pdf

For out of hours, please contact the Clinical Site Management team to see if an appropriately trained staff member is available to carry out a Stroke Swallow Screen.

The Stroke Swallow Screen is not suitable for generalisation to other patient groups as it assumes an acute event affecting swallow function from which recovery can be expected.

## 7. Management of Dysphagia

Following SLT assessment, a clear plan for the patient should be discussed with all appropriate parties, documented and implemented. Depending on the outcome of the assessment, this may include:

- Modification of diet and/or fluid if indicated
- Consideration of allowing oral intake with accepted risks
- Nil by mouth status (NBM)
- Consideration of alternative or artificial support for nutrition/hydration such as IV or subcutaneous fluids, Nasogastric Tube (NGT) or Percutaneous endoscopic gastrostomy tube (PEG), or other means
- Advice for oral care, referral for medication review or patient monitoring

Consideration must be given to the aims and risk vs. benefit of oral, non-oral or mixed feeding. Timescales for likely change, and a clear definition of what a successful outcome for the individual would be, are important.

### 7.1. Nil By Mouth (NBM)

NBM (with or without alternative nutritional support) may well be considered where feeding difficulties are attributable to an acute and potentially reversible cause, or while assessment is being carried out. Clear timescales for review should be recorded. However, placing a "Nil by Mouth" (NBM) restriction upon a patient should be considered a last resort unless there is clear contrary evidence.

Documentation of a NBM decision should be completed and reviewed daily by the medical team daily, as a minimum. SLT review should be as frequently as clinically indicated, and a clear reason should be documented if such reviews will be non-frequent.

For patients placed NBM, ensure that a medication review is carried out promptly (with advice from the ward pharmacist as needed), to ensure that medications are not inadvertently omitted (see the Trust Omitted and Delayed Medicines Standard Operating Procedure for more information).

7.2. Alternative Feeding

Alternative methods of providing nutrition, hydration and medication should be considered wherever a patient is unable to meet their needs orally, and when other methods are felt to be appropriate by the medical team and multidisciplinary team (MDT). All risks, benefits and complications should be considered.

Direction as to whether alternative feeding is appropriate can be taken from evidence base and best practice research and publications.

Indication as to whether someone has previously been considered specifically appropriate for ‘artificial feeding’ can also be taken from the Treatment Escalation Plan (TEP) form. The decision stated on this form can be reviewed and revaluated.

Discussions should take place with the medical team, MDT and patient/families/carers. Decisions may need to be made in best interest if the patient doesn’t have capacity to make such decisions themselves. This should follow the Trust’s guidelines regarding capacity and best interest decision-making.

Guidance for methods of alternative nutritional support should be sought from the medical team and dietitian. Consideration should be given as to whether short term or long term methods are most appropriate, e.g. NGT vs PEG. The Nutrition team and Nutrition nurse will also be able to facilitate such decisions and management.

7.3. Modified Oral Intake

SLTs may suggest modifying oral intake to compensate for dysphagia if assessment suggests modifying diet and/or fluid reduces the aspiration risk or increases comfort, quality of life and enjoyment for the patient, whilst considering the least restrictive approach.

Diet may be modified through specifically altering the food texture, and fluids may be modified through the use of thickening products.

Textured diet menus are available for downloading and printing on BOB (Trust Intranet).

The International Dysphagia Diet Standardisation Initiative (IDDSI) Framework is an international set of descriptors currently used to describe texture modified foods and thickened drinks. The framework is a continuum of 8 levels (0-7). Fluid spans levels 0-4 and diet spans levels 3-7. For more information regarding IDDSI or the descriptors, please visit the IDDSI website. https://iddsi.org

Risks and benefits of modified intake should be considered and discussed, and clear documentation of decisions and recommendations completed. For example:

- In a nursing home the recommendations will be put in the patients care plan and signage will be put in the patients room
- Written recommendations will be left with a patient in their own home
- At NDDH and South Molton Community Hospital (SMCH), a yellow SLT advice sign with recommendations is placed above the patient's bed space.

Decisions can be reviewed as indicated.

Methods of communication may change in any given environment, but always with the aim of being clear and accessible to the patient and everyone involved with their care.

If modified diet/fluid is recommended, SLT can advise if a change in medication form is felt to be indicated. The prescriber should seek advice from the ward pharmacist or pharmacy medicines information service, to ensure that the patients medication regime is reviewed and adjusted, in line with the patients current eating and drinking recommendations.

### 7.4. Eating and/or Drinking at Risk (EDAR)

Where a patient is determined to be at risk of ill effects from continuing oral intake and it is not felt appropriate to keep the patient NBM or provide non oral alternative feeding, decisions may be made to continue with oral intake accepting risks such as aspiration, malnutrition and/or dehydration.

