University Hospitals of Leicester NHS
NHS Trust

Management of Inpatient Oro-pharyngeal Dysphagia Policy

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Author / Originator(s):	Alison Trafford, Adult Speech and Language Therapy Team Leader Theresa Kendrick, Adult Speech and Language Therapy Team Leader
Name of Responsible Committee/Individual:	Kathryn Sutton, Adult Speech and Language Therapy Team Leader Hannah McQueen, Clinical Lead Speech and Language Therapist
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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

January 2016– Review of V1 and addition of IDDSI framework and updated risk feeding protocol

April 2021- Review of V2 and amendment of terminology from the International Dysphagia Framework (IDF) (Boaden, 2006) to Eating and Drinking and Swallowing Competency Framework (EDSCF) (Boaden 2020). Removal of reference to Dysphagia Screening on Acute Wards and reference to this in Acute Stroke only as practice changed.

KEY WORDS

Dysphagia, swallowing difficulties, aspiration, eating and drinking difficulties, Speech and Language Therapy, Oro-pharyngeal.

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy and Procedures for the management of adult inpatients with oro-pharyngeal (OP) dysphagia.

1.2 OP dysphagia can occur due to a variety of problems, commonly including neurological, structural and medical conditions, as well as less well known causes such as difficulty coordinating breathing with swallowing.

1.3 OP dysphagia can occur in all age groups and can affect an individual's quality of life and general health. There is a range in severity of OP dysphagia. Where it is less severe, only minor changes may be needed to improve the efficiency and safety of the eating and drinking process. Where it is severe it can be life threatening including increased risk of choking, pulmonary aspiration which can lead to chest infections, lung damage, aspiration pneumonia and malnutrition. OP dysphagia can affect a person's ability to swallow medication thus impacting on other health conditions. It may also increase the frequency and length of hospital admissions.

1.4 When it becomes apparent that a person has difficulty eating and drinking, competent dysphagia practitioners will identify, assess, treat and manage these difficulties. This may include Speech and Language Therapists (SLT), nurses, doctors and other health professionals.

1.5 The key aims and objectives of this policy are to:

a) Ensure the appropriate management of individuals who have OP dysphagia.

b) Ensure timely and consistent identification, assessment, and management of people with OP dysphagia.

c) Promote a multi-disciplinary team (MDT) approach to the identification and appropriate management of these patients.

2 POLICY SCOPE

2.1 This policy applies to all adult inpatients within UHL.

2.2 The care of adult patients in critical care is complemented by the guidelines for screening and assessment of OP dysphagia in critical care(Trust Reference C34/2007)

2.3 This policy applies to children between the ages of 16-18 as this age group is cared for in adult areas of the hospital. A child is defined by law from birth to 18 years of age.

2.4 This policy applies to permanent and temporary Adult Speech and Language Therapists, Speech and Language therapy assistants, nursing staff, medical staff and all other healthcare staff who care for people with OP dysphagia.

2.5 Adult Speech and Language Therapists are employed by, or working on behalf of, Leicestershire Partnership Trust and working in UHL as a contracted professional service

3 DEFINITIONS AND ABBREVIATIONS

3.1 Aspiration:

Aspiration in this policy refers to food or fluid penetrating the respiratory tract below the vocal cords, 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.

3.2 Aspiration Pneumonia:

A pneumonia as the result of food, liquid or secretions entering into the airway below the level of the true vocal cords.

3.3 Dysphagia

The term dysphagia refers to an impairment of swallowing. A swallow has 4 stages,

anticipatory, oral (including oral preparatory), pharyngeal and oesophageal. Dysphagia refers to impairment in any or all of these stages of the swallow.

3.4 Enteral Feeding

Non-oral feeding methods providing long-term alternatives for hydration and nutrition. Allows the patient to receive complete nutrition through a tube placed directly into the stomach, duodenum or jejunum e.g. nasogastric feeding (NG) percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG).

3.5 Instrumental Assessment of Swallowing:

Tools for assessing dysphagia and obtaining an objective view of swallowing ability i.e.videofluoroscopy (VF) and fibreoptic endoscopic evaluation of swallowing (FEES).

3.6 Level 2 Care Plan Implementation and Level 3 Identification and Implementation of an Interim Eating and Drinking Plan (EDSCF) (Boaden 2020)

Staff fulfilling the roles Level 2 (typically housekeepers or allied healthcare professionals) and Level 3 (typically healthcare assistants and qualified nursing staff (who are not trained to complete the dysphagia screen) contribute to the implementation of OP dysphagia management plans prepared by others and in turn report to a more experienced dysphagia practitioner. These being: Level 4: Nurse Dysphagia Screener, Level 5: Specialist or Level 6: Consultant Dysphagia Practitioners. He/she may prepare oral intake for individuals and contribute to feeding and providing fluids.

3.7 Level 4 Dysphagia Practitioner- Nurse Dysphagia Screener:

Able to identify presenting signs and symptoms and will undertake a protocol-guided assessment of OP dysphagia, working to pre-defined criteria, and are able to implement the actions as per the protocol and disseminate information to individual, carer and team.

