Livewell Southwest

Adult Speech and Language Therapy Service

Dysphagia Policy (Adults)

Version No.2

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Reader Information

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Equality analysis checklist completed	Yes
References/sources of information	**Dysphagia Diet Food Textures Descriptors March 2012** endorsed by National Patient Safety Agency, Royal College of Speech and Language Therapists (RCSLT), The British Dietetic Association, National Nurses Nutrition Group, Hospital Caterers Association. Available on the RCSLT website www.rcslt.org **RCSLT Communicating Quality 3 (2006)** **RCSLT Clinical Guidelines (2005)-** Disorders of Eating, Drinking and Swallowing (Dysphagia). **Interprofessional Dysphagia Competencies Framework**

	available at www.rcslt.org
Associated documentation	All clinical policies and Clinical Supervision Policy
Supersedes documentation	This policy replaces the Learning Disability Dysphagia Policy (Adults) V1.
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Document Review History

Version No.	Type of Change	Date	Originator of Change	Description of Change
1	Ratified	September 2012	Specialist Speech & Language Therapist (Team Leader)	New policy. This policy is now organisation wide – i.e. it's not only for the Learning Disability Service
1.1	Review	August 2014	Specialist Speech & Language Therapist (Team Leader)	Minor changes in procedures.
2.	Minor amends	November 2014	Policy Ratification Group	Ratified.

Dysphagia Policy (Adults)

1 Introduction

1.1 People with neurological conditions i.e. neurodegenerative disease, stroke, dementia, cerebral palsy are at increased risk of Dysphagia, which can lead to physical health problems and serious complications. People with a learning disability also have an increased risk of Dysphagia, although not everyone with a learning disability has Dysphagia.

1.2 Dysphagia can occur in all age groups, and can affect an individual's quality of life and general health. Dysphagia can develop at any age, so a person may begin to experience swallowing difficulties despite not having had problems previously. There is a range in the severity of Dysphagia. Where Dysphagia is mild, only minor changes may be needed to improve the efficiency and safety of the eating and drinking process. Where Dysphagia is severe, it can be life threatening.

1.3 The serious physical health risks and complications of Dysphagia include increased risk of choking which can be fatal, pulmonary aspiration (food and fluid going to the lungs) which may lead to chest infections, lung damage and aspiration pneumonia which can be fatal, malnutrition, increased risk of other infections i.e. urinary tract infection. In addition there may be emotional and psychological problems associated with not being able to eat normally.

1.4 Part of the work of the Speech and Language Therapist (SLT) includes raising awareness amongst carers and provider services of the signs and symptoms of a swallowing impairment (Dysphagia), in order that a referral to SLT for a specialist Dysphagia assessment can be made.

1.5 An holistic approach i.e. considering the persons physical and emotional needs, is essential to improve the safety of the individual with swallowing problems. The persons overall care plan should reflect the fact that the person has a swallowing problem which has an impact on their physical health. The care plan should include appropriate strategies to be used to lower the impact of the Dysphagia, as determined by assessment.

2 Purpose

2.1 This policy provides guidance for use by the Adult Speech and Language Therapy Service, and the Speech and Language Therapists working for the Community Learning Disability Team, both of these services are part of Livewell Southwest (LSW).

2.2 The policy covers people referred with swallowing problems (Dysphagia), it relates to all in-patients on the Mount Gould Hospital site referred to the Adult Speech and Language Service, all patients referred to the Community Speech and Language

Service and people referred to the Speech and Language Therapists in the Community Learning Disability Team.

3 Definitions

3.1 **Dysphagia** - The term Dysphagia refers to an impairment of swallowing. A swallow has 4 stages, oral preparatory, oral, pharyngeal and oesophageal. Dysphagia refers to impairment in any or all of these stages of the swallow.

3.2 **Aspiration** - Aspiration in this policy refers to food or fluid penetrating the respiratory tract below the vocal chords, and entering the lungs. Pulmonary aspiration can have a significant impact on physical health as it can cause lung damage, aspiration pneumonia (which can be life threatening) malnutrition and an increased risk of other infections.