Refer to the Trust's 'Eating and or Drinking at Risk' guideline:

https://www.northdevonhealth.nhs.uk/wp-content/uploads/2019/07/Risk-Feeding-Guidelines-v2.2.pdf

### 7.5. Out of hours management in the acute setting

Whilst having a thorough SLT swallow assessment with recommendations is desirable, this section outlines how the medical team are able to manage a patient's dysphagia (out of SLTs working hours) if a decision is made that alternative hydration/nutrition is not appropriate and they wish to avoid keeping a patient NBM. Commencing a plan for hydration and nutrition rather than waiting for SLT may be desirable to avoid malnutrition/dehydration, reduced quality of life etc.

The medical team can commence oral intake accepting an unknown or suspected level of aspiration and/or choking risk. Please refer to the Eating and/or Drinking at Risk (EDAR) guideline. Rationales and plans should always be documented. It can be suggested that it may be safest to allow the patient to trial the following oral intake until the SLT can further assess:

- Fluids: Water only.
  Water is less likely to cause aspiration pneumonia particularly where scrupulous oral hygiene is maintained (Panther, 2005), (Wynn, 2014) and (Langmore, 2011).

- Diet: Level 4 Puree diet.
  Puree texture is suggested as it may adequately address issues such as choking risks, poor dentition, reduced ability to masticate, cognitive feeding issues where the patient is averse to texture or lumps, and efficiency at mealtimes, fatigue and poor bolus control. The introduction of puree diet can impact on palatability, functional muscle memory and quality of life in some cases, but in this instance it is only suggested as a standby diet until further SLT assessment.

If oral intake is started and there are significant aspiration concerns or it is distressing for the patient, the medical team may choose to place the patient NBM until a SLT review is available.

7.6. Dysphagia Therapy

For some patients, the SLT may feel it is indicated to trial therapeutic exercises in an attempt to improve or maintain the swallow.

Indication for swallow therapy should in most incidences be led by SLT.

Contraindications of each therapy exercise should be reviewed by the SLT in conjunction with the medical team.

Risks and benefits will be discussed with the patient where able.

7.7. End of Life Patients

Many patients coming towards the end of their life may experience swallowing difficulties. Discussions and liaison with the medical team and palliative care team should be carried out considering the patients quality of life, to review whether Speech and Language Therapy is indicated. (See the Trust's End of Life Policy for Adults and Paediatrics, available on Bob.)

7.8. Clinical Nurse Specialists (CNS)

Specialist Nurses can often play an important role in the MDT when contributing to the management of a patient with dysphagia. For example:

- Dementia Admiral Nurse – may prompt reference to NICE guidelines around artificial feeding for people living with Dementia when the medical team are considering options for a hydration/nutrition plan.
- Nutrition nurse – coordinating SLT/dysphagia input and the patients need for a hydration/nutrition plan, and further liaising with the MDT including the Nutrition Team.
- Multiple Sclerosis (MS) nurse – may assist facilitation of patient pathway, using pre-existing knowledge of patients home care needs, family dynamics and previous discussion about patient preference.

7.9. Discharge process from the acute hospital setting

It is essential that eating, drinking and swallowing decisions and recommendations are effectively communicated to the community setting, including those providing care for the patient and the GP. This allows cohesive care of community and acute patients, and, in collaboration with GP practices, can support the patient to be managed at home. These steps are vital to avoiding inappropriate hospital readmissions.

It is the wards responsibility to update SLT on any discharge plans in progress, and essential that SLT are informed of confirmed discharge plans beforehand to ensure SLT can support a complete and safe discharge.

Requirements on discharge from hospital include:

| Requirement | MDT member | Detail |
|---|---|---|
| Report to the GP if indicated | SLT | Ensure the GP is aware of the decision and able support healthcare in the community setting. |
| Transfer to community SLT caseload if indicated | SLT | SLT will transfer onto community team for follow up if indicated. |
| Provide written information on diet and/or fluids if indicated | SLT | SLT are able to provide leaflets regarding modified diet/fluids as required to support provision of the required recommendations after hospital. |
| Verbal handover to discharge destination / care provider as indicated, e.g. care home, family | SLT / Nurse | SLT are able to discuss input during episode of care, give specific details and guidance relating to the patients recommendations, e.g. discussing texture and meal ideas for a puree diet.<br><br>SLT are only able to complete the verbal handover if aware of the discharge. If out of hours or SLT are not updated, it is the nurses' |

| | | |
|---|---|---|
| | | responsibility to ensure recommendations are handed over. |
| Completion of discharge / care associated paperwork as indicated | Registered nurse / AHP | Completion of documents to demonstrate discharge, personal care and therapy needs should also state if patient has any eating, drinking and swallowing requirements as recommended by SLT. |
| Supply of thickening powder for fluids if required | Nursing staff | A sufficient amount should be provided from the ward stock to last the patient until the first prescription can be accessed in the community, e.g. minimum of 1- 2 tins of thickener. |
| Decision and recommendations on the hospital discharge summary | Medical team | Allows clear communication of decision and recommendations.<br><br>This should include the decision whether or not to readmit the patient for acute hospital treatment should they be diagnosed with aspiration pneumonia by the GP. This forms a crucial stage in the process, allowing the patient to leave the acute setting with a clear plan in place informing future management. |

## 8. Medication

Medication can have an impact on a patient's presentation and/or their swallowing. Therefore:

- The patient's medication should be reviewed by the medical team and/or pharmacist; any medicines no longer indicated or medicines that may be impacting on swallow function should be reviewed and optimised.