3.8 Level 5- Specialist Dysphagia Practitioner: (usually) Speech and Language Therapist.

Demonstrates competent performance in the assessment and management of OP dysphagia, working autonomously with routine and non-complex cases.

3.9 Level 6 Consultant Assessment and Management: (usually) Clinical Specialist/ Clinical Lead Speech and Language Therapist.

Demonstrated competent performance in the assessment and management of OP dysphagia, working autonomously with complex cases and specialist caseloads.

3.10 Medical Staff:

In this policy medical staff refers to all medical professionals from Foundation Year (FY1) to Consultant, and includes all specialties.

3.11 Mental Capacity:

The ability to make a particular decision for yourself at the time it needs to be made. Capacity may vary over time due to a variety of factors e.g. delirium, social and emotional pressures.

3.12 Neurological Impairment: This includes: (this list is not exhaustive)

Cerebro-vascular accident (CVA) stroke; head injury; brain injury; subarachnoid haemorrhage; subdural haematoma; brain tumour; post neurological surgery; epilepsy/seizures; cranial nerve disorders; Parkinsons; Huntingdon's disease; cerebellar ataxia; tardive dyskinesia, multiple sclerosis; motor neurone disease; myasthenia gravis; Bell's palsy; bulbar & pseudo bulbar palsy; critical care myopathy/neuropathy; any other muscle wasting diseases; Guillain Barre; encephalitis; meningitis; dementia.

3.13 Nurse Dysphagia Screen:

Protocol-guided dysphagia screening assessment carried out by dysphagia trained Registered Nurses. Doctors and other health professionals can be trained.

3.14 Oro-pharyngeal dysphagia:

This includes swallowing difficulties that occur in either the anticipatory, oral or pharyngeal stages of swallowing e.g. difficulties with chewing, initiating the swallow or propelling the bolus through the pharynx to the oesophagus.

3.15 Risk Feeding:

Risk feeding is when a decision has been made to continue eating and drinking although to swallow is unsafe.

3.16 **Thickener**:

Thickening agent in powder form (either starch or gum based) that alters the viscosity or thickness of liquids resulting in the liquid travelling through the oral cavity and pharynx at a slower rate allowing more time for the triggering of the pharyngeal swallow.

4 ROLES AND RESPONSIBILITIES

4.1 The Medical Director and Chief Nurse are the Executive Leads for this Policy

The Medical Director and Chief Nurse are responsible for the professional performance of healthcare staff within the trust ensuring they that they fulfil their responsibilities as part of their duty of care. They have overall responsibility for the provision of safe care and treatment to patients and have executive responsibility for this policy.

4.2 **The Clinical Management Groups' Heads of Nursing and Clinical Directors** are responsible for ensuring staff in their CMG are aware of the policy; training to be accessed in line with this policy; addressing relevant concerns raised regarding compliance and by monitoring incidents and complaints.

4.3 **Heads of Service and Ward Sisters** are responsible for ensuring staff in their service/ward are aware of the policy; training to be accessed in line with this policy; addressing relevant concerns raised regarding compliance and by monitoring incidents and complaints.

4.4 **Adult Speech and Language Therapy Service (SLT) Manager** is responsible for ensuring that the service is suitably structured and that staff have access to appropriate training and supervision.

4.5 **Adult SLT Team Leaders** are responsible for writing and reviewing the policy and ensuring the team understand and comply with the policy.

4.6 **Speech and Language Therapists (SLTs)** have a responsibility to maintain and work within their professional competency and;

a. to respond to referrals within 2 working days of receipt of referral.

b. to ensure the assessment results are communicated clearly to all relevant members of the MDT immediately after the assessment.

c. to ensure information is provided to carers and relatives which can be verbal or written.

d. to provide training as appropriate to other healthcare professionals.

e. to update other health professionals involved in the care of OP dysphagic patients on changes to national guidelines

4.7 **Dysphagia screening trained registered nursing staff** (Level 4 dysphagia practitioner) covering acute stroke will screen appropriate patients for the presence of OP dysphagia as per the Stroke Pathway or when they are aware, either from medical information passed to them or from nursing observation, that the patient may have swallowing difficulties (see 7.4 and 7.5 for training requirements). It is the Registered Nurses'

responsibility to maintain their competencies and seek refresher training when appropriate. They will be aware of their scope of practice and will not act beyond the boundaries of their competence.

4.8 **All Registered Nursing staff** have a responsibility to:

a. Be able to recognise signs of dysphagia in their patients and risk of aspiration.

b. Liaise with SLT, medical staff and MDT if concerns are raised regarding the patient's eating and drinking ability at any stage of their inpatient stay and

c. Liaise with the medical team regarding the most appropriate management of the patient prior to their swallowing being assessed.

d. Ensure an electronic referral to SLT is made, once agreed.

e. Be compliant with SLT recommendations unless medical management is documented which overrides SLT recommendations.

4.9 **Medical Staff** have overall responsibility for the care of the OP dysphagia patient, and for example, will make decisions regarding patients being placed nil-by-mouth pending swallow assessment and recommending alternative feeding options and fluid provision to optimise management of nutrition, hydration and delivery of medication.

