Worcestershire Acute Hospitals NHS Trust

Feeding at Risk (Eating and Drinking with Acknowledged Risk) Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline should be used in conjunction with;
RCSLT (Royal College of Speech & Language Therapists) Eating and drinking with acknowledged risks: multidisciplinary team guidance for the shared decision making process (adults), September 2021.
RCP Supporting people who have eating and drinking difficulties, March 2021.

Patients are living longer with complex long term conditions and ongoing health needs. Those who are deemed to have an unsafe swallow and at risk of aspiration are not always placed nil by mouth (NBM). There is an increasing need to acknowledge the presence of risk when eating and drinking and its subsequent consequences. The Royal College of Physicians Guidance: Supporting people who have eating and drinking difficulties (2021) references risk feeding as a suitable management consideration, where clinically assisted nutrition and hydration (non-oral nutrition and hydration) is not appropriate or declined.

This guideline is for use by the following staff groups: all medical/ surgical teams and their MDTs, discussing feeding management decisions with patients and their families/ carers during their inpatient stay at Worcestershire Acute Hospitals NHS Trust.

Lead Clinician(s)

Helen Griffiths — Highly Specialist Dysphagia SLT

Mirjana Rasovic — Professional Clinical Lead SLT

Approved by Nutrition and Hydration steering group on:	11th April 2023
Review Date: This is the most current document and should be used until a revised version is in place	11th April 2026

Key amendments to this guideline

Date	Amendment	Approved by:
April 2023	New document approved	N&H Steering Group
7th Aug 23	Feeding at risk form replaced	Helen Griffiths

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Overview

Dysphagia (swallowing difficulties) is often a long term condition associated with a broad range of aetiologies including learning disability, neurological conditions, respiratory conditions such as COPD, stroke, and head and neck cancer. It is a common problem that accompanies ageing and frailty (Smithard 2016). Up to 50% of the population aged 80 and above suffer with sarcopenia (muscle weakness), known to contribute to dysphagia (Von Haehling, Morley & Anker, 2010). Difficulties with swallowing can also contribute to reduced oral intake and weight loss, which can which can be part of a frailty presentation (Frieds frailty phenotype).

Risks of dysphagia and its consequences can include aspiration of food, fluids, medications and saliva into the airway, choking, malnutrition, dehydration, distress, and social isolation. There is no linear relationship between dysphagia resulting in aspiration pneumonia. The development of aspiration pneumonia may occur due to a combination of swallowing impairment and contributory factors such as poor oral hygiene, being dependent on others for assistance when eating and drinking, and high support needs for positioning during mealtimes (Langmore, 2002; Hibberd et al, 2013).

The British Geriatrics Society Guidance 'End of Life Care in Frailty: Dysphagia' 2020, identified that early and future feeding planning are important to consider. Proactive identification and decision making, will avoid mismanagement of dysphagia which can lead to unnecessary investigations, prolonged nil by mouth status, reduced quality of life, or extended use of NG or PEG, and in some instances, unexpected death. As such, it may be deemed appropriate to continue to eat and drink in the presence of ongoing acknowledged risks.

The decision-making and management of dysphagia is complex; involving assessment of nutritional options and recommendations, weighing up benefits and risks, prognosis and capacity to consent (Dibartlo, 2006; Sommerville, 2019). It is paramount to consider social, cultural, religious and spiritual beliefs, in partnership with the patient and/ or family if the patient no longer has capacity.

Definition

The terminology 'Feeding at Risk' in WAHT was first introduced in 2015 with the introduction of a formal pathway following an audit in 2015, highlighting the need to improve the length of time it took to make decisions, alongside improving the decision making process.

Since then, the RCSLT have agreed the term 'eating and drinking with acknowledged risks' for the purposes of their latest guidelines. The terms 'risk feeding, eating and drinking with accepted risk, feeding at risk all refer to:

"The decision to continue to eat and drink despite the associated risks from having dysphagia including aspiration, malnutrition, dehydration and choking." (RCSLT 2021).

After consultation with key members, our Trust has currently opted to continue to use the term **feeding at risk**.