- If a patient is NBM, an alternative route of administration should be considered where medication has been reviewed and remains clinically indicated. See Section 7.1.

- Where medication is being taken orally but a different form is required (such as crushing or liquid medication), advice must be taken from a pharmacist. Changing medication without guidance may render the form unlicensed and could present a risk to the patient.

- Changing the formulation or route of administration of a medicine may require dose change as medicines are not always dose-equivalent when administered by different route (IV / oral), or when administered using different formulations (liquid / tablets / capsules). It is the responsibility of the prescriber to ensure that medication is prescribed in according with the Trust medicines Policy (see Section 5.1.15). The ward pharmacist / medicines information pharmacist can be contact for advice on dosing, formulation or route of administration changes required to medication, following clinical review.

For further guidance, please refer to:

- The Trust Medicines Policy
- The Administration of Medicines Standard Operating Procedure
- The Omitted and Delayed Medicines Standard Operating Procedure.

## 9. Documentation

All referrals (within reason), discussions, decisions and plans should be clearly documented.

Documentation should be in line with RCSLT standards and the Trust policy (Approval of new and revised patient documentation procedure).

Documentation may take place in different forms and be displayed in different places depending on the setting.

For the community SLT and Stroke ESD will write in:

- RiO
- Care Plan for patients in residential or nursing homes.

For ALD SLT teams the SLT will write in:

- Care Notes

For Head and Neck patients the SLT will write in:

- EPRO

For inpatients the SLT will write in:

- Medical Notes
- Yellow SLT advice signs. Note, signs will show the latest dysphagia recommendations. For the latest review, plan for ongoing input, or full SLT information, please refer to the medical notes.

## 10. Choking

Choking occurs when an object becomes stuck in the throat or airway and restricts or blocks air flow to/from the lungs.

To some degree, all patients could be at a level of choking risk not just those with dysphagia; however some factors are likely to increase this risk such as poor positioning or poor alertness when eating and drinking.

For patients with dysphagia, some foods also present as a high choking risk.

Those assisting a patient with oral intake should be aware of the patient's DNAR status. In the event of a respiratory arrest due to choking, refer to the Trusts life support training and relating polices for recognition and emergency action and management of a choking episode.

## 11. Education and Training

For SLT, therapists should have appropriate professional undergraduate and post graduate training to allow them to fulfil their professional role with regard to the management of people with feeding/swallowing difficulties. This will be in line with RCSLT and HCPC requirements and competencies.

For other health professionals this may vary from:

- Completing Dysphagia Essentials e-Learning available on STAR or e-Learning for Heath website. This session covers all the basic theory and practical aspects of how to help a person with swallowing difficulties (dysphagia). This is recommended for all clinical staff.
- Attendance at local training such as Dysphagia workshops, Nutrition Study Days etc.
- Specialist training for nurses, e.g. stroke swallow screens
- Patient specific training

Please refer to your line manager for guidance around the appropriate training required.

## 12. Legal Liability

The Trust as an employer will assume vicarious liability for the actions of all staff, including those on fixed or honorary contracts, providing that:

- Staff have undergone any training identified as necessary
- The member of staff is authorised by the Trust to undertake the procedure
- The provision of this guideline and supporting documentation has been followed at all times.

# 13. MONITORING Compliance with and the Effectiveness of the guideline

## Standards/Key Performance Indicators

13.1. Stroke patients will have a stroke swallow screen completed within four hours of admission.

13.2. Patients with dysphagia or suspected dysphagia will be referred to speech and language therapy and seen within the timeframe outlined below.

13.3. Thickening products will not be left by the bedside of a patient who does not have capacity to understand how to use the product safely.

13.4. Patients with dysphagia and referred to SLT will only be given the correct food and fluid consistencies as recommended by the SLT.

13.5. Bi annual Nutrition Audit, as collated by Nutrition Steering Group (NSG).

13.6. Monthly Nutrition Dashboard, as collated by the Nutrition Steering Group (NSG)

## Process for implementation and Monitoring Compliance and Effectiveness

- The guideline will be monitored through the speech and language therapy department and the nutritional steering group.
- The speech and language therapy leads, professional lead and head of therapies will be key in undertaking the monitoring.
- The speech and language therapy department and nutritional steering group will consider and report non-compliance.
- The guideline will be continuously monitored and audited and improvements will be an ongoing process via work stream groups and team meetings within the speech and language therapy department.
- The guideline is detailed and complex but incident reports should be completed if anyone does not adhere to the guideline.

