The Royal Wolverhampton NHS Trust

CP68

Management of Dysphagia Policy

Contents

Sections			Page
1.0	Policy Statement		2
	1.1	Background	2
	1.2	Purpose of the policy	3
	1.3	Impact of dysphagia	3
	1.4	Incidence of dysphagia	3
	1.5	Expected outcomes of the policy	3
	1.6	Conflicts of interest	4
	1.7	Mental Capacity	4
2.0	Definitions		4
3.0	Accountabilities		
	3.1	Trust Board	5
	3.2	Chief Nursing Officer	5
	3.3	Chief Medical Officer	6
	3.4	All clinical staff	6
	3.5	All staff	6
4.0	Policy detail		6
	4.1	Food and Drink consistency	6
	4.2	Staff Responsibilities	6
		4.2.1 Medical Team	6
		4.2.2 Nursing Team	7
		4.2.3 Dietitians	7
		4.2.4 Speech and Language Therapists	8
		4.2.5 Physiotherapists and Occupational Therapists	8
		4.2.6 Radiology Team	9
	4.3	Training	9
5.0	Financial Risk Assessment		9
6.0	Equality Impact Assessment		9
7.0	Maintenance		10
8.0	Communication and Training		10
9.0	Audit Process		10
10.0	References		10

Appendices

Appendix 1 RWT Framework for Dysphagia

Appendix 2 Incidence of Dysphagia

Appendix 3 Dysphagia Training Matrix

Appendix 4 Modified Diets and Fluids (IDDSI)

Appendix 5 Care Pathway for Management of Dysphagia (adults)

Appendix 6 Neonatal and Ward 21 care pathway for referral/assessment of dysphagia (Children)

1.0 Policy Statement (Purpose / Objectives of the policy)

This policy directs the key steps to ensure the safe and effective identification and management of dysphagia in patients of all ages.

1.1 Background

"Dysphagia (swallowing disorder) is broadly estimated to affect 8% of the general population. This is 580 million people worldwide." (IDDSI website)

Dysphagia covers a range of different problems. High dysphagia has a high risk of aspiration and is typically from neurological disorders. Low dysphagia is usually associated with oesophageal disease.

Following recent serious incidents and complaints along with a review of Datix reports there was a decision that this policy was needed as part of an RWT Dysphagia framework (Appendix 1) to:

- Enable safe and effective care for patients,
- Demonstrate learning from previous events,
- Prevent recurrence of these themes, and
- Ensure best practice and informed staff with appropriate competencies.

The common findings in these reports were that there was a lack of clarity regarding staff roles, and that communication within the MDT was impaired as a result.

The risks associated with this are:

- the patient's dysphagia needs may be overlooked and, or
- the patient's dysphagia needs may be wrongly assessed.

This results in the potential for inaccurate identification of dysphagia, leading to inappropriate management which could result in the patient's ability to protect their airway being compromised.

This could mean that a patient who needs to be nil by mouth is given oral intake. It could also mean that a patient is given oral intake of inappropriate consistency. Either scenario increases the risk of respiratory compromise, prolonged prescribed medication, increased hospital stay and associated morbidity and mortality.

1.2 Purpose of the policy

- To provide for the safe, effective and caring management of patients with dysphagia.
- To state the role and responsibilities of RWT staff in relation to dysphagia.
- To outline the level of training required for individual staff with regard to dysphagia.
- To link to existing RWT guidelines.
- To provide an outline of the impact and incidence of dysphagia.
- To identify the principles of service delivery and best practice for adults and children with dysphagia.
- To reduce the morbidity and mortality associated with dysphagia.

1.3 Impact of dysphagia

Eating, drinking and swallowing difficulties have potentially life-threatening consequences. They can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult and therefore less effective. Swallowing difficulties can result in avoidable hospital admission and in some cases death. They can also lead to a poorer quality of life for the individual and their family.

Early identification and management of dysphagia improves quality of life and reduces the possibility of further medical complications and death. Improved nutrition and hydration have an impact on physical and mental wellbeing. In addition, appropriate identification and intervention for those with dysphagia also produces economic benefits and savings for the wider health economy, including avoided hospital admissions.

Dysphagia impacts on the patient's ability and desire to eat and drink, and without appropriate education and intervention this can lead to malnutrition and dehydration. If all oral intake is stopped, artificial feeding must be considered. The potentially fatal consequences of dehydration are evident within days, but the effects of malnutrition are more insidious with harm taking weeks and months to become evident. Failure to recognise and treat malnutrition can lead to reduced functional ability (e.g., muscle weakness resulting in poor mobility and reduced independence), impact on clinical outcomes (e.g., increased susceptibility to pressure injury and infection) and increased length of stay and care costs. Timely nutrition screening (ref CP17) identifies patients at risk of undernutrition and guides to appropriate management. Nutrition screening using MUST identifies patients at high risk if there has been no nutritional intake for 5 days.

Dysphagia can be a consequence of several conditions as end of life is approached. Guidance on management of patients deemed unsafe to eat and drink who are unsuitable for artificial nutrition and hydration can be found in the Feeding at Risk Guidelines.

1.4 Incidence of Dysphagia

See Appendix 2 for detail.

1.5 Expected Outcomes of the policy

- Increased identification of dysphagia.

- Increased accuracy of dysphagia diagnosis.
- Increase efficacy of management of dysphagia.
- Managing the risk of aspiration of oral intake in patients with impaired airway protection which in turn will reduce the risk to the patient's health by:
    - Reducing the risk of associated morbidity and mortality,
    - Increased access to advanced and instrumental assessment of dysphagia such as videoflouroscopy (VF) or Fibre-optic Endoscopic Evaluation of Swallowing (FEES),
    - Development of well co-ordinated MDT care plans,
    - Reducing the length of hospital stay,
    - Preventing admission if the problem can be safely managed in the community, and
    - Reducing the likelihood of readmission.

