Trust Policy		Worcestershire Acute Hospitals NHS Trust

Dysphagia Policy

Department / Service:	Speech and Language Therapy
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Accountable Director:	
Approved by:	Therapies Clinical Governance Approval Group
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First Revision Due: **This is the most current document and should be used until a revised version is in place**	20th June 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	
Target staff categories	All clinical staff, support staff and operational, clinical and professional leads

Policy Overview:

This policy is aimed at all staff involved in caring for and diagnosing patients with dysphagia, as part of the Trust Multi-Disciplinary Team (MDT). It covers scope of practice for the acute Speech and Language Therapy (SLT) service including acute inpatient and outpatient services.

This policy should be read in conjunction with the sign posted references within this document and on the SLT key documents page, along with national and international guidelines. For patients in community, please liaise with the relevant community speech and language therapy team.

For clarity, this document will use dysphagia in reference to oro-pharyngeal dysphagia. Management of paediatric dysphagia, eating disorders and/ or purely oesophageal dysphagia are not covered by this document.

Key amendments to this document

Date	Amendment	Approved by:
20th June 2024	New Document	Specialist Medicine DMB

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Supporting Documents

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1. Introduction

Worcestershire Acute Hospitals NHS Trust (WAHT) is committed to providing an outstanding level of care to all patients. Clinical staff must be able to identify, refer, monitor and support a patient who has difficulty swallowing (dysphagia) during their care with WAHT. All patients with swallowing problems should be treated with dignity and respect and staff should be competent and safe to deliver the best care and achieve the best possible outcomes. Adults with dysphagia may present in different ways and have varying symptoms. Services should be person-centred and provide a range of interventions which are individually and culturally appropriate.

2. Purpose

The purpose of this document is to detail the process for the identification, assessment and management of patients over 18 year of age, at risk of oropharyngeal dysphagia within the Trust's hospital sites. This includes inpatients at Worcestershire Royal Hospital and Alexandra Hospital as well as head and neck and ENT dysphagia outpatients. This guideline outlines how health professionals can work as core members of the multidisciplinary team (MDT), to enable staff to put patients first by providing a patient centred approach incorporating best clinical practice. To enable high performing clinical practice, and to ensure the Trust's 'best people' ethos is maintained, this document provides guidance on suitable training, competencies and expectations regarding roles and responsibilities of speech and language therapists and Trust staff including doctors, HCAs, nurses and allied health professionals (AHPs).

3. Objectives

The principle aims of this guideline are to:

- Deliver a safe, effective and efficient dysphagia service to the adult population served by the Trust.
- Provide guidance on dysphagia assessment and management in relation to the different multi-disciplinary roles.
- Provide the relevant level of dysphagia training for all staff involved with caring for and/or treating patients in the Trust with swallowing difficulties.
- Adhere to the Royal College of Speech and Language Therapists (RCSLT) dysphagia competencies, assessment and management guidelines.
- Ensure the appropriate supply and usage of thickening agents to patients with dysphagia.

4. Responsibilities

4.1. Head of Therapies/Senior Nursing

- To ensure this guideline is shared and supported across WAHT.
- To support staff within their area of responsibility to access appropriate training so they are suitably educated to identify patients at risk of dysphagia.
- To ensure staff within their area of responsibility can recognise and manage patients at risk of dysphagia to a level appropriate to their role.

- To review, investigate and escalate any incidents via Datix relating to the management of dysphagia

4.2. Speech & Language Therapists (SLTs)

- To undertake comprehensive assessment (there may be multiple assessments over time) leading to accurate diagnosis of dysphagia which may assist with the differential medical diagnosis.
- To advise about patient's specific dysphagia and feeding management options in terms of safety (reducing or preventing aspiration) and balancing with quality of life, considering patient preferences and beliefs.
- To facilitate patients to make informed decisions.
- To work with MDT to optimise nutrition and hydration.
- To provide appropriate strategies, techniques and therapy to help maintain and/or improve swallow function.
- To educate and train others in identifying, assessing/screening and managing dysphagia.

4.3 Pharmacy

- To review, action and document any changes required to medication in line with SLT recommendations for modification whilst an inpatient – formulation consistency, route of administration, interactions, to ensure medication is administered safely and effectively.
- To ensure medication is in the correct consistency and/or route of administration for those with a known dysphagia on admission to hospital.