3.3 **Choking** - Choking refers to a lump of food or non food object blocking the airway so that the person is unable to breathe, or breathing is severely compromised. Choking is a life threatening emergency and must be dealt with immediately by the recognised first aid action of back slaps and/or stomach thrust. Choking can be fatal.

4 Duties & Responsibilities

4.1 The **Chief Executive** has overall responsibility for the safe care and treatment of patients and the implementation of this policy.

4.2 **Directors / Locality Managers** should be aware of this policy and ensure that all staff who work with adults who are at risk of Dysphagia are aware of this policy.

4.3 **Line Managers** - It is the responsibility of line managers to ensure all staff working with people at risk of Dysphagia are aware of this policy. In addition it is the responsibility of the line managers of SLT's working with adults to ensure that those SLTs who are required to work with people with Dysphagia have the necessary qualifications and competencies to do this work. Where the line manager is not a SLT they should involve the Professional Lead with responsibility for Allied Health Professionals (AHP's) within the LSW, when needing to make decisions on an individual SLT's competency to carry out Dysphagia work.

4.4 **Speech and Language Therapists** within LSW, working with adults must understand and comply with this policy. SLTs should provide feedback on the use of the policy to their line managers and the Professional Lead with responsibility for AHP's within LSW.

4.5 **Responsibilities of Managers and Team Leaders of other services**

4.5.1 It is the responsibility of the manager of the unit/ward, or the team leader of a supported living team, to ensure that all members of staff have read the guidelines

from the SLT. It is not the responsibility of the SLT to ensure that individual members of staff in a unit or team have read, and are following, the advice – that is the responsibility of the manager of the unit or team.

4.5.2 It is the manager's responsibility to ensure that the information is incorporated into the persons care plan, and that individual members of staff understand that their duty of care is to follow the care plan. Care plan here refers to the providers care plan which is used for the day to day support of the person.

4.5.3 When a manager has concerns about the ability of members of the staff team to understand the information given and the reasons for the strategies suggested, they can ask for assistance from the SLT. This assistance would usually be given through education and training of members of the staff team, either individually or in groups.

4.5.4 It is the manager's responsibility to ensure that the level of supervision made in the SLTs recommendations is provided to the patient whenever they eat and/or drink.

5 Referral

5.1 In-patients within LSW

5.1.1 All referrals to the in-patient SLT team should be made verbally or in writing, by a member of the medical staff.

5.1.2 All in-patient Dysphagia referrals are seen within two working days, as recommended by the Royal College of Speech & Language Therapy in Communicating Quality 3.

5.1.3 All referrals are logged onto ePEX or SystmOne (as appropriate).

5.1.4 Referrals from SLT's in Derriford Hospital for patients with non- complex Dysphagia who have suffered a cortical Cerebral Vascular Event and who are currently on a feeding regime may be referred to the Nurse Managed Dysphagia Pathway (see flowchart, Appendix A).

5.1.5 All Dysphagia Trained Nurses (DTNs) will be trained by SLT's qualified to Specialist Dysphagia Practitioner level (National Dysphagia Competencies Framework) to a level where they are competent to manage non-complex, post-stroke Dysphagia.

5.1.6 The SLTs are currently employed between the hours of 08.30-16.30 Monday to Friday to respond to referrals. Therefore the DTNs are more likely to be able to respond to referrals in a timelier manner (i.e. if a patient is admitted over the weekend).

5.2 Community

5.2.1 All referrals to the Community SLT Team should be made to the Community

Therapy Team inbox (LSWCIC.therapyreferrals@nhs.net) on the Community Therapy Team referral forms.

5.2.2 All Dysphagia referrals should have the agreement of the person's GP.

5.2.3 Referrals are triaged on a daily (Monday-Friday) basis by a qualified SLT.

5.3 Learning Disability

5.3.1 Referrals for Dysphagia for people with a learning disability are made through the Tamar Referral Appointment Centre (TRAC). Internal referrals can be made via the referrals coordinator. (Contactable on 08451558077)

5.3.2 Referrals for people with Dysphagia with a learning disability are triaged within two working days by a qualified Speech and Language Therapist.

5.4 Dealing with Referrals – Community and Learning Disability SLT

5.4.1 Referrals to the Community SLT Team are triaged to be seen within:

3 working days (score of 30+ at triage, see appendix B).