1.6 Conflicts of Interest

All aspects of this document regarding potential Conflicts of Interest should refer first to the Conflicts of Interest Policy (OP109). In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

1.7 Mental Capacity

Staff should apply the principles of the Mental Capacity Act and Deprivation of Liberty as appropriate.

2.0 Definitions

Term	Explanation
Aspiration	Aspiration is the medical term for the action of material passing though the larynx and entering the airway below the level of the vocal folds. This material could be food, medication or saliva. This can lead to a chest infection or aspiration pneumonia. Aspiration may occur without any overt signs (silent aspiration).
Choking	To interfere with respiration by obstruction of the larynx or trachea which results in an inability to breathe. This could be due to the trachea being constricted or blocked by material, such as food.

Dysphagia	Dysphagia is the term used to describe a swallowing difficulty usually resulting from a neurological or physical impairment of the oral, pharyngeal or oesophageal mechanisms. The normal swallow has 4 phases: oral preparatory, oral, oro-pharyngeal and oesophageal.
Enteral feeding	Tube feeding (also called enteral or non-oral feeding) is a method whereby a patient receives their nutrition, hydration and medication via a tube. A nasogastric tube (NG) is inserted via the nose. A tube can be inserted into the stomach though the anterior abdominal wall e.g. a surgical gastrostomy, a percutaneous endoscopic gastrostomy (PEG), or a radiologically inserted gastrostomy (RIG) (). A tube can be inserted into the jejunum surgically (surgical jenunostomy), via the nose (nasojenunal or NJ tube) or percutaneously though the abdominal wall and into the stomach initially and thence into the jejunum, (a percutaneous endoscopic jejunostomy or PEJ). Tube feeding can be done alongside oral intake or instead of oral intake.
FEES	Fibre-optic Endoscopic Evaluation of Swallowing
MDT	Multi-Disciplinary Team
MUST	Malnutrition Universal Screening Tool
NG	Nasogastric
Nil-by-Mouth (NBM)	Nil-by-mouth is a patient care instruction to take nothing orally (food, drink or medication) as a result of a swallowing difficulty, a medical problem, or if they are awaiting surgery, investigations etc.
ONS	Oral Nutritional Supplement e.g., fortisip
SLT	Speech and Language Therapist
VF	Video fluoroscopy

3.0 Accountabilities

The Royal Wolverhampton NHS Trust will work across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.

3.1 Trust Board

The Trust Board is responsible for assuring that all Trust and public policies, procedures and monitoring systems are in place to ensure that the Trust is compliant in its obligations under the Care Act 2014, Equality Act 2010, Mental Capacity Act 2005, Human Rights Act 1998, Data Protection Act 1998, Quality and Safety Standards and Government requirements.

3.2 Chief Nursing Officer

The Chief Nursing Officer as Executive Nurse is the professional lead for nursing services and therefore has the responsibility to ensure that services meet the needs of the diverse population of people who access RWT, and that services are appropriate, accessible and delivered in a manner that respects the privacy and the dignity of all patients.

3.3 Chief Medical Officer

The Chief Medical Officer is responsible for overall professional leadership of all medical staff to ensure that RWT provides high standards in patient care, and that services are appropriate, accessible and delivered in a manner that respects the privacy and the dignity of all patients.

3.4 All Clinical Staff

All Clinical staff who are involved in the assessment, diagnosis, treatment or care of patients with dysphagia must be aware of and adhere to this policy. They will work within the limits of their competencies (see Appendix 3). Staff will be cognisant of the Mental Capacity Act 2005 (MCA) and ensure that Deprivation of Liberty Safeguards (DoLs) are applied where required.

3.5 All Staff

All RWT staff, including volunteers must know where they can find additional information to support the needs of patients with dysphagia.

Non-clinical staff may have a direct involvement in understanding dysphagia needs e.g., the Catering team.

4.0 Policy Detail

RWT aims to ensure the early identification and safe, effective and caring management of dysphagia in patients of all ages. The Trust will support staff to understand their roles in the identification and management of patients with dysphagia and to work together as an MDT in partnership with patients and their families.

4.1 Food and drink consistency

RWT uses the current international descriptors (Appendix 4) to ensure every member of staff provides reliable and robust delivery of food and drink consistencies for patients with dysphagia.

4.2 Staff responsibilities

4.2.1 Medical Team

The duty of care for the person with dysphagia lies with the responsible doctor (e.g., Consultant or General Practitioner). See 7-day care standards.

The medical team is responsible for the identification of possible dysphagia, referral for assessment, and carrying out the recommendations of the MDT. Referral to the SLT team should follow the care pathways on the intranet (see Appendices 5 and 6).

The medical practitioner with duty of care will make the dysphagia management decision. This is typically made as part of a multi-disciplinary team discussion, usually including SLT, and where possible should include the patient and, or carers.

Where an out of hours decision is needed and key members of the MDT are not available, the medical team will take decisions based on existing advice, current medical needs and best practice. This decision should be reviewed at the earliest opportunity with the MDT.

Any patient admitted without an NG tube and subsequently given an NG tube for feeding should have an MDT discussion at the earliest opportunity and short/ and long-term plans documented. Where the patient has known long-standing use of an NG prior to admission, this is not needed. All patients with an NG feeding tube in situ must be referred to the dietitian.

4.2.2 Nursing Team

The nursing team is responsible for the identification of possible dysphagia, referral for assessment, and carrying out the recommendations of the MDT. Referral to the SLT team should follow the care pathways on the intranet and in Appendices 5 and 6. Policy CP17 gives details of the pathway for those at risk of under nutrition including referral to Dietetics.

Identified nurses who have undertaken training and maintained competencies will have access to and can use the swallow screening tool. This is a delegated SLT role (see training matrix, Appendix 3). SLT maintains a register of those nurses trained and competent for swallow screening.

Nursing staff who have not undertaken training and maintained competencies should not undertake swallow screens.

Nursing staff will ensure that good oral hygiene is maintained. There is evidence to suggest that poor oral hygiene increases the risk of aspiration pneumonia (Langmore 1998).