# 14. References


- The International Diet Standard Initiative. (2020) *IDDSI - International Diet Standardisation Initiative*. [Online]
  Available from: https://iddsi.org/ [accessed 09 January 2020].

- Cork, E. and Davey, J. (2018) SIRI Investigation 14415.

- GOV. (2020) *National Patient Safety Agency*. [Online]
  Available from: https://www.gov.uk/government/organisations/national-patient-safety-agency [accessed 09 January 2020].

- MWC. (2020) "Starved of Care" Report: Investigation into the care and treatment of Mrs V, *Mental Welfare Commission for Scotland*.

- National Patient Safety Agency. Understanding the patient safety issues for people with learning disabilities. UK: National Patient Safety Agency; February 2004.

- Northern Devon Healthcare NHS Trust (2018) *End of Life Policy for Adults and Pediatrics*. North Devon: NDHT.

- Northern Devon Healthcare NHS Trust (2019) *Enteral feeding Policy*. North Devon: NDHT.

- Patient Safety First. (2017) *National Guideline for Swallow Screening in Stroke*.

- Northern Devon Healthcare NHS Trust (2017) *Mental Capacity Act*. North Devon: NDHT.

- Northern Devon Healthcare NHS Trust (2018) *Procedural Documents (Patient Documentation)*. North Devon: NDHT.

- Northern Devon Healthcare NHS Trust (2019) *Risk feeding Guideline*. North Devon: NDHT.

- Northern Devon Healthcare NHS Trust (2019) *Stroke Swallow Screen*. North Devon: NDHT.

- Northern Devon Healthcare NHS Trust (2019) *Videofluoroscopy Procedure for Speech and Language Therapists and Radiographers Standard Operating Procedure*. North Devon: NDHT.

- Reducing the risk of choking for people with a learning Disability: A multi-agency review in Hampshire (2012)
  https://documents.hants.gov.uk/adultservices/safeguarding/Reducingtheriskofchokingforpeoplewithalearningdisability.pdf

- Royal College of Physicians (2010) *Report of a working Party, Oral Feeding Difficulties and Dilemmas. A guide to practical care, particularly towards the end of life*. ISBN:9781860163715: RCS.

- Royal College of Speech and Language Therapists. (2020) *Dysphagia*. [Online] Available from: https://www.rcslt.org/speech-and-language-therapy/clinical-information/dysphagia [accessed 09 January 2020].

# 15. Appendices

## 15.1. Appendix 1

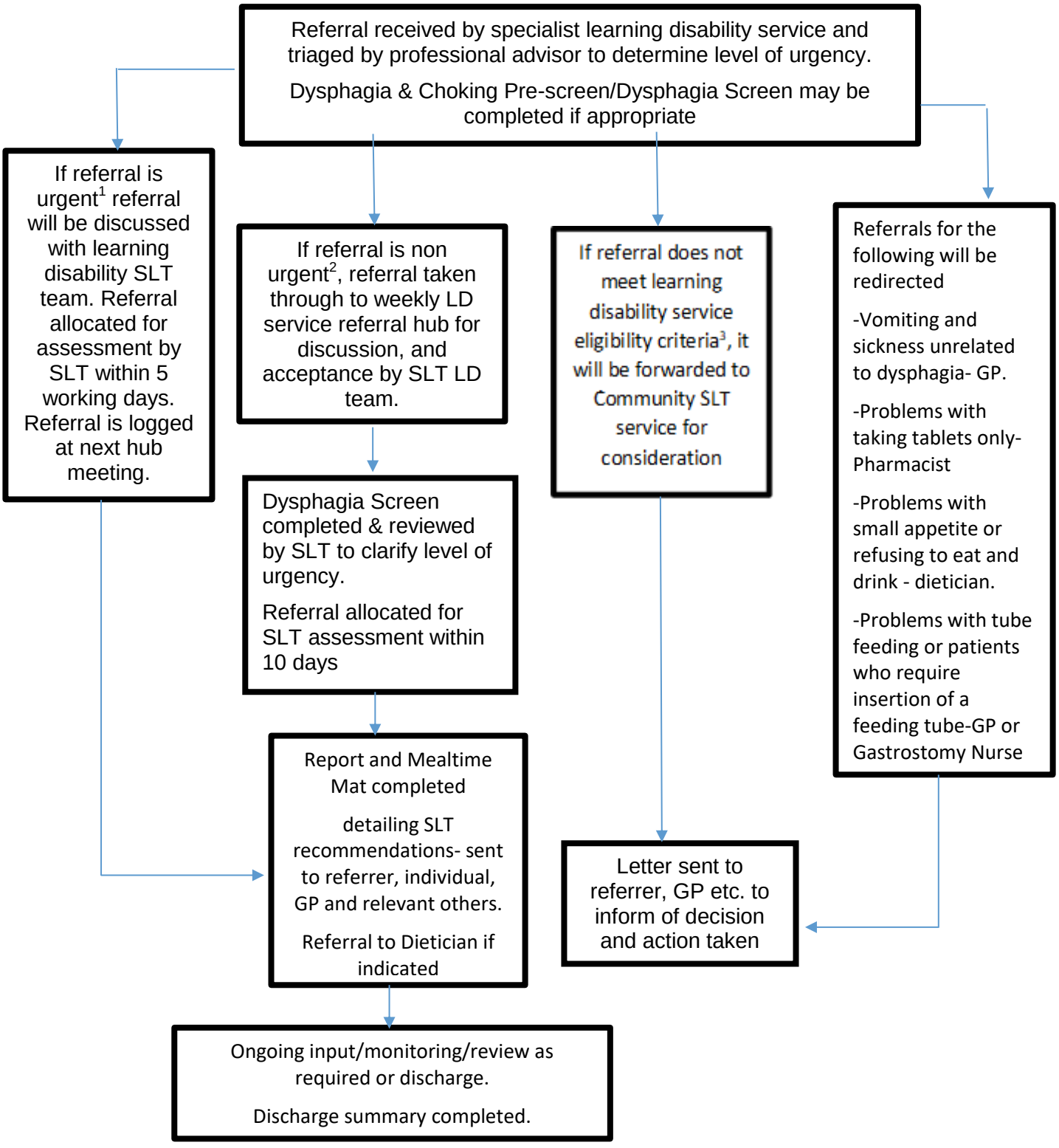
## Guidance for the use, storage and disposal of Thickening Agent and Supplements for patients with dysphagia.