Objectives

The principle of this guideline is to aid the achievement of an effective decision making process and promote a person centred problem-solving approach. This is achieved by clearly outlining the roles and responsibilities, of adequately trained MDT members via an agreed pathway for decision making. The pathway outlines key process and milestones the MDT should take when deciding if someone is appropriate to access feeding at risk, and if so, how this is tailored to the individuals needs and timely planning for the future implications of the decision.

Roles and Responsibilities

Taken from RCSLT 2021 Eating and drinking with acknowledged risk.

Roles	Responsibilities within SDMD for individuals eating and drinking with acknowledged risks
Individual/ family/carer (those closest to the individual)	Be consulted on wishes/interests/beliefs. Provide information on eating and drinking preferences, mealtime routines, cultural, religious and spiritual beliefs associated with food.
Medical practitioner	Initiate the dialogue regarding the risks involved and if there are grounds to doubt whether the individual has capacity to make a decision about their nutrition, undertake a capacity assessment (particularly applicable during weekends/evenings in hospital settings). Refer to SLT for a swallowing assessment. Ensure anticipatory/advance health care plans are completed when needed. Include eating and drinking with acknowledged risks recommendations in letters/correspondence.
Speech and language therapist	Conduct a clinical assessment of swallowing. Conduct or facilitate a capacity assessment for nutritional options if needed. Discuss findings of the swallow assessment with the MDT, including the individual and their significant others. If possible, provide written information on eating and drinking with acknowledged risks (see General Medical Council tips for handling difficult conversations and RCP framework for conversations for ethically complex care). Make intervention person-centred and support recommendations that form the basis of how individuals will eat and drink with acknowledged risks.

Consultant/GP	Has overriding responsibility of individuals under their care and therefore often makes the decision, particularly within an inpatient setting (for those individuals lacking capacity), taking fully into account the individual's wishes and the rest of the MDT's views. The consultant or GP should consider the appropriateness for treatment escalation in the event of an anticipated decline in the person's condition, whether they are in hospital or in their own home/care home.
Dietitian	Support the individual to optimise their nutritional intake. Evaluate candidacy of the person for alternative nutrition and hydration options. Support other members of the MDT regarding the development and implementation of the individual's nutrition and hydration care plan. Support palliative care regarding eating and drinking at the end of life.
Physiotherapist	Discuss chest management with the medical team and ceiling of care with regard to respiratory needs. Provide assessment and recommendations about optimal positioning and postural support for eating and drinking.
Nurse	Use professional judgement to identify if an individual is likely to be a candidate for eating and drinking with acknowledged risks and highlight to the medical professional/SLT. Appropriate nursing handover should take place to ensure that risks are acknowledged and minimised with scrupulous mouth care and optimum seating position. Support the individual to follow eating and drinking recommendations as much as is possible. Document and escalate issues. Act as the person's advocate, evaluating care and risk managing situations when SLT advice is not available, in conjunction with medical colleagues, the person and their family. Reviewing general physical health in community settings. Escalate concerns back to the MDT/GP as appropriate.
Healthcare assistant	Support the individual to follow eating and drinking recommendations as much as is possible. Document and escalate issues if needed.

Palliative care	Inform the MDT if an individual has been placed on the end-of-life pathway. Provide support to the individual or those close to them on eating and drinking at the end-of-life. Ensure individuals identified as 'actively dying' have a plan of care including symptom control and psychological, social and spiritual support for the individual and family.
Pharmacy	Coordinate medication with medical professional and SLT to ensure medication is in a form which is easier to swallow (UK Medicines Information on thickening agents; Cichero, 2013; Manrique et al, 2016).