4.2.3 Dietitians

Registered dietitians assess, diagnose and treat diet and nutrition problems including those resulting from dysphagia following appropriate referral.

Following dietetic assessment, dietitians provide patient- centred interventions and support care planning to optimise nutritional intake e.g., with food fortification, oral nutritional supplements (ONS) or enteral feeding. Dietitians prescribe and supply ONS for inpatients who require them. Dietitians support feed at risk discussions, provide advice on implementing enteral feeding and weaning from it, as nutritional needs are met by the oral route, and contribute to discharge planning. Many of the patients they treat remain dysphagic, some for a considerable period. Referral to SLT team should follow the care pathways as available on the intranet and in Appendices 5 and 6.

RWT Dietitians work across acute and community settings to support patients with or who are at high risk of undernutrition (as per CP17).

Dietitians also work with Catering to ensure that all hospital menus meet nutritional standards and educate MDT colleagues on identification and management of undernutrition.

4.2.4 Speech and Language Therapists (SLT)

The RCSLT (Royal College of Speech & Language Therapists) advises that SLTs have a unique role in the assessment, diagnosis and management of swallowing difficulties as follows:

- Play a key role in the diagnosis of dysphagia,
- Help people regain their swallowing through exercises, techniques and positioning,
- Promote patient safety through modifying the texture of food and fluids, reducing the risk of malnutrition, dehydration and choking,
- Promote quality of life, taking into account an individual's and their families' preferences and beliefs, and helping them adjust to living with swallowing difficulties,
- Work with other healthcare staff, particularly dietitians and nurses, to optimise nutrition and hydration, and
- Educate and train others in identifying, assessing and managing dysphagia, including families and the wider health and care workforce.

The RWT SLT team receives referrals, assesses and provides advice and, or a management plan for implementation by the MDT. SLT aim to see patients within 2 working days of referral.

Referral to SLT for adult patients

The RWT SLT team advises that for adult patients the MDT use the 'Care Pathway for Management of Dysphagia /Swallowing problem' available on the intranet (Appendix 5) for guidance on how to manage a patient's swallow, when and how to refer.

Referral to SLT for paediatric patients

For children, staff should consult the 'Neonatal and Ward A21 care pathway for referral and assessment of dysphagia' also available on the intranet (Appendix 6).

4.2.5 Physiotherapists and Occupational Therapists

Physiotherapists and occupational therapists work in a variety of areas with patients who have dysphagia. Many of the patients they treat remain dysphagic, some for a considerable period. Referral to SLT team should follow the care pathways as available on the intranet and in Appendices 5 and 6.

The aim of the physiotherapists and occupational therapists is to act as a key MDT members in the identification and management of these patients. With underlying knowledge of the pathology and pathophysiology, they are able to highlight those patients that may be at potential risk and identify them to key MDT members with appropriate skills i.e., SLT, nursing staff and doctors where there is a concern, to ensure that appropriate screening and assessments are completed accordingly.

As key members of the MDT, physiotherapists and occupational therapists consider and implement posture and seating management. This is an integral aspect of dysphagia management, as there is evidence that demonstrates good positioning can reduce the risk of aspiration pneumonia and support position during receipt of correct oral intake.

Physiotherapists within the inpatient services are also available to advise and support from a chest clearance perspective. This may take the form of MDT discussion around current chest state, ability to cough, and subsequently assisting with chest clearance where this may be indicated.

4.2.6 Radiology Team

Radiology has a limited role to play in dysphagia. The role is primarily in the assistance of the diagnosis where instrumental assessment is needed, but they also insert RIGs. The best method for a radiological diagnosis is using video fluoroscopy

Video fluoroscopy may only be carried out by appropriately trained staff.

A formal report from the radiologist undertaking the procedure will be made available to the referring clinician.

4.3 Training

Staff will work within the limits of their competency. All staff will adhere to their professional guidelines (where applicable).

The training matrix (Appendix 3) lays out a tiered approach to training for RWT staff demonstrating the complexity of dysphagia assessment and management. There are a range of training opportunities for different staff groups. No staff member will undertake duties for assessment or management of dysphagia with patients unless they have undertaken the appropriate training and maintained competencies in that area. It is the duty of all staff to ensure they do not work outside of their competencies.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
x	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

7.0 Maintenance

The Services Manager for Speech & Language Therapy will work with the Nutrition and Hydration Steering Group to ensure this policy is maintained including any updates needed to ensure current best practice.

8.0 Communication and Training

The policy will be disseminated via Trust Communication /policy updates to all staff.

Managers should assess the training needs of their team(s) and ensure appropriate training is identified, planned and executed (both in terms of staff release and funding).

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Monitoring to demonstrate compliance with the policy	Matrons/ Service Managers	Analysis of Datix incidents	Exception reports	Governance
Annual audit	SLT	Audit to monitor compliance with identified priority area(s) of the policy	Once each year	Nutrition Support Steering Group

10.0 References

O'Loughlin G, Shanley C. Swallowing problems in the nursing home: a novel training response. Dysphagia 1998; 13, 172-183.

Shune SEK, et al. Association between severity of dysphagia and survival in patients with head and neck cancer. Head and Neck 2012; 34:6, 776-84.

Martino R, et al. Dysphagia after stroke: Incidence, diagnosis, and pulmonary complications. Stroke 2005; 36:12, 2756-2763.

Mann G, Hankey G, Cameron D. Swallowing function after stroke prognosis and prognostic factors at 6 months. Stroke 1999; 30, 744-748.

Frempong-Boadu A, et al. Swallowing and speech dysfunction in patients undergoing anterior cervical discectomy and fusion: A prospective, objective preoperative and postoperative assessment. Journal of Spinal Disorders and Techniques 2002; 15:5, 362-368.

Hartelius L, Svensson P. Speech and swallowing symptoms associated with Parkinson's disease and multiple sclerosis: a survey. Folia Phoniatrica 1994; 46:1, 9-17.