4.10 **Health care assistants, housekeepers and any staff involved in serving meals or feeding patients** are responsible for informing the Registered Nurse of any concerns they have regarding a patient's swallow and feeding ability.

4.11 **All employees** of UHL who care for people with OP dysphagia must be aware of this policy and are expected to follow it at all times.

5 POLICY STATEMENTS AND PROCEDURES

5.1 All patients admitted to UHL, where there is concern about their swallow ability, must have their swallow ability assessed.

5.2 Although it is well recognised that Speech and Language Therapy are the main profession who are competent to assess and manage OP dysphagia. (Communicating Quality 3, RCSLT, 2006.) Other professionals can become competent to follow protocol guided screens in order to identify OP dysphagia. (Boaden, 2020) Please see section 7, Education and Training Requirements.

5.3 Dysphagia screening is established for acute stroke admissions only. If it is appropriate to do so, a dysphagia screening trained Registered Nurse will complete a dysphagia screening assessment using the dysphagia screen protocols relevant for their clinical area. See Appendix 1.

5.4 The National Clinical Guidelines for Stroke (Royal College of Physicians, 2016) recommend that all patients presenting with new stroke symptoms have a swallow assessment within 4 hours by a healthcare professional who has undergone dysphagia screen training. Screening for normal fluids and Easy to Chew Diet is completed in the Emergency department.

5.5 Once a patient is transferred to the UHL Acute Stroke Unit and if it is appropriate to do so, a dysphagia screening trained stroke nurse will complete the section of the screening protocol which includes assessment of modified drinks and food. See Appendix 1.

5.6 A referral to SLT must be made via the appropriate electronic system where further dysphagia management is required for stroke patients or where concerns are raised in other acute clinical areas.

5.7 Patients will be seen within 2 working days of receipt of referral by Speech and Language Therapy.

5.8 If the patient identified with OP dysphagia is admitted either in the week and particularly if out of hours, at weekends or on bank holidays; a clinical decision must be made as to whether the patient can wait within the time frames of this policy to be seen by the SLT. If the patient is unable to wait, their nutrition, hydration and medication must be managed by their medical team. This includes the decision to continue oral intake with/ without additional fluids or nutritional support or placing the patient nil-by-mouth pending SLT assessment. If the patient is placed nil-by-mouth alternative fluids e.g. IV fluids should be given to ensure adequate hydration. Early alternative feeding can be considered and non-oral delivery of medications also needs to be addressed.

5.9 For the Speech and Language Therapy dysphagia assessment procedure please see Appendix Two

5.10 The Internationally agreed terminology for texture modification of food and fluids is attached (see Appendix Three, IDDSI

5.11 Please see Appendix Four for the full Acute Wards Inpatient dysphagia pathway

5.12 For UHL's protocol for oral intake in patients who are assessed to be at risk of aspiration, see Appendix Five. Some patients may be confirmed to have dysphagia but because of their condition or level of risk, it is deemed appropriate for them to continue to eat and drink with the risks of aspiration being accepted.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All Speech and Language Therapists caring for patients with OP dysphagia are Health and Care Professionals Council (HCPC) registered, dysphagia trained at post graduate level and work at least to the level of Specialist Dysphagia Practitioner. Newly qualified SLTs receive dysphagia training in-house enabling them to work at a Level 5: Specialist Dysphagia Practitioner (SDP) level.

6.2 SDPs may then access accredited intermediate and advanced external dysphagia training to enhance skills further, leading to competencies at Consultant Dysphagia Practitioner (CDP) Level 6. SDP and CDP practitioners will have evidence of achieved competence and this will be maintained via their own continuous developmental practice in accordance with their professional and regulatory bodies. Training needs will be reviewed at their annual appraisal.

6.3 Training is provided by the Adult Speech and Language Therapy department supporting this policy, enabling successfully trained Registered Nurses on the Acute Stroke Unit to complete a protocol-guided swallow screen and to work as a Level 4 Dysphagia Practitioner/ Nurse Dysphagia Screener (NDS) (previously referred to as a Foundation Dysphagia Practitioner (FDP)). If not trained locally, evidence of competencies achieved externally need to be provided to the relevant line manager, to enable practice at Level 4 within UHL.

6.4 Nurse Dysphagia Screeners will maintain their competencies by regularly completing screening assessments on appropriate patients. The protocol enables nurses to recommend, if appropriate, that these patients may commence oral feeding on normal fluids and easy to chew foods or textured-modified foods and drinks pending SLT review.

6.5 SLT Team provide Housekeeper awareness as part of the Trust Training.

6.6 Speech and Language Therapist competence at Level 5: Specialist Practitioner level require:

a. Knowledge of normal anatomy, physiology and neurology of swallowing.

b. Knowledge of the underlying causes and resulting pathological physiology of abnormal swallowing.

c. Knowledge of the signs of abnormal swallowing.

d. Knowledge and understanding of contraindications.

e. Knowledge and importance of preparing patients physically and psychologically.

f. Knowledge and ability to clinically assess the swallow.

g. Knowledge and ability to use the supplementary assessment tools of pulse oximetry, cervical auscultation, electromyography where appropriate.

h. Knowledge of risk of aspiration severity.

i. Knowledge of generation of hypothesis.

j. Knowledge of remedial techniques.

k. Knowledge of and ability to recognise the need for a detailed dysphagia management plan based on consideration of the information and results obtained during the assessment process.

l. Knowledge of the importance of reassessing the patient's needs.

m. Knowledge of relevant UHL policies (see references).