4.4 Patient facing clinical staff in inpatient setting

- Ensure inpatient referrals to SLT are timely, appropriate and are fully completed with relevant information.
- Responsible for obtaining information about a patient's food and fluid textures, for those patients admitted to hospital with a known dysphagia.
- Have an awareness of current patients who may be at risk of dysphagia, and take reasonable action to reduce the risk of aspiration and choking.
- Adhere to SLT recommendations, including ensuring accurate food and drink textures are documented on the handover.
- Ensure all patients requiring modified food and fluids have the information displayed at the bed space either by SLT posters (if seen as inpatient) or written on the patient board (if known recommendations from the community setting and acute SLT not required).
- Have relevant awareness of dysphagia such as signs of dysphagia/aspiration, safer eating and drinking strategies, knowledge of food and fluid textures. Key documents: Speech and Language, IDDSI food fluid textures https://iddsi.org/. Complete Trust Dysphagia Awareness training on ESR – available soon.
- Ensure correct food and drink consistencies are presented to patients at meal times, foods/drinks brought in from out of hospital e.g. by relatives.

- Be aware of the safe storage, use and disposal of thickening powder and supplements for patients with dysphagia.
- Ensure thickening powder is kept out of patient reach (where a patient is deemed at risk of not being aware of their actions) to avoid accidental ingestion. NHS England » Patient safety alert – Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder
- Report any incidents relating to dysphagia via Datix.
- Keep accurate records for oral intake and document any relevant information about a patient's eating and drinking on Sunrise Electronic Patient Record.
- Contact the SLT department if you have concerns about a patient's swallowing, where it has not already been addressed.
- Update SLT with relevant information e.g. medical decisions made about feeding management, results of investigations, changes to swallow presentation.
- Assist with safe discharge planning – ensure SLT recommendations are handed over to relevant parties and written on discharge summary, Dysphagia Passport (if needed) goes with patient and thickener provided (if needed).
- To be aware and comply with Trust policies and guidelines which have relevance to dysphagia e.g. Feeding at Risk guideline, MUST (Malnutrition Universal Screening Tool.

4.5 Housekeeper/HCA and Catering Staff

NB only the first point is relevant to catering.

- Ensure the correct meal is provided, correctly prepared, served at the recommended temperature and well presented.
- Have relevant awareness of dysphagia such as signs of dysphagia/aspiration, safer eating and drinking strategies, knowledge of food and fluid textures.
- Key documents: Speech and Language, IDDSI food fluid textures https://iddsi.org/. Complete Trust Dysphagia Awareness training on ESR – available soon.
- Be aware of the safe storage, use and disposal of thickening powder and supplements for patients with dysphagia.
- Ensure thickening powder is kept out of patient reach (where a patient is deemed at risk of not being aware of their actions) to avoid accidental ingestion. NHS England » Patient safety alert – Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder
- If relevantly trained and competent to do so, thicken drinks to the correct consistency.

4.6 Doctors

- Ensure inpatient referrals to SLT are timely, appropriate and are fully completed with relevant information.
- To lead feeding management decisions e.g. alternative feeding vs feeding at risk. This includes MDT discussion, family meetings, providing clear explanations to patients and their families. Key Documents: Speech and Language or Adult Feeding Decisions, **Feeding Management Decisions Flowchart** http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3821

- Clearly document decisions and actions, including advanced care plans, on EPR/Sunrise and complete relevant documentation e.g. Feed at Risk form – Key Documents: Speech and Language – Feeding at risk http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3820
- Work with SLTs to consider appropriate medical investigations and onward referrals indicated to help investigate cause and/or progression of dysphagia.
- Make timely feeding management decisions which documented clearly on EPR/Sunrise and communicated to relevant parties to avoid unnecessary delays in care e.g. prolonged NBM.
- For patients placed NBM due to dysphagia, ensure a medication review is carried out promptly (with advice from the ward pharmacist as needed), to ensure that medications are not inadvertently omitted. Key Documents: Medicines – Nil by Mouth http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1591
- Update SLT with relevant information e.g. medical decisions made about feeding management, results of investigations, changes to swallow presentation.
- Assist with safe discharge planning – ensure SLT recommendations are written on discharge summary and thickening powder (if needed) is prescribed on TTOs.