McKinstry M, Tranter M, Sweeney J. Outcomes of dysphagia intervention in a pulmonary rehabilitation program. Dysphagia, published online 18 July 2009.

Luggers K. Dysphagia in the elderly stroke patient. Journal of Neuroscience Nursing 1994; 26, 2.

Chadwick DD, Jolliffe J, Goldbart J. Adherence to eating and drinking guidelines for adults with intellectual disabilities and dysphagia. American Journal on Mental Retardation 2003; 108:3, 202-211.

Hickman J, Jenner L. ALD and dysphagia: issues and practice. Speech and Language Therapy in Practice 1997, 8-11.

The Learning Disabilities Mortality Review (LeDeR) Programme, 2017, University of Bristol Norah Fry Centre for Disability Studies

McClave SA, DeMeo MT, DeLegge MH, et al. (2002) North American Summit on Aspiration in the Critically Ill Patient: Consensus statement. Journal of Parenteral and Enteral Nutrition; 26(6), S80-86.

Elsbeth AC Calis MD et al (2008) *Dysphagia in children with severe generalized cerebral palsy and intellectual disability*, Volume 50, Issue 8 Developmental Medicine and Child Neurology

Sally K. Archer et al (2013) *Dysphagia in Duchenne muscular dystrophy assessed by validated questionnaire*, Volume 48, Issue 2, Pages 240-246 International Journal of Language and Communication Disorders

http://www.chfed.org.uk/how-we-help/information-service/caring-for-heart-children/feeding-children-with-heart-conditions/

B Mathisen et al (1999) *Feeding problems in infants with gastro-oesophageal reflux disease: A controlled study*, Volume35, Issue2, Pages 163-169, Journal of Paediatrics and Child Health

Hyman, P (1994) 'Gastroesophageal reflux: One reason why baby won't eat', *The Journal of Pediatrics,* 125(6 part 2), pp. S103-S109

Fraser, D Munro (2003) 'Dysphagia in Children: a Paediatric Surgical Perspective', *International Congress Series,* Advances in Paediatric ORL: Proceedings of the 8th International Congress(1254), pp. 135-139.

https://www.amazon.co.uk/Cleft-Care-Practical-Health-Professionals/dp/1903877024

http://journals.sagepub.com/doi/pdf/10.1177/1359104501006002006

Crary, M and Groher, M 2003. Introduction to Adult Swallowing Disorders, Pub: Butterworth-Heinermann.

Costa Bandeira, A., Azevedo, E., Vartanian, J. G., Nishimoto, I., Kowalski, L. and Carrara-de Angelis, E., 2008. Quality of Life Related to Swallowing After Tongue Cancer Treatment. Anna Karinne, *Dysphagia*, **23** (2):183.

Groher, M E & Crary 2016 Dysphagia: Clinical Management in Adults and Children 2nd Edition

Langmore S, Terpenning M.S, Schork, A, Chen Y, Murray J.T, Lopatin D, Loesche W.J (1998) Predictors of aspiration pneumonia: How important is dysphagia?, *Dysphagia,* 13 (2):69-81

Leslie, P., Drinnan, M., Zammit-Maempel, I., Coyle, J., Ford, G., and Wilson, J. 2007. Cervical Auscultation synchronized with images from endoscopy swallow evaluations. *Dysphagia*, **22** (4): 290-298.

Marks, *L. and* Rainbow *D.* 2001. *Working with Dysphagia*. pub: Speechmark.

Murry, T. and Carrau, R. 2001. *Clinical Manual of Swallowing Disorders* Singular Publishing Group, San Diego.

National Institute of Clinical Effectiveness. Cerebral palsy in under 25s: assessment and management. NICE guideline [NG62] Published date: January 2017

National Institute of Clinical Effectiveness. Oral health: local authorities and partners. NICE guidelines [PH55] Published date: October 2014

National Institute of Clinical Effectiveness. Transcutaneous neuromuscular electrical stimulation for oropharyngeal dysphagia. Interventional procedures guidance [IPG490] Published date: May 2014

National Patient Safety Agency (NPSA) Dysphagia Expert Reference Group Dysphagia Diet Food Texture Descriptors. 2011.

Rosenvinge, S. and Starke, I. 2005. Improving care for patients with dysphagia. *Age and Ageing*, **34** (6):587-593.

IDDSI website

Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust, 2010 (initial inquiry)

The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013

Mental Capacity Act 2005

Mental Capacity Act 2005 - Code of practice

Winterbourne View Hospital: Department of Health review and response

Winterbourne View: Transforming Care One Year On

National Clinical Guidelines for Stroke – fourth edition (2012)

https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

Part A - Document Control

Reference Number and Policy name: CP68 Management of Dysphagia Policy	**Version:** V2.0 December 2022	**Status:** Final	**Author:** Service Manager – Speech & Language Therapy **Director Sponsor:** Chief Nursing Officer

Version / Amendment History	Version	Date	Author	Reason
	V1	January 2019	Speech & Language Therapy Service Manager	New Policy
	V1.1	May 2022	Speech & Language Therapy Service Manager	Review by Chief Officer Sponsor extended to July 2022 – Pending full review
	V2.0	October 2022	Speech & Language Therapy Service Manager	Full review including minor amendments to main policy (no significant changes) Appendices updated

Intended Recipients: Trust Wide - This policy applies to all staff members who are directly employed by RWT and for whom RWT have a legal responsibility. This includes clinical and non–clinical staff, students and bank staff.	
Consultation Group / Role Titles and Date: Nutrition Support Steering Group Chief Nurse Medical Director	
Name and date of Trust level group where reviewed	Trust Policy Group December 2022
Name and date of final approval committee	Trust Management Committee January 2023

Date of Policy issue	January 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	Review date Every 3 years December 2025

Training and Dissemination:

Staff will be trained in accordance with their professional body recommendations. Additional training will be available to enable RWT staff to comply with this policy and with best practice. A Training Matrix is available in Appendix 1.