6.7 Performance Requirements:

a. Able to assess patient's swallow.

b. Able to prepare the patient for procedure both physically and psychologically.

c. Able to obtain consent.

d. Able to assemble and prepare equipment.

e. Able to carry out dysphagia assessments according to competence.

f. Able to describe a risk of aspiration.

g. Able to generate a hypothesis for the dysphagia.

h. Able to advise on appropriate feeding strategies.

i. Able to observe infection prevention measures thoroughly.

j. Able to respond to any adverse reactions/complications and report.

k. Able to dispose of equipment and waste material in a safe and correct manner.

l. Able to complete appropriate documentation.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Method	Frequency	Reporting arrangements	Lead(s) for acting on recommendations	Change in practice and lessons to be shared
Incident forms Keys search words include:- aspiration, dysphagia, thickened drinks, TTO's, swallow advice, mouthcare	Adult Speech and Language Therapy Team Leader	Datix report	Monthly	Adult Speech and Language Therapy management team meetings (held monthly)	Adult Speech and Language Therapy Management Team	Adult Speech and Language Therapy Team will be kept informed of any changes via relevant meetings
New referrals are seen within the standards.	Adult Speech and Language Therapy Team Leader	System One reports	Annual	Adult Speech and Language Therapy management team meetings (held monthly)	Adult Speech and Language Therapy Management Team	Adult Speech and Language Therapy Team will be kept informed of any changes via relevant meetings
New stroke referrals are seen within the standards	Adult Speech and Language Therapy Team Leader	SSNAP data	Annual	Stroke Physicians, Adult S&LT management team.	Adult Speech and Language Therapy Management Team	Adult Speech and Language Therapy Team will be kept informed of any changes via relevant meetings
Number of stroke nurses attending the nurse dysphagia training and completing the practical competencies.	Nursing Managers/ CNS Acute Stroke Unit	Document	Annual	Adult S&LT management team. Clinical Nurse Specialist Stroke	Adult Speech and Language Therapy Management Team	Adult Speech and Language Therapy Team will be kept informed of any changes via relevant meetings

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore, is to provide a safe environment free from discrimination and treat all individuals fairly, with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Supporting References

Boaden E, Eating, Drinking and Swallowing Competency Framework, 2020

Communicating Quality 3, Royal College of Speech and Language Therapists guidance on best practice in service organisation and provision, 2006

International Dysphagia Diet Descriptors Initiative (IDDSI) Evidence Framework 2019

National Clinical Guidelines for Stroke (5th edition), Royal College of Physicians, 2016

Evidence Base

Lennard-Jones JE (2000), Ethical and legal aspects of clinical hydration and nutritional support. BMJ 85(40)398-403
RCSLT Clinical Guidelines 2005

Skelly RH (2002) Are we using percutaneous endoscopic gastrostomy appropriately in the elderly. *current opinion in Clinical Nutrition & Metabolic care 5(1)35-42*

UHL Policies:

UHL Infection Prevention Policy	B4/2005
Personal Protective Equipment Policy	B10/2012
UHL Hand Hygiene Policy	B32/2003
Cleaning and Decontamination Policy	B5/2006
Policy for Documenting in Patient Health Records	B30/2006
Consent Policy	A16/2002
Procedures for Manual Handling of Patients (4th Edition, 2010)	N/A
UHL assessment and management of oro-pharyngeal dysphagia on patients in the critical care and high dependency units	C34/2007
UHL Fibreoptic Endoscopic Examination of Swallow policy	B27/2013
Waste Management Policy	A15/2002
Records Management Policy UHL	B31/2005
Records management policy Adult SLT service	2010
Incident reporting	B57/2011
Mental Capacity Act Policy	B23/2007

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

10.2 This document will be reviewed and updated in April 2023 by the SLT Team Leaders and dysphagia lead and specialist clinician(s).

Appendix One

Patient Label ***Contraindications:*** *Laryngectomy- medical management* *Document in Medical Notes why not completed.* *Refer to SLT:* *Head and Neck Cancer, Tracheostomy, baseline dysphagia/ known to SLT/ on recommendations.* *Voice problems following intubation/ extubation*	**UHL Dysphagia Trained Nurse** **Stroke Swallow Screening Assessment** **Adult Speech & Language Therapy Service** **0116 2585363 (Ext. 5363)**			
	Date:	**Time:**	**Ward:**	**Screen:** **1 2**
	Assessor (Sign and Print Name) :			

Basic Swallow Screen for Adults

PRE ASSESSMENT CHECK	✓	✖	ACTION IF NO
Is patient on oxygen? Are oxygen sats above 90% on nasal cannulae? Is this normal for them?			STOP
Is patient alert enough for assessment?			STOP
Is patient able to be sat upright?			STOP
Is mouth clean, moist and free of infection?			STOP and give mouth care
Is chest clear?			STOP and refer to Physio and SLT

Do not proceed further if answered NO to any questions above.
Repeat screen within 24 hours.