4.7 Volunteers

- Do not assist and feed patients who have dysphagia. Key Documents: Nutrition and Dietetics – A Guide to assisting adults to feed and supporting the patient experience – Volunteer Feeding http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3822

5. Dysphagia

5.1 Definition

Dysphagia is the medical term used to describe an oral, pharyngeal or oesophageal swallowing problem. It can be acute, chronic, transient, static or progressive in presentation. Swallowing involves multiple factors such as neuromuscular control and co-ordination, sensory perception, gastrointestinal function, cardio and respiratory support, and integration from the autonomic nervous system (RCSLT, accessed March 2023).

Dysphagia can result in, or contribute to negative health conditions such as chest infections, choking, weight loss, malnutrition and dehydration, which can have serious or life limiting consequences. It is recognised that prompt intervention in the management of dysphagia can prevent costly and life-threatening complications, such as aspiration pneumonia (Feng et al., 2019). Odderson et al. (1995) showed that the incidence of aspiration pneumonia due to dysphagia could be reduced from 6.7% to 0% through effective management.

Swallowing difficulties can have a negative impact on quality of life (RCSLT, accessed March 2023). Embarrassment and lack of enjoyment of food can have significant social consequences for the person with dysphagia and their family.

5.2 Causes of dysphagia in adults

- Neurological conditions e.g. stroke, dementia, Parkinson's Disease (PD), Motor Neurone Disease (MND), Multiple Sclerosis (MS), Progressive Supranuclear Palsy (PSP), head trauma, brain tumour, sub arachnoid haemorrhage, Guillain-Barré, muscular dystrophy
- Respiratory conditions e.g. COPD
- Congenital/ developmental e.g. learning disability, cerebral palsy
- Oncology e.g. head and neck cancer, lung cancer, oesophageal cancer
- Ageing and frailty e.g. sarcopenia
- General medical conditions e.g. urinary tract infection (UTI)
- Tracheostomy
- Trauma or surgery e.g. thyroid operation
- Structural changes e.g. pharyngeal pouch
- Medication side effects e.g. neuroleptics
- Treatment side effects e.g. radiotherapy
- Psychogenic

5.3 Identifying dysphagia

- Drooling
- Dry mouth
- Poor dentition or oral hygiene
- Prolonged meal times
- Food or drink spillage from lips
- Lack of chewing
- Food residue in the mouth after swallow
- Nasal regurgitation
- Coughing or choking when eating and drinking
- Poor cough when eating or drinking
- Decrease of oxygen saturations when eating and drinking
- Eye watering
- Change of face colour e.g. reddening
- Discomfort when swallowing
- Sensation of food/drink sticking in the mouth or throat during and after swallow
- Wheezing or increased respiratory rate after swallow
- Wet voice after swallow
- Recurrent chest infections
- Unintentional weight loss
- Fatigue
- Reflux, vomiting, regurgitation

5.4 Behaviours which can impact swallow safety when eating and drinking

- Suboptimal positioning
- Reduced alertness Lack of interest or recognition of food and drink
- Not wearing dentures/ill fitting dentures
- Holding food/drinks in the mouth
- Fast pace of eating and drinking
- Cramming/overloading food in the mouth
- Swallowing food without chewing
- Agitation or poor attention when eating and drinking

5.5 Potential consequences of dysphagia/behaviour affecting swallow safety

Taken from RCSLT (accessed March 2023).

- Aspiration is when food, drink, medication or saliva enters the airway (below the level of the vocal cords and into the lungs). Aspiration can lead to a lung infection known as aspiration pneumonia (Marks & Rainbows, 2001).
- Choking and death (Marik & Kaplan, 2003)
- Poor nutrition and weight loss (Wright et al, 2005)
- Dehydration
- Poor oral health
- Poor health (Hudson et al, 2000)
- Anxiety and distress within the family (Choi-Kwon et al, 2005)
- Hospital admission or extended hospital stay (Low et al, 2001)
- Reduced quality of life (Nguyen et al, 2005).