5 working days (score of 25-29 at triage).

10 working days (score of 18-24 at triage).

15 working days (score of 10-17 at triage).

20 working days (score of less than 10 at triage).

NB. The scoring may be overridden by the clinical judgement of the triaging SLT, on consultation with another SLT colleague.

Referrals are triaged on information provided by the referrer, and additional information collected by the triaging SLT. This may include information from ePEX, SystmOne, the patient or carer and/or further information from the referrer.

5.4.2 Referrals to the Early Supported Discharge Team (ESDT) are accepted as part of the general handover, or when issues are raised by the multi-disciplinary team (MDT). They are triaged using ESDT criteria.

5.4.3 Referrals to the Learning Disability SLT Team are triaged as follows:

As Soon As Possible (ASAP) (high risk of choking/aspiration, severely inadequate fluid/ nutritional intake) **seen within two working days.**

Priority 1 (risk of choking/aspiration, inadequate fluid/nutritional intake) **seen within 10 working days.**

Priority 2 (stable or improving Dysphagia, with alternative feeding) **seen within 20 working days.**

Referrals are triaged on the information provided by the referrer. If insufficient information is included, the referral may be returned to the referrer with a request for additional information.

These response times are from receipt of referral as recommended by the RCSLT Communicating Quality 3 (2006).

5.4.4 All referrals are currently logged onto SystmOne.

5.4.5 The Community and Learning Disability (LD) SLT services do not provide an emergency service. The Community SLT service is open 08.00-16.30 Monday-Friday only. The LD SLT service is open 09.00-17.00 Monday-Friday only.

5.4.6 If a person has become very dehydrated and confused due to not being able to take in enough fluid, hospital admission may be needed to rehydrate the person – advice needs to be sought from the persons GP.

5.4.7 If a person has severe chest infection or aspiration pneumonia due to aspiration of food or fluid, hospital admission will be needed.

5.4.8 Community and LD SLT patients who are admitted to Derriford are seen by the speech and Language therapist team who work there. These SLTs will assess the persons swallowing skills, form a management plan and liaise with the community SLTs as needed during the persons stay, and on discharge.

6 Consent

6.1 Where the person with Dysphagia has capacity to consent to referral for an assessment of their swallow, the referrer should seek consent to the referral from the person themselves before making the referral.

6.2 If the person does not have the capacity to consent to the assessment, the SLT will carry out the assessment in the patient's best interests, based on the information from the referrer.

6.3 Following assessment, when drawing up the management plan, the SLT must determine the person's capacity to understand the risks that have been identified, and their capacity to understand the rationale for the strategies that are being suggested in the management plan. As demanded by the Mental Capacity Act, the SLT must take reasonable steps to try and explain - in a way the person can understand - the relevant information about their swallow, the risks that face them as a result, including why certain behaviours may be increasing the risk of choking and/or aspiration, and the appropriate strategies recommended to manage those risks.

6.4 Whether or not a person has capacity, the SLT will involve the person themselves as much as possible in the decision making and take into account the person's likes /dislikes of different foods /drinks and aspects of eating and drinking that are important to that person, based on information given to the SLT by the client and /or carers. This information will inform the management plan as far as possible.

7 Assessment

7.1 The SLT may observe the service user at mealtimes and in different environments. The purpose of this is to assess the relevant factors related to a person's eating and drinking skills:

- Level of independence and involvement.
- Interaction.
- Motivation/interest in eating and drinking.
- Physical environment.
- Positioning.
- Food placement.
- Amount presented and bolus size.
- Utensils.
- Presentation.
- Pacing (i.e. speed of eating and drinking).
- Texture and consistency of food and drink.
- Knowledge, skills and abilities of the person(s) supporting the client.
- Any behaviours the person has which increase their risk of choking.

7.2 The safety and efficiency of the patient's eating, drinking and swallowing will be assessed. This may include "bedside assessment" and/or manual assessment of the swallow and cervical auscultation and/or pulse oximetry. SLTs who are Specialist Dysphagia Practitioners who have received formal training in the technique must only use cervical auscultation alongside clinical swallow evaluation. Clinical decision making will not be based solely on the outcome of cervical auscultation or pulse oximetry.