To be read in conjunction with:

- CP17 - Management of Adult Inpatients at Risk of Under Nutrition
- CP45 - Management of Enteral Feeding Tubes
- OP14 - Catering Policy
- Percutaneous Tracheostomy Insertion Procedure for the ICCU
- CP41 - Safeguarding Children in Hospital
- CP53 - Safeguarding Adults
- Mental Capacity Act 2005
- CP06 Consent Policy
- OP94 Protected Meal Times
- MP01 - Prescribing, Storage and Administration of Drugs
- MP09 - Electronic Prescribing and Medicines Administration (ePMA) Policy
- End of life care guidelines
- Feed At Risk guidelines
- NICE Nutrition Support in adults Clinical Guideline 32 (2006 updated 2017)
- NICE Cerebral palsy in children and young people, Quality standard [QS162] Published date: October 2017
- NICE Gastro-oesophageal reflux disease in children and young people: diagnosis and management, NICE guideline [NG1] Published date: January 2015
- Quality standards QS24 (2012)
- Health and Social Care Act 2008 (Regulation 14) Nutrition and Hydration
- Local guidance CP 17, CP45, OP94,Catering operational Policy.

Initial Equality Impact Assessment (all policies): **Completed Yes**

Full Equality Impact assessment (as required): **Completed Yes**

If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114

Contact for Review	Charlotte Colesby Service Manager – Speech & Language Therapy Dr Cathy Higgins Divisional Medical Director/Consultant Paediatrician, Division 3
Implementation plan / arrangements (Name implementation lead)	Charlotte Colesby Service Manager – Speech & Language Therapy Dr Cathy Higgins Divisional Medical Director/Consultant Paediatrician, Division 3
Monitoring arrangements and Committee	Nutrition Support Steering Group

Document summary / key issues covered:

The aims of the policy are:

- To provide for the safe, effective management of patients with dysphagia,
- To state the role and responsibilities of RWT staff in relation to dysphagia,
- To outline the level of training required for individual staff with regard to dysphagia,
- To identify best practice and develop practice as needed to ensure optimally safe and effective services for adults and children presenting with dysphagia,
- To link to existing RWT guidelines,
- To provide an outline of dysphagia and its impact, and
- To identify the principles of service delivery to adults and children with dysphagia.

Part B **Ratification Assurance Statement**

Name of document: CP68 – Management of Dysphagia Policy

Name of author: Charlotte Colesby Job Title: Services Manager – Speech and Language Therapy

I, the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: 

Date: 14/10/22

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

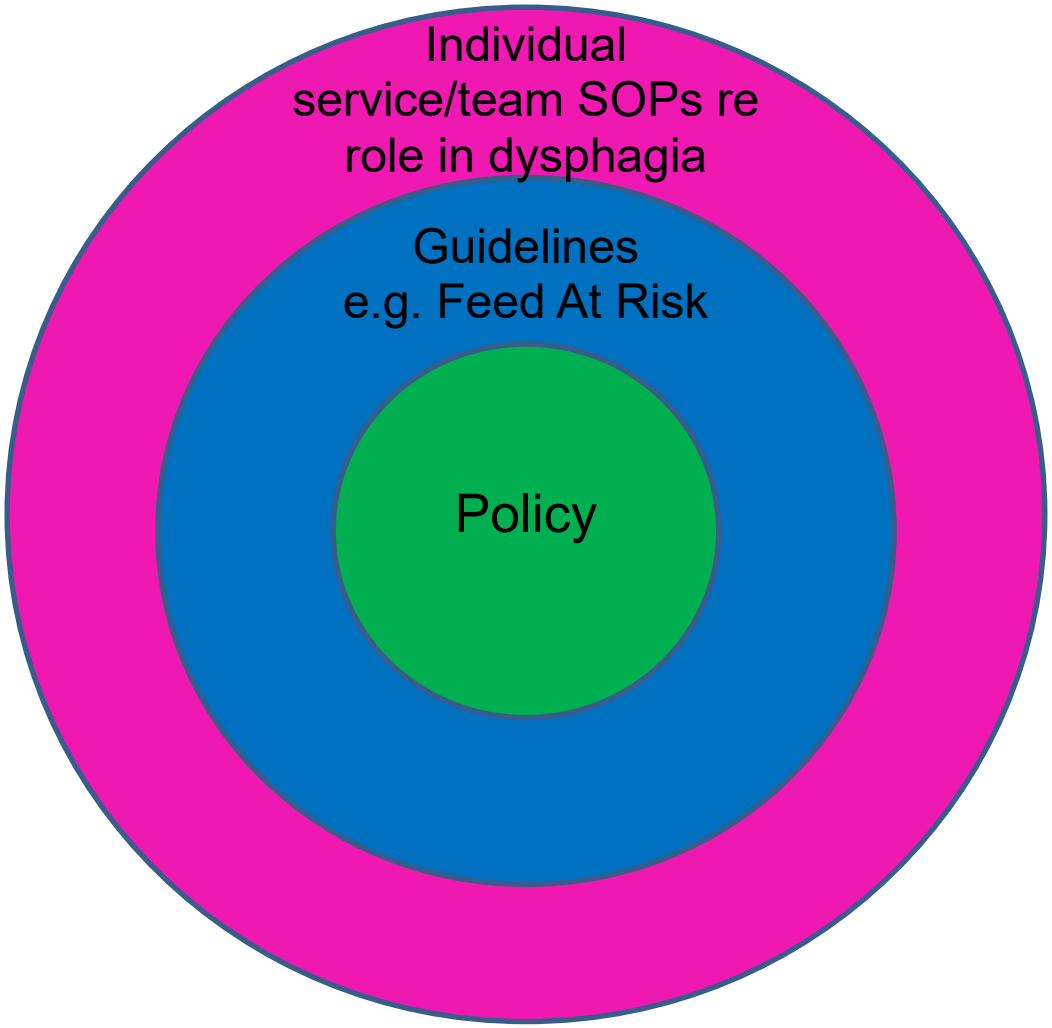
- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

CP68 APPENDIX 1

Trust framework for Dysphagia



The centre of the framework is the policy, Exceeding Expectations by growing our reputation for excellence as the norm.