Patients may present with aspiration pneumonia without the usual identifying signs of dysphagia. This is known as silent aspiration.

6. Referring to SLT:

Educational information about SLT referrals. Key Documents: Speech and Language – Inpatient Dysphagia Referral Pathway Acute Patient Dysphagia Referral Pathway (3).PDF

Parkinson's Disease patients: establish patient baseline eating and drinking recommendations, and if there are no NEW swallowing problems then use the relevant poster to indicate the patient's food and fluid consistencies.

Lesson of the week - PD.docx

7. Assessment of Dysphagia:

7.1. Background Information

On receipt of referral, SLT will gather relevant background information before proceeding to assessment. SLT may also liaise with patient, family/carers, AHPs and ward staff.

Information may include:

- current and past medical history
- relevant investigations
- other professions' involvement, may include contacting community SLT teams
- patient observations e.g. NEWS2
- food and fluid charts
- medications
- dietary restrictions including allergy and/or cultural/religious considerations

7.2. Consent

SLT will gain consent from a patient before commencing a session. Key Documents: Trustwide – Policy for Consent to Examination or Treatment
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2846

7.3. Clinical swallow assessment

If a duty to assess has been clearly identified from background information gathering then a clinical bedside swallow assessment is likely the next step of the process. The aim is to identify a differential dysphagia diagnosis and to identify recommendations to reduce or prevent aspiration. This type of assessment may be used at subsequent reviews to establish a patient's current swallow presentation.

Clinical bedside assessment includes:

- Introducing self to patient, explain role and rationale for assessment.
- Obtaining patient consent.
- Observing patient presentation - alertness, ability to interact, hold attention and communicate, positioning, vision, hearing.
- Complying with Trust infection control requirements such as hand hygiene and PPE.
- Conducting an oro-motor assessment to ascertain muscle strength, cranial nerve involvement, voice and voluntary cough quality, visualise oral structures and cavity, review dentition.
- Swallow trials of different methods of delivery and different food and drink consistencies +/- trial of compensatory strategies, as clinically indicated.
- Using other tools to support assessment such as laryngeal palpation, pulse oximetry and cervical auscultation.

Contraindications to completing a clinical swallow assessment may include:

- Where a patient does not give consent or does not willingly participate e.g. they are not perceived to have given implied consent.
- Where assessment would cause physical or mental distress
- Respiratory problems:
    - Where supplementary oxygen is required and cannot be safely removed without oxygen desaturation for the duration of the assessment
    - Where a tracheostomy is in situ with a cuff up (unless further appropriate instrumental assessment is available).
    - Where a patient is intubated and ventilated.
    - Where a patient is unable to tolerate tracheostomy cuff deflation for the duration of assessment.
- Where a patient cannot be roused for assessment or cannot maintain alertness for the duration of an assessment.
- Where a patient is cannot sit upright or is unable to maintain adequate positioning for assessment/eating and drinking, either independently or supported.
- Poor oral hygiene – see section 3+4 of Mouthcare Matters (Health Education England, 2016).

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

7.4. Instrumental Swallow Assessment

Where there are unanswered clinical questions relating to a patient's swallow function, instrumental swallow assessment may be appropriate to further investigate the swallow mechanism, determine aspiration risk, identify any texture modification/postural or behavioural strategies which may facilitate safer swallowing and to help guide quality of life decisions for feeding management.

7.4.1. Fibreoptic Endoscopic Evaluation of Swallowing (FEES)

FEES is a SLT led swallow assessment via flexible nasendoscope inserted via the nose which enables visualisation of the naso, oro and laryngopharyngeal structures, secretions, sensory response and pharyngeal swallow function. Trials of different food and fluid textures are given with the scope insitu. It enables identification of any pharyngeal swallow deficit and the detection of penetration or aspiration which may occur pre/peri and post swallow. Key Documents: ENT and Audiology http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1266

Patient Leaflet. 'What is FEES?' Key Documents: Speech and Language, Instrumental Assessment, Leaflets.worcsacute.nhs.uk/~documents/route%3A/download/3324/

7.4.2. Videofluoroscopy (VFS)

VFS is a modification of the standard barium swallow X-ray examination. Oropharyngeal swallowing physiology and anatomy is evaluated as the patient eats and drinks a radiopaque substance such as barium sulphate. The radiopaque substance is mixed with food and drink. The moving images of the swallow enables the identification of any oral, pharyngeal or oesophageal swallow deficit and the detection of penetration or aspiration which may occur pre/peri and post swallow.