7.3 When appropriate, the person may be referred for a Video Fluoroscopy Study (VFS) of the swallow. This is carried out at Derriford Hospital. Referral for VFS needs to be made by the person's GP, usually at the request of the SLT. In addition, the referring SLT will complete the Derriford SLT VFS referral form and return to the Lead VFS Speech and Language Therapist at Derriford. In addition to the SLT who has referred the person, an SLT from Derriford will be present at the at the VFS – it is this SLT who has the required competency to interpret the VFS and give appropriate recommendations for management of the swallow which will contribute to the overall management plan for swallowing for that person.

8 Speed of Assessment and Intervention

8.1 Assessment cannot always be done quickly as there are factors which influence both the assessment and intervention for the patient. The timing of the assessment

and intervention may be affected by:

- Respiratory and nutritional status.
- Medical status.
- Physical environment.
- Development.
- Emotional, psychological and behavioural well-being.
- Prognosis.
- Feelings of the carers, especially those who have a close emotional attachment to the person (i.e. spouse, parents, family carers).

9 Investigation by other Clinicians

9.1 It may be necessary for the SLT to refer the patient on for further investigation by other clinicians:

- Dietician for nutritional assessment if there is concern regarding nutritional adequacy. The dietician provides information on achieving appropriate nutritional balance, intake of energy, nutrients and fluids. Nutrition supplements to be recommended if person is unable to manage sufficient nourishing food.
- Physiotherapist (i.e. for advice on positioning while eating / drinking and assessment of respiratory function).
- Occupational Therapist – for advice on appropriate utensils for eating / drinking and possibly mealtime management.
- Psychologist - for support in dealing with difficult feelings surrounding eating and drinking, and difficult feelings that arise when changes to this are needed.

9.2 In addition the person may be advised to visit the dentist for a check-up and possible treatment when this is indicated.

9.3 The SLT will liaise with medical staff and/or the clients GP as and when needed. This includes the need to check out medical information, make a referral for VFS or when requesting a prescription for a thickener.

10 Intervention

10.1 The SLT will discuss the results of the assessments and proposed intervention with the person, the medical staff and/or carers, and involve these people in decision making as much as possible.

10.2 When working with adults with Dysphagia, the most likely form of intervention is to reduce risks around eating and drinking by modifying any or all of the following:

- Presentation of food/drink.
- Posture/positioning.
- Food placement and bolus size.

- Food characteristics (temperature, texture, taste, consistency) Note: Classification and description of food textures will be done using the Dysphagia Diet Food Texture Descriptors April 2011.
- Pacing (i.e. speed of eating and drinking).
- Utensils.
- Frequency, timing and size of meals.
- Mealtime environment.
- Support given to the person while eating / drinking in order to manage any behaviours, which are significantly increasing the risk of choking and / or aspiration.

10.3 The SLT will ensure that the effects of any recommended modifications or changes are assessed, to ensure that they are appropriate in striving to achieve the safest and most efficient swallow possible for the client.

10.4 Where texture modifications are being recommended, the SLT will take into account the persons food preferences and strive to make the recommendations as least restrictive as possible whilst keeping the person safe.

10.5 A referral to the Dietician should be made if there is a need to make significant changes to the types of food which can be offered to the person, or if the assessment identifies that the person's ability to eat or drink enough to sustain energy and nutritional needs is significantly compromised. In the in-patient setting this is usually assessed by the Multi Disciplinary Team using the Malnutrition Universal Screening Tool ('MUST').

10.6 Written advice/information will be left at the bedside/care home/unit/patients own home. This will be explained to the patient and/or carer by the SLT. In community settings, a signature will be required to acknowledge receipt of this information. In care homes or other units, the care plan will be updated to include information / recommendations regarding eating and drinking. Considering the person's physical needs and their emotional needs, it is essential to improve the safety of the individual with swallowing problems. The persons overall care plan should reflect the fact that the person has a swallowing problem which has an impact on their physical health, and/or a behaviour that increases their risk of choking. The care plan should include appropriate strategies to be used to lower the risk of choking and / or the impact of the Dysphagia, as determined by assessment and advice.