ORAL CHECK	✓	✖	COMMENTS/ ACTION IF NO
Does patient have own teeth?			
Are dentures in and well fitted if worn?			
Is facial expression normal and symmetrical?			
Is patient able to open and close mouth?			
Is patient coping with own saliva/not drooling?			STOP and refer to SLT
Has patient got a strong voluntary/reflex cough?			STOP and refer to SLT (?dyspraxia)
Is their voice clear and strong (eg. not wet/gurgly/ hoarse or a whisper (aphonic)?			STOP and refer to SLT
Are you able to proceed to the next stage?			STOP and try later/refer to SLT

ORAL ASSESSMENT	✓	✖	COMMENTS/ ACTION IF NO
Facial Weakness? No □ Yes □ Left □ Right □			1. Spread lips into a smile/say 'ee'.
			2. Puff cheeks out keeping lips together.
Tongue deviation on protrusion/lateral movement? No □ Yes □ Left □ Right □			1. Stick tongue out. 2. Move tongue around cheeks
Dysarthria indicated? No □ Yes □ **Dysphasia indicated?** No □ Yes □			Refer to SLT for Communication Assessment
Are you able to proceed to the next stage?			STOP and refer to SLT

PHARYNGEAL ASSESSMENT	✓	✖	ACTION IF NO
Moisten mouth with damp mouth care sponge and ask patient to swallow. Does she/he:			
1. Swallow without delay?			Continue with caution
2. Achieve complete up and over laryngeal movement?			STOP
3. Swallow without coughing?			STOP
4. Have a clear voice after swallowing (not wet/ gurgly)			STOP
5. Have no change in breathing pattern (not breathless)?			STOP
Are you able to proceed to the next stage?			STOP and refer to SLT. Consider dyspraxia/comprehension

SWALLOWING TRIAL	OBSERVATIONS Check for signs of aspiration up to 60 seconds after												OUTCOME	
NORMAL FLUIDS (NF/Level 0) WATER	Larynx moves up and Over?			No coughing/ throat clearing?			No change in breathing/ SOB?			Voice clear after swallow?			PASS	FAIL
Give 3 tspns													Continue to sips	On SU- try TF/NBM. Ref to SLT
Give 3 sips													Continue with sips	On SU- try TF/NBM. Ref to SLT
Allow patient to take sips from cup													NF. Proceed to trials of EC food	On SU- try TF/NBM. Ref to SLT

Easy to Chew (EC) including bread e.g. banana, bread+ butter, muffin..	Able to bite bits off? Chew and keep food in mouth?	No coughing? No throat clearing?	Mouth clear of residue?	Voice clear after?	PASS	FAIL
Give small piece of food-2 further if managed					Proceed to larger pieces	NF & PD. Refer to SLT
Give larger pieces with self-feeding					NF & EC diet. Monitor 24 hrs	NF & PD. Refer to SLT

Extended Screen only to be carried out on Ward 25/26: Stroke Unit

THICKENED FLUIDS (TF) Moderately Thick-Level 3	Larynx moves up and Over?			No coughing/ throat clearing?			No change in breathing/ SOB?			Voice clear after swallow?			PASS	FAIL
Give 3 tspns													Continue to sips	NBM Refer to SLT
Give 3 sips													Continue with sips	NBM Refer to SLT
Allow patient to take sips from the cup to ax if supervision needed													TF and trials of PD	NBM Refer to SLT

PUREED FOOD (PD) (Level 4) Thick yoghurt, custard, mousse, etc.	Larynx moves? Swallows in 5 seconds or less?	No coughing/ mouth clear after?	No increase SOB?	Voice clear after?	PASS	FAIL
Give 1 tspn pureed food. Further 2 if managed					Continue with self-feeding	NBM and refer to SLT
Assess self-feeding					TF & PD	TF & PD nurses to feed. Ref to SLT

Post Assessment Recommendations

PASS: Normal fluids Pureed diet (Level 4) (no teeth) Easy to Chew (EC) Diet (Soft diet-SD)
If patient passes on drink and food trial, offer normal drink and Easy to Chew diet and observe with meals/ drinks and move onto normal meals if baseline and managing after one full day of observation/ or before discharge.

PASS MODIFIED: Thickened fluids: Moderately Thick Level 3 Pureed diet (Level 4) Refer to SLT
If patient is placed on any modified consistencies, supervise with ALL meals and drinks.