At WAHT VFS is undertaken by a Consultant Radiologist and a SLT who are appropriately trained to undertake and interpret this radiological assessment.

Patient leaflet: 'What Is Videofluoroscopy?' Key Documents: Speech and Language, Instrumental Assessment, Leaflets.

https://www.worcsacute.nhs.uk/patient-information-and-leaflets/documents/patient-information-leaflets-a-z/3228-what-is-videofluoroscopy

7.5. Swallow Screens

Early identification of swallow problems reduces the incidence of pneumonia, particularly in stroke (Bray et al, 2017). NICE (2022) and RCP (2023) require that all suspected and confirmed stroke patients have a swallow screen administered within 4 hours of hospital admission. SLT provide training to nurses on the stroke ward and to selected senior nurses on AMU within WAHT to provide a water swallow screen on suitable patients. Stroke Clinical Nurse Specialists are also trained by SLT to administer an advanced stroke swallow screen. Any patient failing the water swallow screen or is placed on modified diet and fluids following the advanced screen should then be referred to SLT.

Water swallow screen.docx

Advanced stroke swallow screen.docx

8. Management of Dysphagia

Following assessment SLTs will provide a clear plan which will be documented in the patient's notes, SLT related actions implemented and where possible, discussed with relevant parties e.g. patient, family/carer, nursing staff, doctor, AHP.

Potential assessment outcomes:

8.1. Nil by mouth (NBM) with need for feeding management plan – see below.
NBM may be recommended where no safe food and fluid textures can be identified, pending medic/MDT discussions about feeding management. Key Documents: Speech and Language or Adult Feeding Decisions.

8.2. Feeding Management Decisions Flowchart
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3821

8.3. Modified diet and fluids.
Altering the texture of food or drinks, with the least restrictive approach, may help to reduce the risk of aspiration, improve comfort, increase quantity of oral intake, enhance quality of life and enjoyment for the patient. There are internationally standardised descriptors for different food and drink textures which can be recommended https://iddsi.org/framework/ . Risks and benefits for modifications need to be considered.
Medics/MDT to consider alternative non-oral nutrition and hydration e.g. NG, PEG, IV fluids.

8.4. Alternative non-oral nutrition and hydration
Alternative methods of providing nutrition, hydration and medication should be considered wherever a patient is unable to meet their needs orally and in context of their overall health presentation. Risks, benefits and complications should be considered. Key Documents: Speech and Language or Adult Feeding Decisions, **Feeding Management Decisions Flowchart** http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3821

8.4.1. **NG feeding** may be considered for short term alternative non-oral nutrition and hydration where swallow function recovery is anticipated or uncertain. Key Documents: Nutrition and Dietetics
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2866

8.4.2. **PEG feeding** may be considered for longer term alternative non-oral nutrition and hydration where a patient is unable to meet needs orally due to being completely NBM or having reduced quantities e.g. for comfort, slow swallow rehabilitation. PEG Policy - Key Documents: Nutrition and Dietetics
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2870

8.5. Feeding at risk.
If a decision to **feed at risk** is made then it with the acknowledgment that a patient will continue to eat and drink despite the associated risks from having dysphagia including aspiration, malnutrition, dehydration and choking (RCSLT, 2021). Key Documents: Speech and Language – Feeding at risk http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3820

8.6 Nutrition MDT.
The **Nutrition MDT** is a multidisciplinary team set up to support decision making around tube feeding. Key Documents: Nutrition and Dietetics
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2871
Medics/MDT to consider referrals for other investigations e.g. barium swallow, OGD.
Medics/MDT to consider referral to other specialities e.g. ENT, gastroenterology.
SLT to consider instrumental swallow assessment (see assessment section).