10.7 A report summarising the results of the assessment will be written and circulated to the GP and other relevant professionals involved in the persons care. For people with a learning disability, a copy will be sent to Adult Social Care to ensure that they are aware of the level of support or supervision the person needs when eating / drinking. In the case of in-patients, this report will be written in the medical notes and a treatment plan put in the nursing notes at the end of the bed.

11 Review

11.1 This comprises on-going monitoring by the local SLT within defined timescales. Any necessary modifications will be made to the patient's treatment strategy, and distributed to all concerned.

11.2 Updated reports will be written and distributed when changes are made.

12 Discharge

12.1 The person with Dysphagia will be discharged when management strategies are in place and nutritional status is stable. This will be discussed with the person and / or their carers prior to discharge. If the person receives only non-oral nutrition and hydration, they will be discharged from the Speech and Language Therapy Service but continue to be monitored by the Dietician who has responsibility for monitoring people with gastrostomy feeding tubes.

12.2 A Discharge Report will be written and distributed to relevant parties.

12.3 On discharge from an in-patient setting, the SLT will complete the relevant section of the Discharge Summary and onward referral to the Community or LD SLT will be made, with detailed handover, if indicated.

13 Non-Oral Nutrition

13.1 The SLT will contribute to the multi-disciplinary decision regarding the potential need for partial or total non-oral nutrition and hydration. The multi-disciplinary team, including the service user and significant carers, will be involved in reaching this decision. The SLT's role is to contribute information concerning safety and efficiency of oral intake and prognostic indicators for improvement.

14 Choking

14.1 Choking refers to the airway being blocked by a food or non food object so that the person is unable to breathe. This is an emergency and is life threatening. A significant number of people die from choking each year.

14.2 People with a learning disability and people with dementia are at increased risk of choking. This may be as a result of swallowing impairment (Dysphagia) and / or behaviours which increase the risk of choking.

14.3 Some people do not have Dysphagia, but do have cognitive and behavioural problems which may result in disorganised eating or drinking (i.e. they have a behaviour which increases their risk of choking). This includes eating very quickly, and/or cramming a lot of food into the mouth at once. These people are at as high a risk, or even higher risk, of choking, as people who have a mechanical swallowing impairment (Dysphagia).

14.4 Due to the increased risk of choking amongst people with a learning disability, a referral may be made to an SLT in the Community Learning Disability Team, for a person with a learning disability, where a high risk of choking has been identified due to behaviours which increase the risk and/or a choking incident has occurred. The SLT will carry out a screening swallowing assessment, and also assess the level of risk of choking that the behaviours present.

14.5 If a possible swallowing impairment is identified at this screening, the SLT will carry out a full Dysphagia assessment and implement a management plan as detailed in this policy.

14.6 If no swallowing impairment is identified at screening, the level of risk of choking due to the persons behaviours when eating, appropriate ways of managing that risk, and the possible fatal consequences of not following the guidelines, will be explained in person and in writing to the manager(s) of providers of services for that person. Appropriate ways of managing the risk may include some texture modification and supervision while eating and may also involve referral to Psychology and /or the Community Support Team (Challenging Behaviour) for further assessment and advice on management.

14.7 Strategies which reduce the risk of choking from happening at all are the best way to reduce the incidence of death from choking amongst people with a learning disability and people with dementia. This is more effective than relying on people to take life saving action when choking occurs. All organisations that provide services to people who have swallowing problems should ensure that the staff in their employment are:

- First Aid trained in recognising and dealing with choking.
- Have an awareness of swallowing problems and the risks these carry – and an awareness of recognition of a swallowing problem and when to refer to Speech and Language Therapy for assessment and advice.

15 Conflict of Opinion

15.1 Every reasonable effort will be made to resolve a conflict of opinion about appropriate management of the swallowing impairment.

15.2 If the conflict of opinion is not resolved despite reasonable effort, and as a result, the safety of the person is significantly at risk (i.e. the person is at high risk of choking), physical ill health due to aspiration and/or malnutrition, then a best interests meeting will be requested, if the person does not have capacity to make decisions about appropriate management of their swallowing problem.