| Instruction | Responsible |
|---|---|
| If a patient has been assessed and found to require either thickening agent and or supplement foods, this should be clearly documented.<br><br>For inpatients at the North Devon District Hospital this will be in the medical notes and a yellow SLT advice sign above the bed.<br><br>In the community this is documented on RIO. Care home records for patients can be electronic or paper depending on care home. A Mealtime Mat is provided when appropriate. Reports are sent to the referrer, GP, patient and care home (if applicable).<br><br>For ALD this will be on Care Notes and using mealtime mats as appropriate. | All staff |
| Thickening agent and supplements should be stored in the ward kitchen, practice kitchen, on the drinks trolley or patient's bedside locker. Whilst being stored it should be out of reach of patients unless they have been assessed as able to thicken their own drinks. | All staff |
| After thickening a patient's drink, return the thickening agent to the ward kitchen, practice kitchen, drinks trolley or patient's bedside locker. | All staff |
| After administering supplement drinks used for enteral feeding such as NGT or PEG, please dispose of opened cartons and return any unopened cartons to the kitchen. | Nursing staff |
| Ensure supplement drinks are provided at the correct consistency. DO NOT thicken supplement drinks. If a patient requires supplement drinks and is on thickened fluids, ensure the supplements provided are manufactured at the correct thickness level. | All staff |
| All patients should be made aware of the risks of consuming thickening agent if not added to drinks. A patient must be assessed as competent to thicken their own drinks prior to self-management. This should be documented.<br><br>The patient should be made aware of the risk to other patients if thickening agent is left within reach of other patients. | SLT, Nurse, Ward Manager |
| All staff need to be made aware of the NHS England National Safety Alert relating to ingestion of thickening powder and be aware of the risks of consuming thickening agent if not mixed with a drink https://www.england.nhs.uk/2015/02/06/psa-fluidfood-thickening- | All staff |

| | |
|---|---|
| powder/ | |
| All staff should be aware of the NHS Improvement Patient Safety Alert that patients with dysphagia on a modified diet should be given food and fluid textures as described by the International Dysphagia Diet Standardisation Initiative (IDDSI)<br><br>https://improvement.nhs.uk/documents/2955/Patient_Safety_Alert_-_Resources_to_support_safer_modification_of_food_and_drink_v2.pdf | All staff |
| Ensure the correct SLT recommendations for fluid consistency are in place and up to date prior to the use of thickening agent for any patient.<br><br>Refer to SLT entry in medical or electronic notes or in care plans for residential/nursing homes. Yellow SLT advice sings above the bed will be used for inpatients and mealtime mats will be provided for community patients.<br><br>Patients admitted to the ward/care setting who are already using thickener, should continue to follow their current recommendations for thickening fluids unless new concerns arise, in which case follow SLT referral processes. | Trained staff |

15.2. Appendix 2

# Adult Learning Disability Dysphagia Pathway



[1] *Higher priority for dysphagia is determined by the level of risk, distress, complexity and impact on life. These referrals will be picked up as a matter of priority*

-Preventable illness and death
-Prevention of hospital admission
-Supporting hospital discharge

[2] Medium priority will be actioned when there is capacity. Whilst waiting, some Consultation/advice may be offered alongside other MDT members. The presence of positive factors in a person's life will help determine priority. Non-urgent dysphagia referrals fall within this category of risk

-Non urgent assessments and management
-Non urgent reviews

[3] IATT services are available to all adults over the age of 18, with a diagnosed learning disability and registered with a Devon GP (excluding Plymouth). People will be offered a service providing they meet the referral criteria for IATT:

1) Whose needs are not able to be met in Primary care or Mental health services? (despite reasonable adjustment) due to the complexity of presentation or severity of Learning Disability.