8.7. Tastes for Pleasure.

Where patients are in the last 72 hours of life and oral intake is not achievable or comfortable they can be offered their favourite drink flavour as part of their oral care regime. Key Documents: Speech and Language – End of Life, or Palliative and End of Life Care http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1673

8.8. Oral care advice.

Maintaining good oral care is essential to keeping the mouth in a healthy condition. Patients who are NBM or having reduced oral intake are more predisposed to oral health problems. Key Documents: Nursing http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2857

Medication review request (see below section).

Timeframe for SLT review (if indicated).

8.9. Discharge from SLT

- Therapy/management is not appropriate or required
- When a patient is no longer progressing, has reached full resolution of their difficulty or they have reached their maximum potential
- Dysphagia and/or choking risk managed or reduced as far as possible
- Patient with capacity is non-compliant with SLT recommendations
- Patient is no longer registered with a GP practice within Trust locality
- Patient self discharges or service refused
- In accordance with DNA Policy
- Transfer to other SLT service e.g. community SLT in patient's locality, community stroke team
- Patient initiated Follow Up (PIFU). Key Documents: Trustwide http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3302

Actions required from MDT when a patient is discharged – see below table:

Requirement	MDT member	Detail
Report to the GP if indicated	SLT	Ensure the GP is aware of the decision and able to support healthcare in the community setting.
Transfer to community SLT caseload if indicated	SLT	SLT will transfer onto community team for follow up if indicated.
Provide written information on diet and/or fluids if indicated	SLT	SLT are able to provide leaflets regarding modified diet/fluids as required to support provision of the required recommendations after hospital.
Verbal handover to discharge destination / care provider as indicated, e.g. care home, family	SLT / Nurse	SLT are able to discuss input during episode of care, give specific details and guidance relating to the patients recommendations, e.g. discussing texture and meal ideas for a puree diet. SLT are only able to complete the verbal handover if aware of the discharge. If out of hours or SLT are not updated, it is the nurse's responsibility to ensure recommendations are handed over.
Completion of discharge / care associated paperwork as indicated	Registered nurse / AHP	Completion of documents to demonstrate discharge, personal care and therapy needs should also state the most recent eating, drinking and swallowing recommendations to the clinical risk is minimised.
Supply of thickening powder for fluids if required	Nursing staff	A sufficient amount should be provided from the ward stock to last the patient until the first prescription can be accessed in the community, e.g., minimum of 1 - 2 tins of thickener.
Decision and recommendations on the hospital discharge summary	Medical team	Allows clear communication of decision and recommendations. This should include the decision whether or not to readmit the patient for acute hospital treatment should they be diagnosed with aspiration pneumonia by the GP. This forms a crucial stage in the process, allowing the patient to leave the acute setting with a clear plan in place informing future management.

		The clinician completing the hospital discharge summary must ensure the most recent eating and drinking recommendations are documented to ensure the clinical risk is minimised.

Table content largely taken from North Devon Trust Dysphagia policy.

9. Therapy

Following assessment, it may be the SLT identifies that a patient is appropriate to participate in a swallow rehabilitation programme or in certain H+N cancer cases, a pre-treatment programme. In WAHT, SLT can offer dysphagia therapy exercises and strategies, EMST and Biozoon. Suitability is led by SLT clinical judgement on a case by case basis.

Key Documents: Speech and Language, Swallow Therapy and Management
http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1807?persist=True

10. Medication:

Medication can have an impact on a patient's swallow presentation. The parent medical team and/or pharmacist should review medicines which may impact a patient's swallow function.

If a change in medication format is required (e.g.crushing or liquid medication), advice must be sought from a pharmacist. Changing the formulation or route of administration of a medicine may require dose change as medicines are not always dose-equivalent when administered by different route (IV / oral), or when administered using different formulations (liquid / tablets / capsules). Changing medication without guidance may render the form unlicensed and could present a risk to the patient.

Key Documents: Medicines http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1566

It has been agreed within WAHT SLT department that patients who require IDDSI Level 4 pureed/Level 5 minced and moist diet will likely need medications in a non-solid format. If SLT has undertaken a swallow assessment and non-solid medication is indicated, SLT will document this in the patient notes. It is the responsibility of the parent medical team to ensure this is actioned.

If a patient is NBM, the medical team should consider an alternative route of medication administration. This is particularly important for patients whose medication administration is time critical e.g. Parkinson's Disease.