Capacity assessment

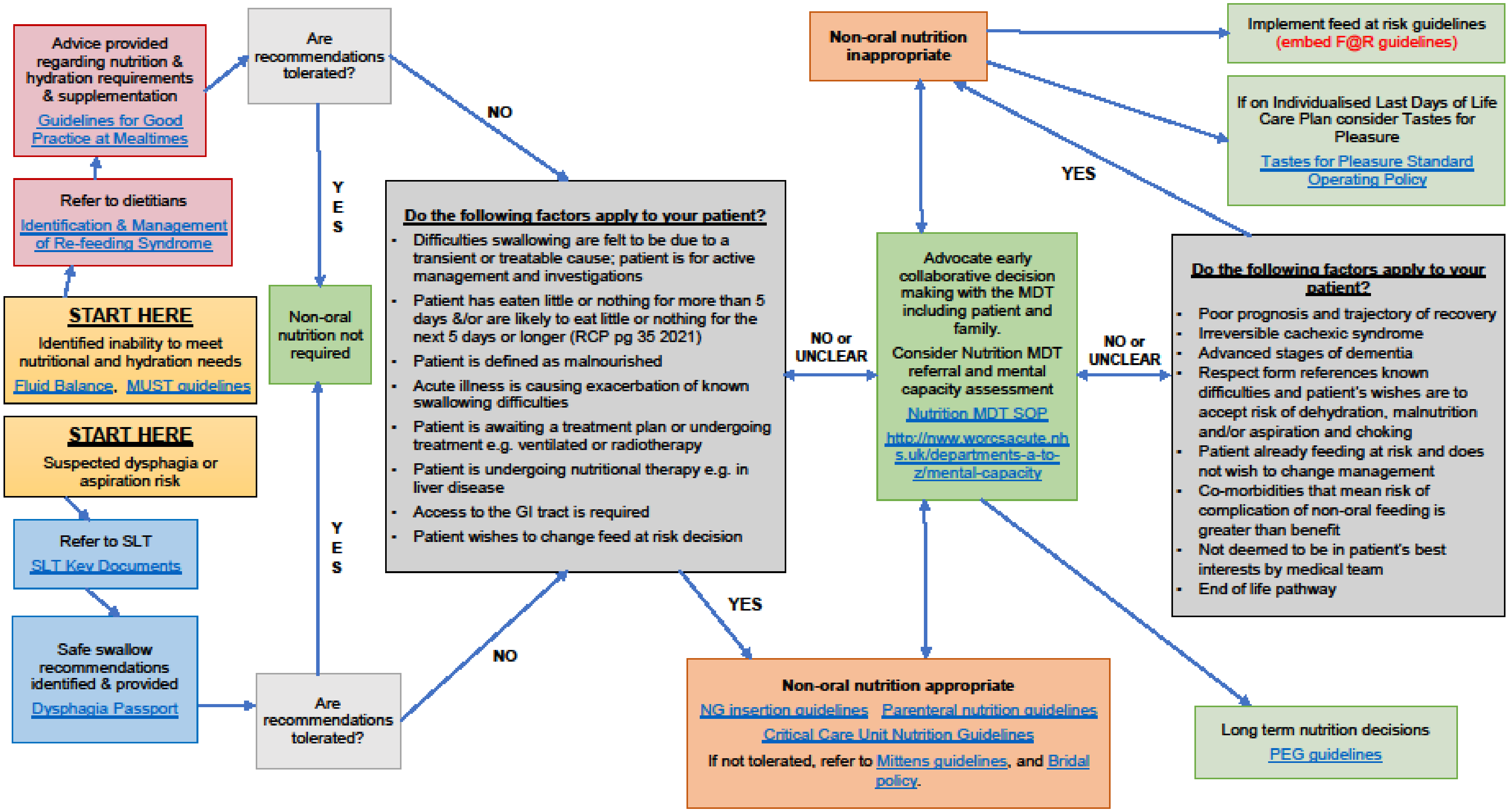
It is the role of the MDT to clearly document decisions made about a patient's capacity in relation to their ability to make an informed feeding management decision. The following links provide national and local guidance.