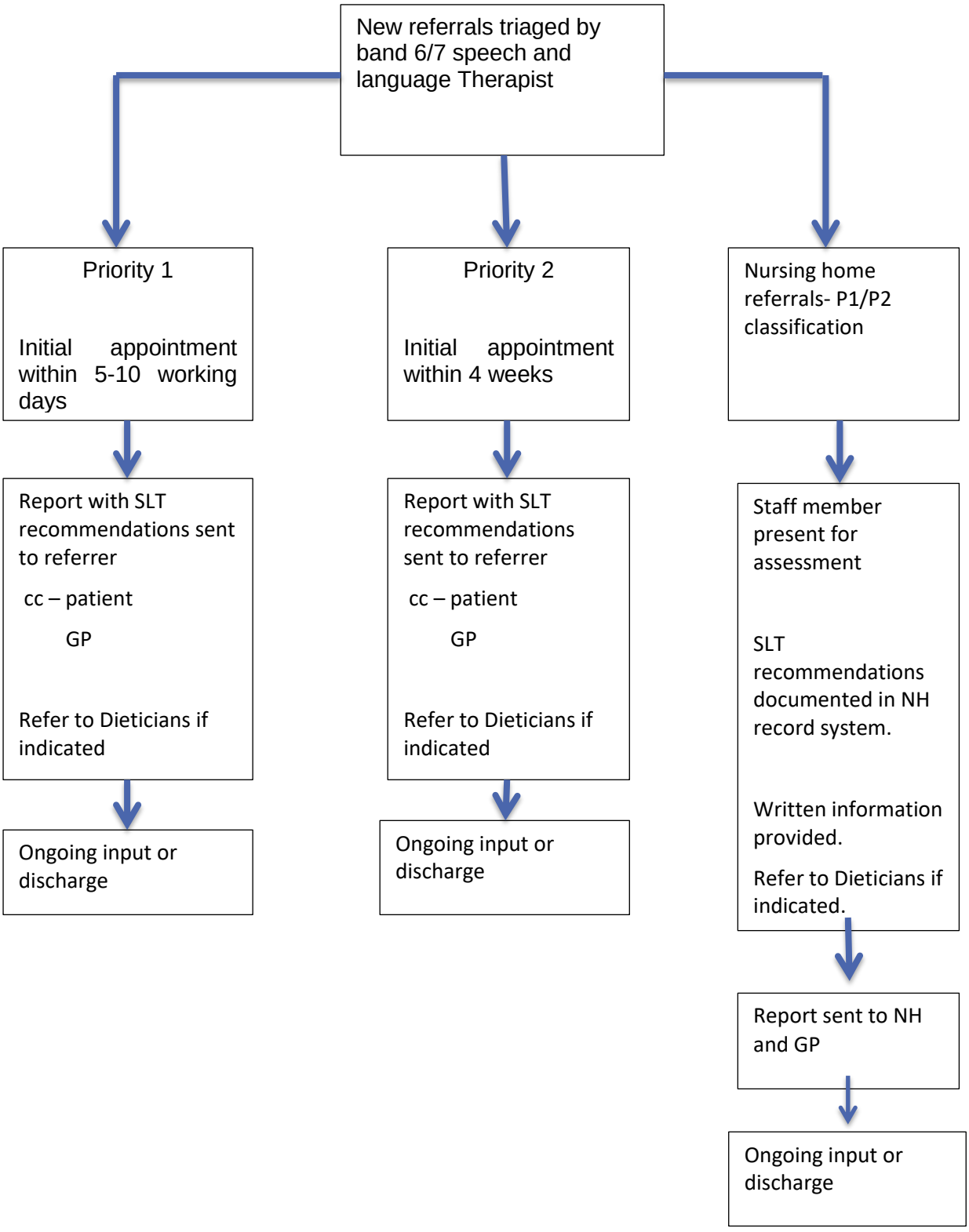
2) The person has a Learning Disability as described by the World Health Organisation (ICD-10) (WHO) 5, International Classification of Mental and Behavioural Disorder Diagnostic Guideline. Learning disability includes the presence of:

-A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
-A reduced ability to cope independently (impaired social functioning);
-Started before adulthood with a lasting effect on development