11. Documentation:

Staff will adhere to WAHT guidelines and the Health and Care Professions Council (HCPC) standards for record-keeping (HCPC, accessed 2023)**.** When SLT have had a direct or indirect contact with a patient, this will be documented.

Key Documents: Health Records http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1127

11.1 SLT clinical notes

Inpatients: SLT write their entry using the electronic patient record (EPR) – Sunrise for non critical care wards and ICCA for critical care units. They are paperlight for other correspondence which cannot be uploaded to EPR e.g. emails, FEES reports.

Paper notes are still being written for the emergency department.

Outpatients: SLT write their entry on CLIP.

11.2 SLT related documents

11.2.1. If SLT has made recommendations for oral intake, signage will be placed in the patient's bed space. There are signs for NBM, oral trials, full oral intake, feeding at risk.

11.2.2. SLT may provide a Dysphagia Passport where a patient has been recommended full oral intake or is feeding at risk.

Key Documents: Speech and Language:

IDDSI food and fluids textures
http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1756?persist=True

Dysphagia Passport http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3174

All staff who are seeking SLT documentation for current inpatient admissions should refer to SLT entries in the medical notes/Sunrise. For SLT information relating to previous acute inpatient admissions or outpatients, staff should refer to CLIP and/or Sunrise.

11.3 Feed at Risk form

When a feed at risk decision is being made the parent medical team for the patient should complete the Feeding at Risk form.

Key Documents: Speech and Language, Feeding at risk
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3820

Key Documents: Speech and Language or Adult Feeding Decisions, Feeding Management Decisions Flowchart http://whitsweb/KeyDocs/KeyDocs/DownloadFile/3821

12 Choking:

Choking is when there is a partial or complete obstruction in the throat or airway which restricts or blocks airflow into and out of the lungs. Choking is a risk to all people when eating and drinking but for people with dysphagia this risk increases. Other factors which can increase choking risk are poor positioning, poor alertness, eating quickly, cramming food into the mouth, not chewing food before swallowing.

Staff should be aware of an inpatient's CPR status which is identified on their **ReSPECT** form if one is in place, in the event of a respiratory arrest due to choking. Staff should be up to date with WAHT's annual mandatory training in level 2 Adult Basic Life Support.

Key Documents: Resuscitation – ReSPECT
http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1274?persist=True

13 Education and Training:

SLTs will have completed the appropriate undergraduate, post graduate or degree level apprenticeship training to have the required knowledge and skills to assess and manage oral and pharyngeal swallow problems. SLTs are governed by the Health and Care Professions Council (HCPC) and the Royal College of Speech and Language Therapists (RCSLT).

All WAHT staff who have any involvement with patients with dysphagia will be expected to complete a one off ESR e-Learning on Dysphagia Awareness – available soon.

SLTs at WAHT provide education to many forums:

- Placements for SLT undergraduate/postgraduate/apprentice students.
- Swallow screen training (see section 7.5).
- Dysphagia awareness sessions e.g.Nutrition and Hydration Champions, student nurses
- Bespoke dysphagia education where a need is identified and a formal request is made.
- Co-host the Nutrition and Hydration Champions workshop.
- Feeding management presentation to junior doctors and previously delivered similar training to senior doctors.
- Pre-agreed observation sessions for medical students and physician associates.
- Adhoc observations sessions for other health profession students on placement e.g. Student nurses, student OTs, student dietitians.
- Observations days for adults who are seeking experience prior to applying for/commencing a SLT degree course and post 16 work experience students potentially seeking an AHP career.
- Education to patients and their families to support their understanding of their specific swallowing difficulties.

14 Monitoring and compliance

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

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?**
7.5	Swallow screens	Monitoring of competency attainment and record of staff trained	Annually	SLT	SLT department and relevant wards	Annually
8	MDT documentation of SLT eating and drinking recommendations	Datix submission where SLT recommendations have not been recorded or inaccurately recorded on EDS	Monthly	Nutrition and Hydration Steering Group	SLT department, Nutrition and Hydration Steering Group	Monthly
11.1	SLT documentation of SLT eating and drinking recommendations.	SLT case note audit	Annually	SLT	SLT department	Annually

15. Policy Review

This policy with be reviewed every 3 years by senior WAHT SLT staff; Dysphagia Lead/Professional Lead/Other Band 7 SLT.