The guidelines support Safe and Effective practice by ensuring that staff work within their own sphere of competence and that they understand the knowledge they need to maintain their skills.

The SOPs ensure that staff are enabled to be Kind and Caring by enabling them to act in a way which is respectful to others, their own professions and themselves.

APPENDIX 2

Incidence of dysphagia

Dysphagia often forms part of other health conditions for which a person is being treated so it is difficult to be certain of the prevalence rate. However, research has found the following rates of prevalence and incidence in adults.

- Between 50-75% of nursing home residents (1).
- Between 50-60% of head and neck cancer survivors (2).
- Between 40-78% of stroke survivors (3) – of those with initial dysphagia following stroke, 76% will remain with a moderate to severe dysphagia and 15% with profound dysphagia (4).
- In 48% of patients undergoing cervical discectomy and fusion (5).
- In 33% of the people with Multiple Sclerosis (6).
- In 27% of those with Chronic Obstructive Pulmonary Disease (7).
- In 10% of acutely hospitalised older people (8).
- In 5% of adults with a learning disability (9), 5% of community-based individuals with learning disabilities and 36% of hospital-based individuals (10).
- People with Learning Disability aged 25–34 were more likely to have aspiration pneumonia listed in Part I of their Medical Certificate of Cause of Deaths (11).
- Aspiration is the leading cause of pneumonia in Intensive Care and contributes significantly to the overall morbidity and mortality of the critically ill patient (12).

In children research has found the following rates of prevalence and incidence.

- 99% of children with severe cerebral palsy have dysphagia (13).
- In Duchenne Muscular Dystrophy dysphagia is common with progression of disease (14).
- Approximately one in a hundred children with a cardiac disorder has a risk of concomitant feeding difficulties (15).
- Feeding problems affecting behavior, swallowing, food intake and mother child interaction have been found to be common in infants with gastro-oesophageal reflux (16, 17).
- Long-term follow up of infants who have had an oesophageal atresia repair has shown that between 60% and 70% experience problems with dysphagia (18).
- Cleft lip and palate affects approximately one in every 600-700 births, effective feeding is compromised by the inability to achieve negative pressure, to draw fluid from the teat or breast (19).

- There is a high incidence of behavioral feeding difficulties associated with children who have had a traumatic medical history, e.g., tube feeding, surgery, tracheostomy etc. (20).

APPENDIX 3

Dysphagia Training matrix

		Medical Team	Nursing Team	HCAs	AHPs	Catering Staff	SLTs
Pre-Entry Level	A background overview including some information about dysphagia	X	X	√	X	√	X
Level 1	Dysphagia Awareness – Basic Training	√	√	√	√	X	√
Level 2	Can undertake swallow screening (if completed training and maintain competencies)	√	√	X	√	X	√
Level 3	Comprehensive swallow assessment and develop a dysphagia care plan	X	X	X	X	X	√
Level 4	Advanced dysphagia assessment and management plans for complex dysphagia.	X	X	X	X	X	√

Please see above Dysphagia Training Matrix which specifies the different levels of dysphagia training for different staff groups. This refers to suitability for training and does not imply that all staff should undertake this training. Where there is a clinical need, staff should be trained to the appropriate level prior to undertaking work. The SLT team can provide signposting and/or training at pre-entry and level 1. At Level 2 the SLT team provide training and monitoring of competence. They hold the register for this. Levels 3 and 4 are for SLTs only and records are maintained within the team and by individual SLTs.

Other staff not included in the above chart can contact Charlotte Colesby (SLT Service Manager) to discuss an appropriate level of training for their staff group.