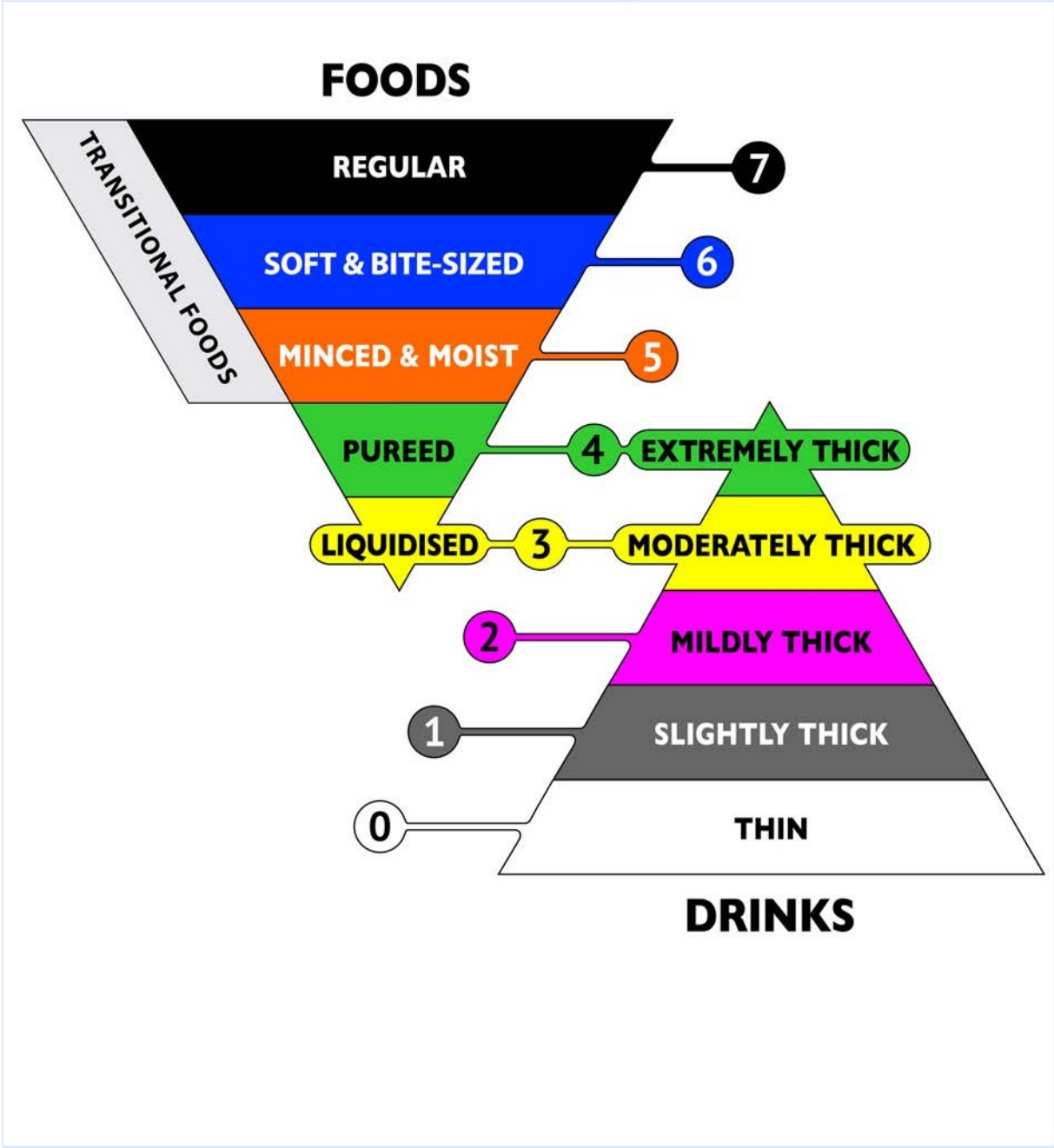
FAIL: NBM Regular mouth care Refer to SLT Agree nutrition/hydration management with medics (NG / IV fluids/ Sub cut fluids)

Remember to review and reassess in 24 hours if SLT not available

Procedure / Process for the Speech and Language Therapy Assessment of Oro-pharyngeal Dysphagia		
No.	**Action**	**Rationale**
1	Take a detailed history from the medical notes if available, and/or gather as much information as possible from referring agent, relatives, patient and/or carers. Following surgery consent may need to be gained from the surgeon as to what consistencies the patient may be assessed with.	To ensure there are no contraindications to assessment.
2	Introduce yourself as the Speech and Language Therapist and explain that the purpose of your visit is to assess the patient's swallow and feeding ability. Ask for consent to the proposed swallowing assessment.	To establish understanding and ensure a valid consent is obtained. To promote dignity.
3	Position the person appropriately, asking for assistance from trained personnel if necessary.	To ensure comfort and dignity and that optimal position for a safe swallow is possible.
4	Apply PPE as per UHL Policy	To minimise risk of infection
5	Carry out an oro-motor assessment with the patient.	To ascertain muscle strength/cranial nerve involvement, voice quality, possible compliance level and any need for suction.
6	Different thicknesses of liquid may be used in the assessment as appropriate. Different textures of food used during an assessment may be smooth yoghurt, banana, bread and butter as appropriate. Encourage the patient to take teaspoons or sips of liquid and/or food either independently or assisted, as appropriate.	To obtain clinical information on which to judge the pattern of events and inform a hypothesis.
7	Use palpation, cervical auscultation, and pulse oximetry as appropriate.	To obtain additional information on which to judge the pattern of events and inform hypothesis.
8	Formulate a hypothesis for the swallow.	To provide a rationale for the presenting oropharyngeal dysphagia informing the management plan.
9	Describe aspiration risk	To provide the referrer, healthcare professionals, patient, carers or relatives of the risk of aspiration. To inform the management plan.
10	Trial compensatory measures as appropriate to reduce the risk of aspiration.	To minimise the risk of aspiration and promote oral intake.
11	Take into account the need for further investigations such as instrumental examination of swallow or onward referral to other specialities.	To provide further diagnostic information. (UHL Fibreoptic Endoscopic Examination of Swallow policy B27/2013)
12	Dispose of PPE as per UHL policy and any unused food/liquids and utensils.	To prevent cross infection and maintain hygiene standards.
13	Decontaminate hands as per UHL Policy.	To prevent cross infection and maintain hygiene standards.
14	Liaise with other health care professionals as appropriate and available, regarding the assessment findings and future management.	To ensure prompt communication of the assessment findings and recommendations.