NICE Decision making and mental capacity 2020	decision-making-and-mental-capacity-p
RCSLT 2021 (page 9 & 10)	Eating-and-drinking-with-acknowledg
RCP 2021	RCP Supporting people who have ea
BMA, RCP, GMC 2018	bma-clinically-assisted-nutrition-hydrati
Trust Mental Capacity information	http://nww.worcsacute.nhs.uk/departments-a-to-z/mental-capacity/ Complete: mental capacity assessment record (MCA1) & if required, best interests checklist (MCA2)

A second clinical opinion from a senior clinician may be helpful in determining feeding management in best interests to account for patient individuality and/or where there is no consensus. The person providing a second opinion should have relevant clinical knowledge and experience and may not be part of the team directly treating the patient (BMA/RCP/GMC, 2018; RCP, 2021).

Worcestershire Acute Hospitals NHS Trust

Adult feeding management decisions



Adult Feeding Management Considerations: Decision Aiding Flowchart

Feeding at risk process summary

Taken and adapted from Lewisham and Greenwich NHS Trust with their permission.

Patient with suspected dysphagia or aspiration risk
Establish nature of dysphagia (see feeding decisions flowchart)

↓

If not felt to be due to transient or treatable causes
Initiate Risk Feeding Pathway (section 1 of feeding at risk form)

↓

To inform decision-making process
Conduct Capacity Assessment (medical team complete sections 2 & 3 of feeding at risk form)

↓

Detailed dysphagia assessment
(see SLT dysphagia assessment in medical notes)

↓

Collaborative decision-making
Consider: Team, patient and family/carer discussion, leaflet for patient/family for further reflection (medical team complete sections 3 & 5 of feeding at risk form)

↓

Authorisation of process
Feeding at risk form to be signed by Consultant

↓

Clear documentation and handover
Medical decision communicated to ward MDT, SLT completed feed at risk signage (medical team complete sections 5 & 6 of feeding at risk form)

↓

Discharge Planning
Acknowledgement of risk feeding and future management in Advance Care Planning (medical team complete section 4 of feeding at risk form)

↓

Discharge
RESPECT form and EDS summary completed by medical team.
Nursing handover to discharge destination of recommendations and ceiling of care. SLT summary report to GP and copy to Community SLT completed within 48 hours; add feed at risk alert to Trust computer system.

The benefits of clear communication throughout the pathway include: consistency in the management of nutrition and hydration between wards and from hospital to home; support to those who are involved with feeding at the point of delivery and; avoidance of inappropriate hospital re-admission.

Changes of Circumstance

There may be occasions where it is appropriate to review a feeding at risk decision. For guidance on this refer to the Adult Feeding Management Pathway. Examples may be;

- Patient appears to have significantly improved,
- Patient has become more symptomatic where they have previously tolerated a level of aspiration e.g. head and neck patients,
- Patient expresses a wish to explore non-oral nutrition and hydration
- Patient wishes to have food/fluid consistencies outside of SLT risk reducing recommendations
- A new diagnosis

Resources

Feed at risk form for completion by medical team	PF WR5122 Feeding At Risk Form Versior
Feed at risk leaflet	**Feeding at Risk - Patient Information**
Feed at risk letter template	FAR letter template.rtf
Feed at risk poster template	SLT Feed at Risk RECOMMENDATION
Handling Difficult Conversations	https://gmcuk.wordpress.com/2016/05/13/handling-difficult-conversations-ten-top-tips/

Legal Issues

Mental Capacity

You must work on the assumption that every adult patient has the capacity to make an informed decision about their feeding. If a patient's capacity to make the decision is impaired, the patient must be provided with all the appropriate help and support to maximise their ability to participate in the decision making process.

Please see the MCA Code of Practice (revised 2020), GMC Guidelines (updated 2019) and WAHT Consent to Examination or Treatment Policy (2016) for additional information and advice on decision making with patients who lack capacity.

It is the role of the MDT to clearly document decisions made about a patient's capacity in relation to their ability to make an informed feed at risk decision.

Documentation

This document aims to reflect the discussions and include the decision to eat and drink with acknowledged risks as required for governance, assurance and reassurance. It ensures that staff assisting patients to eat and drink are protected from liability providing they have acted with due care.

Emergency Procedures

In the event of difficulties leading to a life threatening situation, a positive duty to act arises and health professionals are then required to do whatever would be reasonably expected of them in the circumstances. The MDT should follow Health and Safety guidelines, ensure they are adequately prepared for such an event, and be familiar with the emergency procedures for choking.