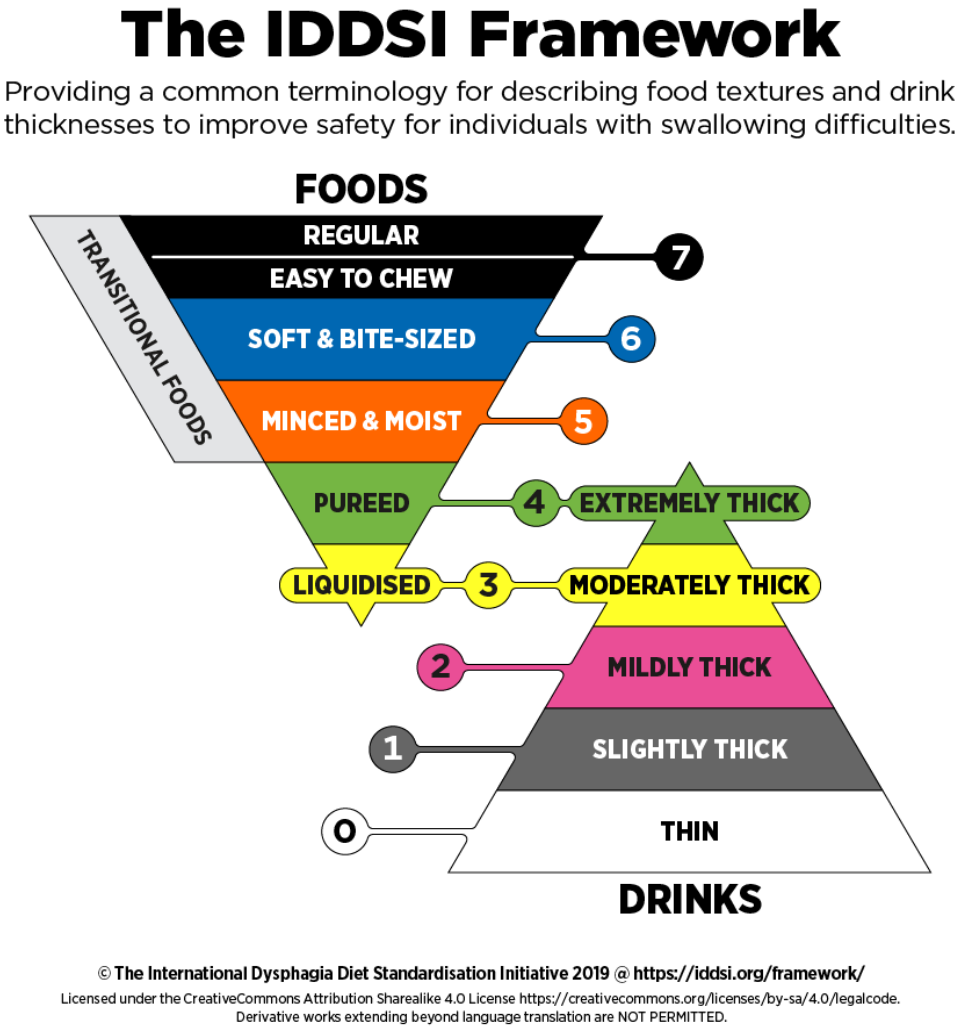
APPENDIX 4

Modified diets & fluids

International Dysphagia Diet Standardisation Initiative - improving safety of patients with dysphagia

The IDDSI framework is culturally sensitive, measurable, and applicable to individuals of all age groups in all care settings. It consists of 8 levels where drinks are measured (0-4) and foods measured from 3-7.

This is endorsed by NHS England, The British Dietetic association (BDA) and Royal College of Speech and Language Therapists (RCSLT). This will be implemented across RWT and the wider Health care economy by April 2019.

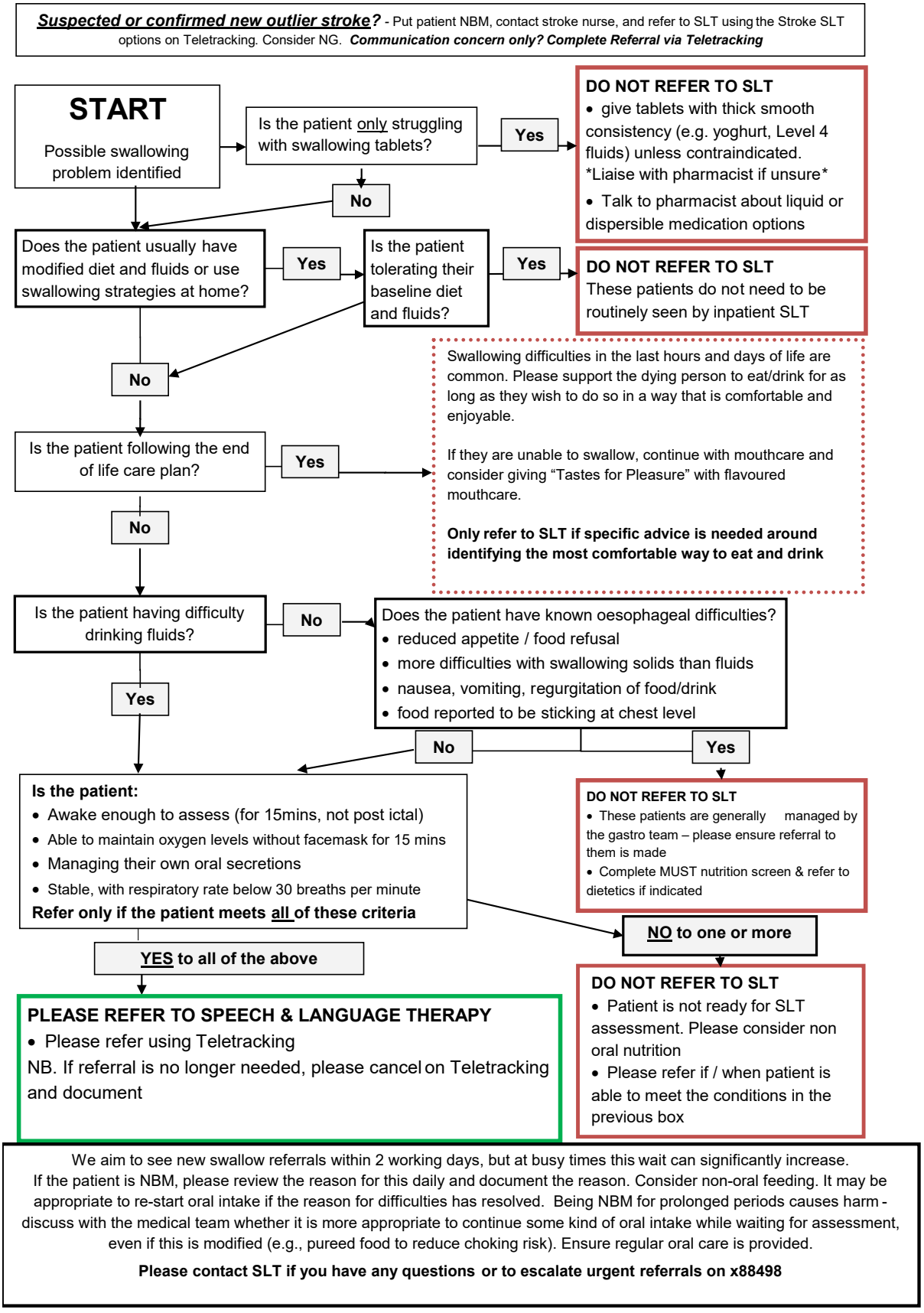


APPENDIX 5

Care Pathway for Management of Dysphagia /Swallowing problem

SLT work Monday – Friday (not including Bank Holidays) standard hours

STEP 1: Is this patient appropriate for a referral to Speech and Language Therapy (SLT)?



We aim to see new swallow referrals within 2 working days, but at busy times this wait can significantly increase. If the patient is NBM, please review the reason for this daily and document the reason. Consider non-oral feeding. It may be appropriate to re-start oral intake if the reason for difficulties has resolved. Being NBM for prolonged periods causes harm - discuss with the medical team whether it is more appropriate to continue some kind of oral intake while waiting for assessment, even if this is modified (e.g., pureed food to reduce choking risk). Ensure regular oral care is provided.