Procedure / Process for the Speech and Language Therapy Assessment of Oro-pharyngeal Dysphagia		
No.	**Action**	**Rationale**
15	Complete the bedside sign with eating and drinking recommendations and place above the patient's bed.	To ensure the recommendations are clearly communicated to all who may provide food or drink to the patient.
16	Where possible inform patient, carers and/or relatives of the assessment results and provide relevant information including bedside signs and leaflets	To ensure patient and any carers/relatives understand the assessment results and any changes which may need to be made to their eating and/or drinking.
17	Document findings in SLT clinical notes	To clearly communicate and record the recommended changes to the patient's eating and drinking.
18	Document findings in medical notes	To ensure accurate records are maintained and clearly communicate and record the recommended changes to the patient's eating and drinking. To maximise understanding of the recommended changes to the patient's eating and drinking.
19	If the patient is discharged from SLT following initial assessment the SLT will document the recommendations and reason for discharge in the medical notes. See flow chart in appendix 1.	To ensure the medical and nursing teams are aware of and understand the reasons for the discharge and recommendations
21	When a patient has been discharged from UHL, SLTs will communicate, via verbal and written reports, their findings and recommendations to colleagues, carers, GP's as appropriate. If thickner has not been prescribed on TTOs are requested an electronic request can be sent to the GP via SystmOne (See appendix 1 flow chart).	To ensure continuity of care, awareness and understanding of others involved in the ongoing care of the patient.

IDDSI
International Dysphagia Diet Standardisation Initiative
www.iddsi.org



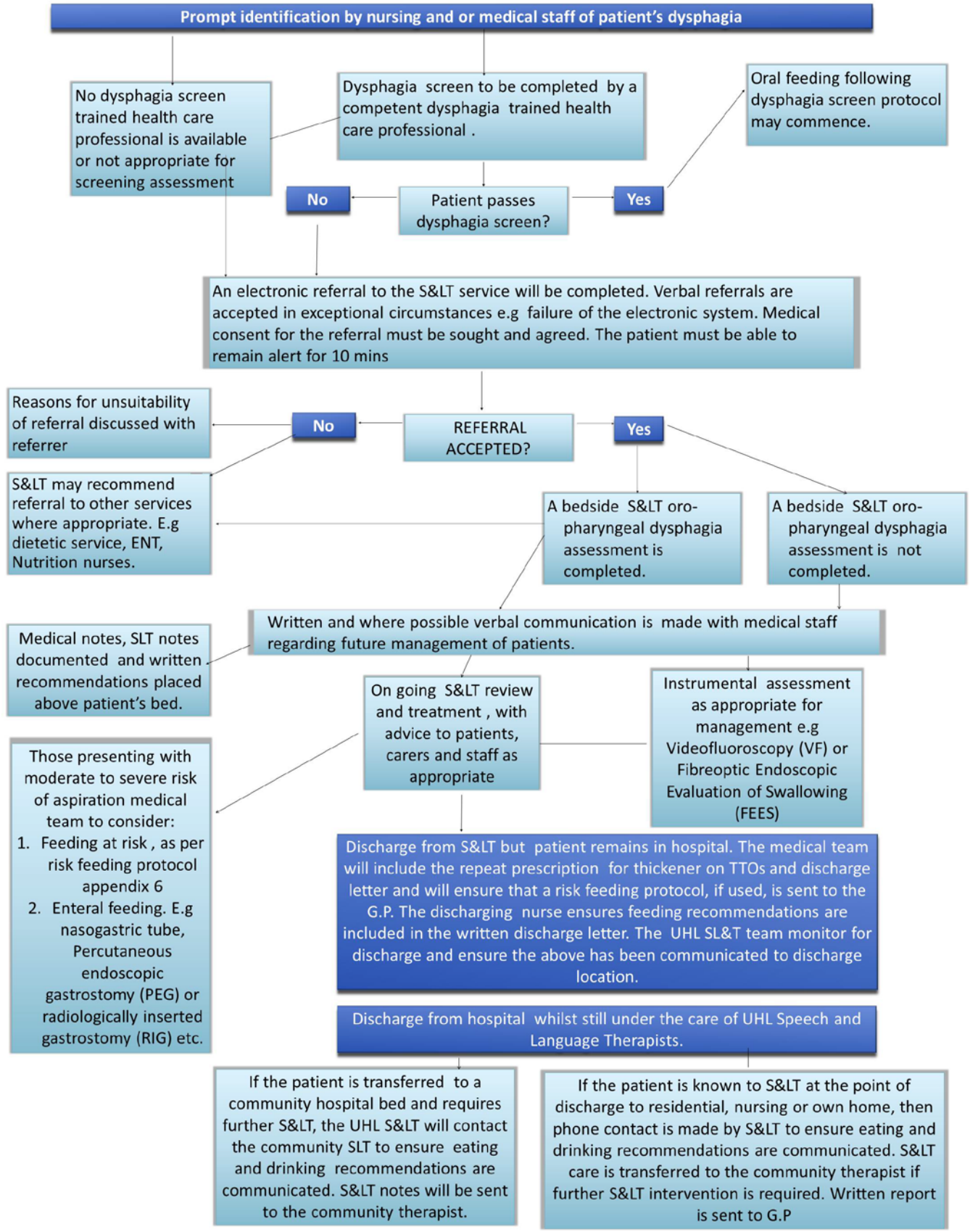
The International Dysphagia Diet Standardisation Initiative (IDDSI) was founded in 2013 with the goal of developing new global standardised terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures.