15.3 If a person's safety is at risk due to carers disregarding advice despite reasonable efforts having been made to explain the advice and resolve any conflicts of opinion, the SLT must report a safeguarding concern to the Safeguarding Lead.

15.4 SLTs undertaking Dysphagia work will discuss in clinical supervision, any areas of conflict that arise as part of this work. It is important to use supervision to determine what is 'reasonable effort' (15.1 - 15.3 in this document) and how long it is safe, or not, to delay making a best interests decision.

16 Training, Qualifications

16.1 SLT's carrying out Dysphagia work must have successfully completed Dysphagia training to a specialist Dysphagia practitioner level as described in the Inter Professional Dysphagia Competencies Framework. SLTs who are qualified to Foundation Dysphagia Practitioner level may carry out Dysphagia work with adults only under the supervision of a SLT who is qualified to Specialist Dysphagia Practitioner level and who has appropriate and proven experience in working with adults with Dysphagia.

16.2 These therapists must undertake regular clinical supervision related to their Dysphagia work, and include updating their Dysphagia knowledge and skills within their overall continuing professional development (CPD).

16.3 SLTs within the service who are undertaking their postgraduate training in Dysphagia, and SLT students who are on placement with the service will carry out Dysphagia work under the supervision of a SLT who is qualified to Specialist Dysphagia Practitioner level.

16.4 Education and training of Nurses / Health Care Assistants / support workers / carers - a Manager / Team Leader may identify that their team, or specific members of the team have insufficient knowledge and skills and / or are not complying with the guidelines. In order to increase awareness, knowledge and skills that will enable workers to do their job effectively the SLT may offer education/ training to workers through:

- Meeting with the manager and staff team at a staff meeting.
- Meeting with individual or small groups of the staff team.
- More formal training which may be charged for.

17 Monitoring Compliance and Effectiveness

17.1 SLT's will do peer audit on a random sample of referrals annually to check for compliance with this policy.

17.2 SLT Team Leaders in each area and / or LSW SLT Clinical Lead will review each SLT's registration / CPD annually and identify any ongoing training needs.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