Please contact SLT if you have any questions or to escalate urgent referrals on x88498

Initial Management of Eating/Drinking Difficulties

Things to consider

- Check if there is any history of swallowing difficulty (check clinical web portal, liaise with family, next of kin and carers) to see if patient has any previous swallow recommendations.
- Is the patient alert enough for oral intake?
- If patient is alert enough, observe carefully how they are managing with food and drink.

Signs of Difficulty

- Coughing or choking.
- Wet or gurgly voice.
- Shortness of breath or changes in breathing.
- Holding food or drink orally or residue remains in the mouth, or food or drink falling from the mouth.
- Patient has become chesty following admission and is at high risk for swallowing difficulty.
- Patient is complaining of difficulty swallowing or refusing tablets.
- Patient is frail and elderly with a history of recurrent chest infections or weight loss or is spiking a temperature

Actions where patient is not alert

- If not alert enough, try later.
- Medical team will advise on provision of hydration, nutrition and medication in the short term.
- Maintain good oral care to prevent further infection risk and for patient comfort.
- If patient is placed NBM, consider alternative feeding if appropriate.

Referral To Speech and Language Therapy

- Refer to SLT on Teletracking.
- Select appropriate referral reason (e.g., swallow eating and drinking or swallow NBM)
- Contact details are as follows:

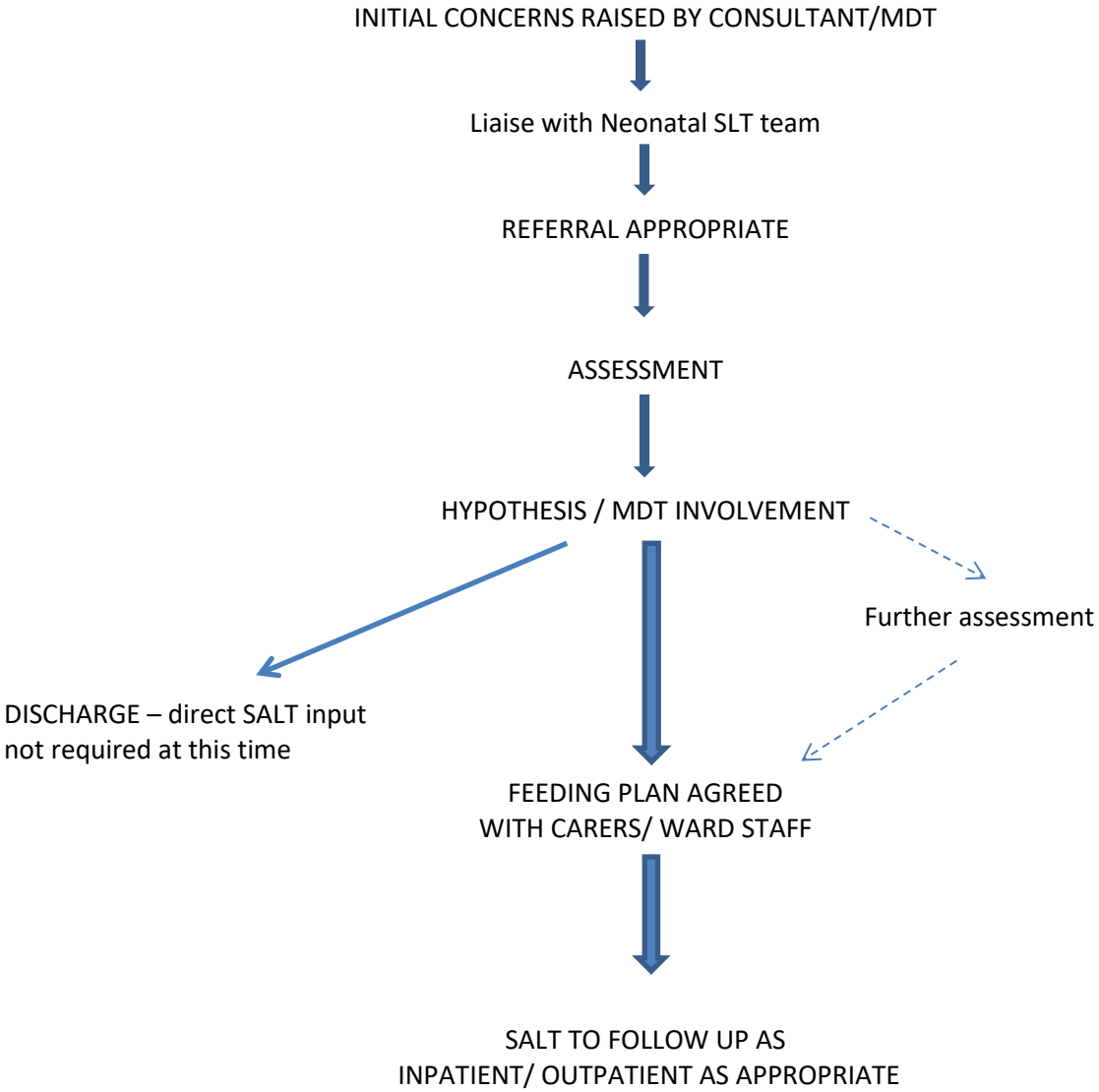
Acute Stroke and General Medicine Team x88498;
Head and Neck Team x86118;
Critical Care x81711.

Information on how to refer to the community SLT team can be obtained from the SLT Dept on 01902 444363.

APPENDIX 6

Neonatal and Ward A21 care pathway for referral/assessment of dysphagia

PAEDIATRIC SPEECH AND LANGUAGE THERAPY
NEONATAL AND WARD A21 CARE PATHWAY FOR REFERRAL/ ASSESSMENT



Information on how to refer outpatients can be obtained from the SLT Department on 01902 444363