Health professionals need to be aware of the CPR decision documented on a patient's ReSPECT form as this will determine the course of emergency treatment a patient will receive. In the event of a choking incident, a patient will always receive emergency treatment for choking and/or respiratory arrest. If this progresses to a cardiac event the CPR procedure should be followed.

Competence

Speech and Language Therapy

All SLTs that become involved with feeding at risk decision making must have completed the appropriate dysphagia competencies equivalent to RCSLT Dysphagia Training and Competency Framework 2014, Level C – Specialist Level Dysphagia Practitioner.

Medical Team

Feed at risk decisions are the ultimate responsibility of the Consultant in charge of the patient's care. The Consultant accepting this responsibility must be aware of the Feed at Risk Guidelines, the Adult Feeding Management Pathway and the MCA Code of Practice, and feel competent to apply the content to the situation of the individual.

All Health Professionals

It is the responsibility of all health professionals to ensure they are up to date with their Mandatory training, particularly in relation to Mental Capacity and Resuscitation.

Abbreviations

COPD	Chronic Obstructive Pulmonary Disease
NG/NGT	Nasogastric tube
PEG	Percutaneous endoscopic gastrostomy
WAHT	Worcestershire Acute Hospitals Trust
RCSLT	Royal College of Speech & Language Therapists
MDT	Multi-disciplinary team
MCA	Mental Capacity Act
SDMD	Shared decision making in dysphagia
SLT	Speech and language Therapist
RCP	Royal College of Physicians
G.P	General Practitioner
EDS	Electronic discharge summary
GMC	General Medical Council

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
		Audit, datix, attending SLT training	annually			

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Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr Susan Powell, Consultant in Elderly Care
Morag Inglis, SLT & Dietetic Manager
Dr Nicola Heron, Consultant in Palliative Care

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Therapies clinical governance
Nutrition and Hydration steering group

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Mirjana Rasovic

Details of individuals completing this assessment

Name	**Job title**	**e-mail contact**
Mirjana Rasovic	Professional Clinical Lead SLT	Mirjana.rasovic@nhs.net

Date assessment completed	18.10.22

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Guideline for feed at risk decision making and pathway
What is the aim, purpose and/or intended outcomes of this Activity?	Provide up to date information and guidance on medical practice in the context of feeding management decisions, particularly feeding at risk, in line with national changes.
Who will be affected by the development & implementation of this activity?	x Service User x Patient x Carers ❑ Visitors x Staff ❑ Communities ❑ Other ________________________ ❑
Is this:	x Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	RCSLT RCP GMC BGS
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Engaged with key stakeholders including Consultant in elderly care, and SLT team and wider therapy leads through clinical governance panel.
Summary of relevant findings	All in agreement for need to update key docs with accurate resources and guidance

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			People can experience temporary or permanent dysphagia (swallowing problems) from a wide range of backgrounds and circumstances. Having an up to date guideline will enable equal access to the appropriate staff and pathway, irrespective of differences.
Disability	x			
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic	x			

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	x			People can experience temporary or permanent dysphagia (swallowing problems) from a wide range of backgrounds and circumstances. Having an up to date guideline will enable equal access to the appropriate staff and pathway, irrespective of differences.

Section 4

What actions will you take to mitigate any potential negative impacts?	**Risk identified**	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Timeframe**
	Lack of awareness of pathway	Promotion of new guidance via key docs and comms team	**Helen Griffiths**	**2 months**
	Misinterpretation of content	*Step by step guide through decision making process and signposting to relevant governing bodies/ evidence base*	*Helen Griffiths*	**ongoing**
	High rotation of staff	**Training of medical staff and health care professionals**	**Helen Griffiths**	**ongoing**
How will you monitor these actions?	**Audit and investigation of datix.**			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**On 3 yearly document review**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	M Rasovic
Date signed	18.10.22
Comments:	
Signature of person the Leader Person for this activity	H Griffiths
Date signed	18.10.22
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

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

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.