Three years of ongoing work by the International Dysphagia Diet Standardisation Committee has culminated in a final dysphagia diet framework consisting of a continuum of 8 levels (0–7). Levels are identified by numbers, text labels and colour codes.

https://iddsi.org/framework

Leicestershire Partnership NHS
NHS Trust

Speech and Language Therapy – Acute Wards
Inpatient Dysphagia Care Pathway



Patient Name:
NHS No.
DOB:

Leicestershire Partnership NHS
NHS Trust

University Hospitals of Leicester NHS
NHS Trust

Appendix Five

Medical Decision: Risk Feeding Protocol

Swallowing Assessment /Advice *to be completed by the Speech and Language Therapy (SLT) Team*

Swallowing assessment by the SLT team has identified a severe dysphagia with the following risks;

☐Aspiration (food / drink entering the lungs) Other / Comments:

☐Choking
☐Distress
☐Malnutrition / Dehydration

If decision is to risk feed then the following is recommended to **reduce** risks:

☐Normal / Thin Fluid
☐ Level 1 Slightly Thick
☐Level 2 Mildly Thick Fluids
☐ Level 3 Moderately Thick Fluids
☐Level 4 Extremely Thick Fluids

Other Advice / Comments:

☐Regular Food (Level 7)
☐Easy to Chew Food
☐Soft and Bite-Sized Food (Level 6)
☐Minced and Moist Food (Level 5)
☐Pureed Food (Level 4)
☐Liquidised Food (Level 3)

☐Mouthcare

Signed: Date:

Print Name:

Medical Team Decision *to be completed by the medical team*

Consultant / SpR / GP Name: _____

Based on a capacity assessment it has been deemed the above named person **does / does not** have capacity to make a feeding decision.

The above named person is not appropriate for long term non-oral feeding due to:

☐Palliative Care (Poor prognosis / short life expectancy)
☐Procedure Risk outweighs benefits of enteral feeding
☐Patient has declined artificial nutrition and hydration

☐Other:_____

The decision acknowledges that if oral intake is unsafe keeping the patient Nil By Mouth (NBM) or feeding by alternative means is not in accordance with their wishes or best interests. Therefore risk feeding is agreed, whereby the patient continues to eat and drink accepting that their health may deteriorate as a consequence.

Decision to Risk Feed *to be completed by medical team*

The patient either has capacity, or does not have capacity and the decision to risk feed has been made in their best interest. This decision has been discussed with the next of kin and / or other relevant parties named below:

Name: Relationship:

'Risk Feeding' Information Leaflet has been given to the patient / family ☐

Management Plan *To be completed by medical team (with consideration of ceiling of treatment)*

Expected Signs	Suggested Action
Chest infection / pneumonia	_____
Dehydration	_____
Malnutrition and weight loss	_____
Visible signs of distress	STOP and try later
Coughing / wet 'gurgly' voice	STOP, encourage cough, resume when clear, or later
Choking	Back slaps / abdominal thrusts / 999
Pocketing of food in mouth	Feed slowly, clean mouth after eating

Other:

_____

_____

_____

_____

_____

Good oral hygiene / mouth care is essential to reduce complications associated with aspiration

Re-Refer to SLT if

- The patient's health improves
- The patient appears to be managing oral intake without difficulty (e.g. no coughing, distress or change in chest status) possibly warranting diet / fluid upgrade.

Risk Feeding Protocol Signed Off By: *To be completed by medical team*

Signature: Date:

Print Name: Role:

Guidelines

- The medical team is responsible for conducting the capacity assessment for risk feeding decisions. If the patient has impaired communication the SLT should be involved to facilitate understanding, decision making and communication of wishes to maximise capacity.
- The medical team may decide that risk feeding is the preferred option prior to SLT assessment
- Advance directives should be taken into consideration in risk feeding decisions
- It is essential that a risk feeding decision is discussed and communicated to the patient / family / carer by the medical team
- **If completed in hospital, when the patient is discharged, a copy of this form MUST be sent to the GP, home and the SLT team**