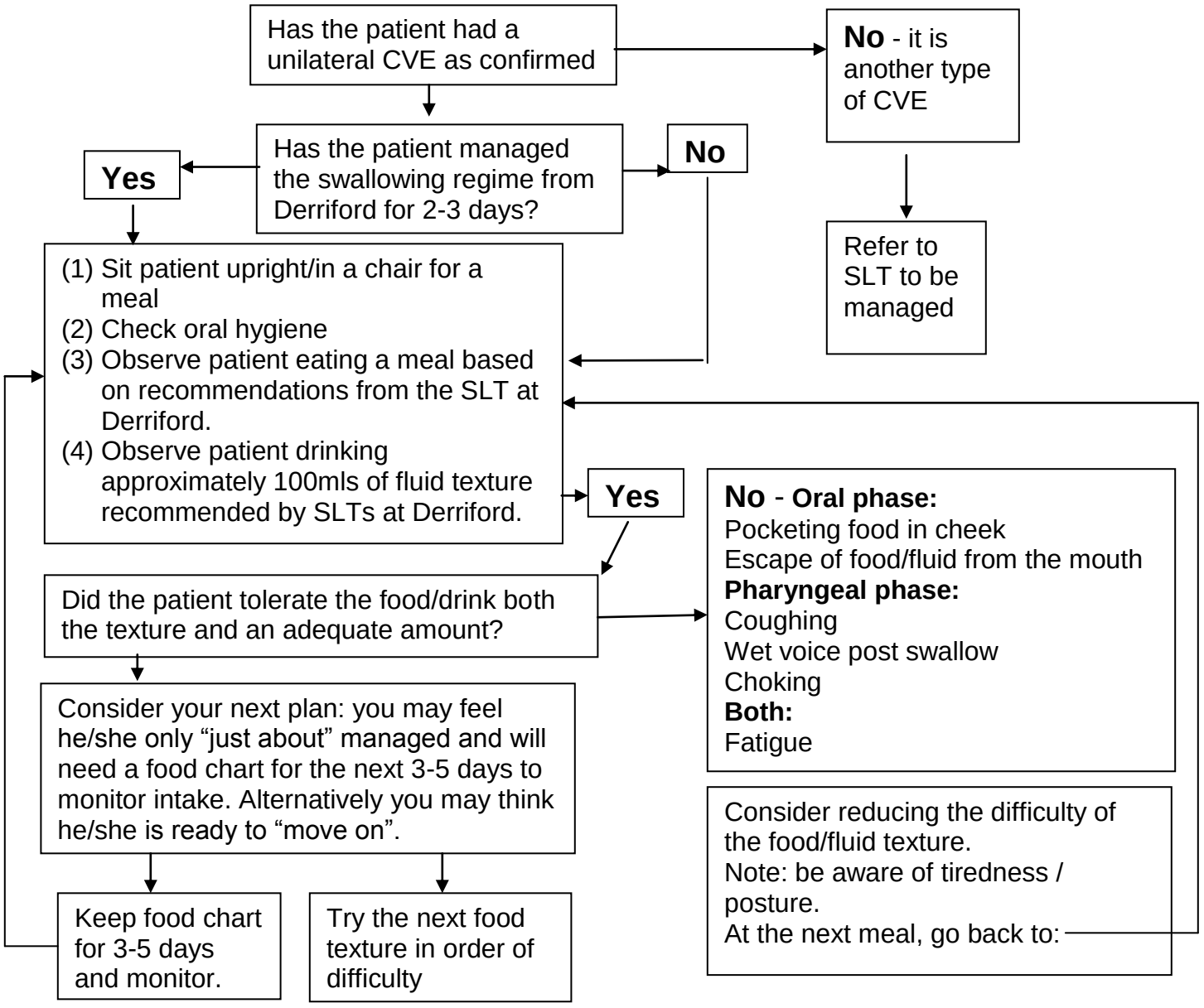
Date: 19th December 2014

Appendix A

Nurse Managed Dysphagia Protocol Flowchart

Mount Gould Stroke Rehabilitation Unit

Up to half of all stroke patients experience some type of Dysphagia in the acute phase of stroke. Within approximately four weeks, nearly all of these will have resolved. While they are improving, most patients follow a pattern of recovery which is 'managed' on the wards by modifying their diet and fluids. This should fit into the protocol below:



At each stage, remember to change the information on the board in the kitchen, above the patient's bed and in the care plan.

If in doubt about any decision you make, find an SLT and talk the process through. If none are available, place the patient nil by mouth or reduce to the easiest texture that they can manage until one is available to speak to.

Flowchart devised by SLT Team Leader (In patients) 20/12/05. Reviewed November 2014

Name:
NHS Number:

Appendix B

Name:
NHS Number:

Telephone Triage for Dysphagia Referrals

1. Is the GP aware of the referral?

   Y **N** (return to referrer)

2. Where does the patient live?

   At home (alone) =5
   At home (carers) =3
   Residential home =1
   Nursing home =0

3. Is the patient coughing on? (score both)

Food	**Fluids**
No =0	No =0
Occasionally =3	Occasionally =3
Often =5	Often =5

4. Has the patient experienced a recent severe choking episode? i.e. Has the airway been blocked by food?

   Y = **Urgent (3 day) referral.** **N** =0

5. Does the patient have a history of chest infections?

   None =0
   3 or less (in last 6 months) =3
   4 or more (in last 6 months) =5

6. Has the patient suffered significant unexplained weight loss?

   Y =3 **N** =0
   Amount lost……..

   (has referral to dietetics been made?)

7. Does the patient have a PEG

   Y **N**

8. Has the swallow deteriorated in the past month?

   Y =3 **N** =0

9. Current eating and drinking:

Food	**Fluids**
Normal	Normal
Soft	Thickened
Puree	

10. Is the patient currently able to take their medication?

    Y =0 **N** =5 (have syrup meds been prescribed?)

11. Has the patient been assessed by SLT in the last 6 months?

    Y =0 **N** =3

Score:

30+ = Urgent (3day)
25-29 = 5 day
18-24 = 10day
10-17 = 15 day
Less than 10 = 20+ days

Triage sheet devised by SLT Team Leader (Community) September 2013