SLT Learning Disability Service 17/01/20
Review date: 17/07/20

15.3. Appendix 3

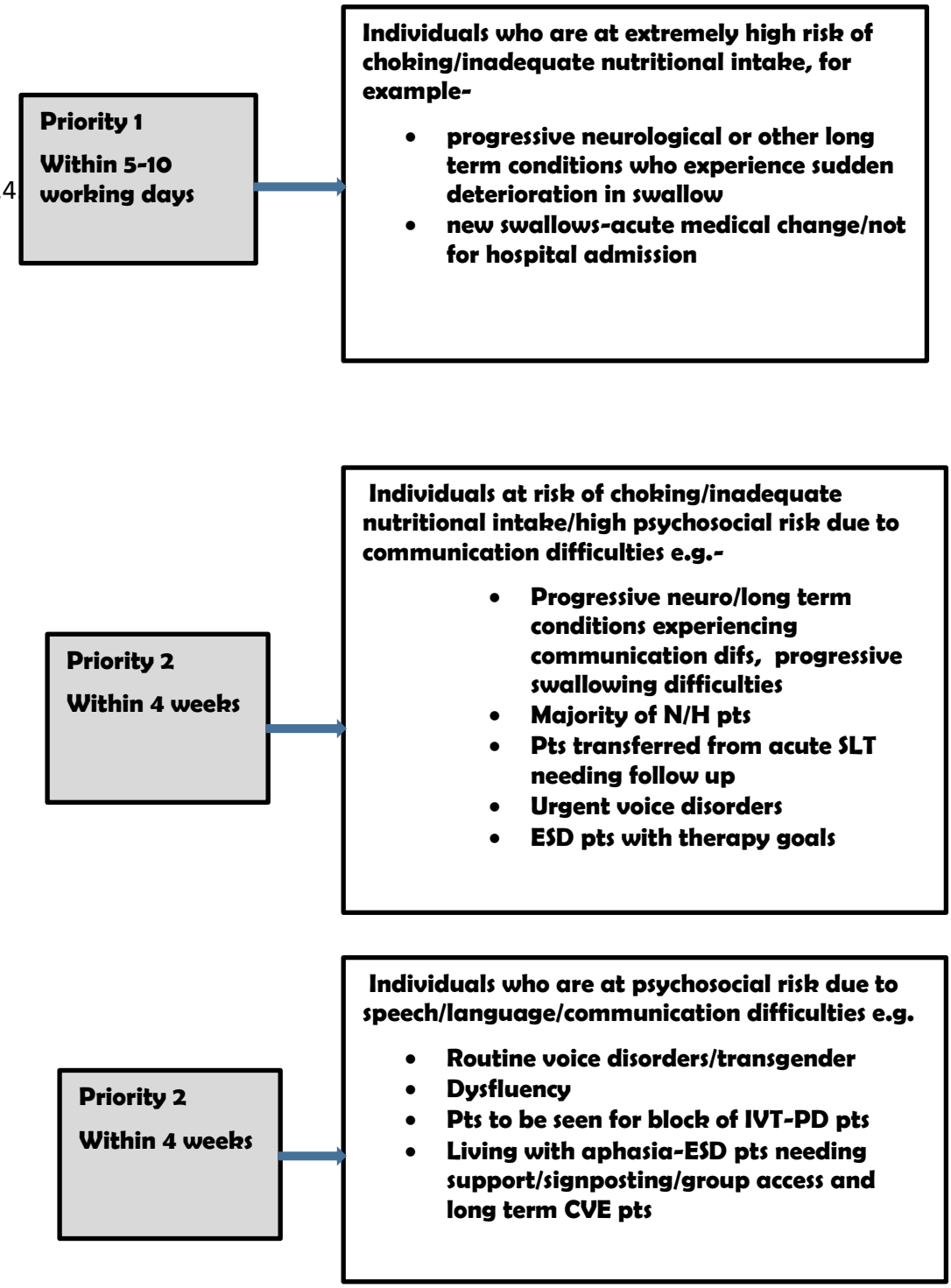
# COMMUNITY DYSPHAGIA PATHWAY



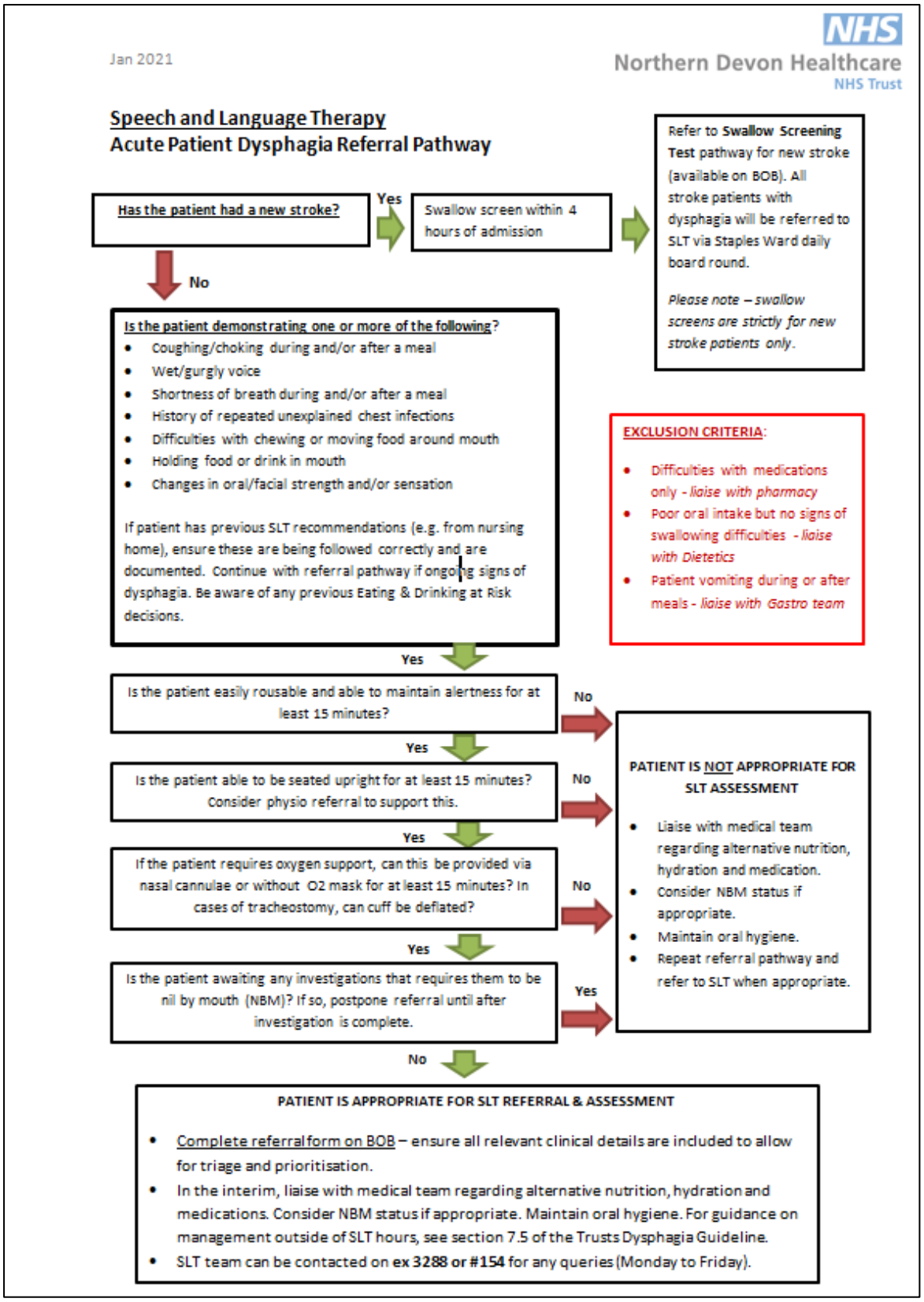
# PRIORITISATION OF COMMUNITY REFERRALS

NB-The RCSLT recommended response time of seeing patients within 2 working days of receipt of referral is not achievable within the community setting due to level of resourcing/geography of N Devon.

15.4



## 15.4 Appendix 4



NHS
Northern Devon Healthcare
NHS Trust

# SLT ACUTE PRIORITISATION SYSTEM

Response times are guided by the Royal College of Speech and Language Therapists recommendations, Care Pathways – Guidance (2018).

To meet RCSLT guidelines, a **new referral should be seen within 2 working days**, however in a situation with an influx of new referrals and reduced staffing, prioritisation of the caseload should follow the below criteria.

## PRIORITY 1

- Patients who are at significantly high risk of aspiration/choking/inadequate nutrition
- Patient is NBM with no established non-oral route for nutrition, hydration and medication.
- Patient is currently on limited trials of oral intake.
- Patient where nutrition/hydration status is causing distress.
- Where swallow disuse is a clinical concern.
- Where patient has commenced oral intake but there are ongoing swallowing concerns.
- Where the need to contact relatives / arrange meetings etc. is deemed essential.
- Where SLT attendance at an appointment has been deemed essential, e.g. ENT.
- Patients due to be discharged and needs review prior to discharge.
- Communication initial assessment / input to diagnose and provide advice to patient, family and ward, where:
    - Communication is essential for providing consent
    - If lack of communication poses a significant risk factor.
    - If review of communication will facilitate on discharge.
- Urgent discharge paperwork.

## PRIORITY 2

- Patient is NBM but with fully established non-oral route for nutrition, hydration and medication, and review is appropriate with a view to re-introducing oral intake.
- To review swallow for a change of diet / fluid consistency.
- Swallowing or communication therapy which is deemed to be non-urgent based on above criteria
- Discharge paperwork / onward referral to SLT if non-urgent - to ensure still completed in a timely manner

## PRIORITY 3

- SLT aims completed and patient is felt to be stable but a final review is needed to ensure that management/discharge plans are correct.

Jan 2021