16. References

Bray BD, Smith CJ, Cloud GC, Enderby P, James M, Paley L, Tyrrell PJ, Wolfe CDA Wolfe, Rudd AG. (2017). Journal of Neurology, Neurosurgery and Psychiatry. The association between delays in screening for and assessing dysphagia after acute stroke, and the risk of stroke-associated pneumonia. 88(1), 25-30. https://www.ncbi.nlm.nih.gov/pubmed/27298147

Marks L & Rainbow, D. *(*2001). *Working with Dysphagia*. Speechmark.
Dysphagia and eating, drinking and swallowing needs overview. https://www.rcslt.org/speech-and-language-therapy/clinical-information/dysphagia/ (accessed March 2023)

Feng MC, Lin YC, Chang YH, Chen CH, Chiang HC, Huang LC, Yang YH, Hung CH. (2019). Journal of Stroke and Cerebrovascular Diseases. The mortality and the risk of aspiration pneumonia related with dysphagia in stroke patients. 28, 1381–1387.

Health and Care Professions Council. Standards of Conduct, Performance and Ethics. https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf (accessed 3/4/23).

Health Education England (2016, updated 2019). Mouthcare Matters. https://mouthcarematters.hee.nhs.uk/wp-content/uploads/sites/6/2020/01/MCM-GUIDE-2019-Final.pdf

International Dysphagia Diet Standardised Initiative. https://iddsi.org/

National Clinical Guideline for Stroke for UK and Ireland (2023), endorsed by the RCP: National-Clinical-Guideline-for-Stroke-2023.pdf (strokeguideline.org)

NCEPOD. (2021). Hard to Swallow? A review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell Dysphagia in people with PD_Hard to Swallow_Full report.pdf (ncepod.org.uk)

NICE guidelines: stroke and transient ischaemic attack in over 16s: diagnosis and initial management (2022) Overview | Stroke and transient ischaemic attack in over 16s: diagnosis and initial management | Guidance | NICE

Odderson IR, Keaton JC and McKenna BS. (1995). Archives of Physical Medicine and Rehabilitation. Swallow management in patients on an acute stroke pathway: Quality is cost effective. 76(12), 1130-1133.

Royal College of Speech and Language Therapists. (2021). Eating and drinking with acknowledged risks: Multidisciplinary team guidance for the shared decision-making process (adults).

17. Background

17.1 Equality requirements

See Supporting Document 1 for details. Nil significant to describe/report.

17.2 Financial risk assessment

See Supporting Document 2 for details. Nil financial cost related to this policy.

17.3 Consultation

Relevant stakeholders were consulted in the development of this policy – see below.

Contribution List

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

Designation
Nil individuals – cross section of relevant professions and advisors achieved via committees, see below.

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

Committee
Therapies Clinical Governance
Medicines Safety Committee
Nutrition and Hydration Steering Group
Speech and Language Therapy Department
Nutrition and Dietetics Department

17.4 Approval Process

Key stakeholders have been consulted and their comments have been considered in the development of this document – see Committee Contribution List above for details. It has also been reviewed by the Medicines Safety Committee.

17.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Supporting Document 1 – Equality Impact Assessment form

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;

NHS Worcestershire Acute Hospitals NHS Trust

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	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Helen Griffiths	Speech and Language Therapy Dysphagia Lead	Helen.griffiths4@nhs.net

Date assessment completed	22.12.23

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Dysphagia Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	See body of document.			
Who will be affected by the development & implementation of this activity?	❑x ❑x ❑x ❑	Service User Patient Carers Visitors	❑x ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ❑x 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.	See body of document.			
Summary of engagement or consultation undertaken (e.g. who and how have you	See body of document.			

engaged with, or why do you believe this is not required)	
Summary of relevant findings	See body of document.

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			
Disability	x			
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		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
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 deprivation, travelling communities etc.)	x			
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that	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
arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts? N/A	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

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	Helen Griffiths
Date signed	22.12.23
Comments:	
Signature of person the Leader Person for this activity	Helen Griffiths
Date signed	22.12.23
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:	

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.