

**Dysphagia**

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| **Policy** |

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| **This Version** | 1.0 | **Status** | Draft |
| **Replaces** | Dysphagia And Nutritional Support Policy  For people living in the community setting and In-Patients in Community Hospitals And Mental Health Units |
| **Approval Date** |  | **Where** |  |
| **Ratification Date** |  | **Where** |  |
| **Date Of Issue** |  | **Review Date** |  |
| **Applies To** | All staff across acute and community working with patients with dysphagia in Somerset | **Exclusions** |  |

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1. **INTRODUCTION**

1.1 The purpose of this policy is to outline procedures to ensure that people with dysphagia are:

* Referred to the appropriate service.
* Receive timely investigation, diagnosis and treatment of their dysphagia.
* Supported to eat and drink as safely as possible minimising risk of aspiration and choking.
* Supported to maximise nutrition and hydration within the context of their swallowing disorder.
* Supported to maximise enjoyment and quality of life around eating and drinking.

1.2 The policy aims to ensure that a multi-professional approach is taken in the care and management of people with dysphagia.

1.3 The policy aims to ensure that family and carers are appropriately involved and informed about the person’s swallowing difficulties and associated nutritional support needs.

1.4 This policy is guided by the Eating and Drinking Competency Framework (RCSLT 2019).

1. **DEFINITIONS**

**Dysphagia**

2.1 A swallowing disorder resulting from a neurological or physical impairment of the oral, pharyngeal or oesophageal structures.

**International Dysphagia Diet Standardisation Initiative (IDDSI)**

2.2 A framework to ensure that food and fluids texture descriptions are standardised and consistent.

**Pharyngeal Pouch (Zenker’s Diverticulum)**

2.3 A small bulge or pocket that occurs in the pharynx (throat).

**Stricture**

2.4 A narrowing in the pharynx or oesophagus.

**NBM (Nil By Mouth)**

2.5 Term used when a person should not have any oral intake, either for medical reasons, such as prior to surgery or because their swallow is not safe.

**Specialist Dysphagia Assessment**

2.6 Carried out by qualified Speech and Language Therapist taking account of the onset of the dysphagia, alertness, respiratory and nutritional status, associated relevant medical conditions and medications, any previous dysphagia assessments and recommendations and the current difficulties associated with eating and drinking.

**Multi-Disciplinary Working**

2.7 An interdisciplinary approach with different professionals working together to provide holistic patient care.

**Service Users**

2.8 This term refers to people with dysphagia, families and carers, education, medical, allied health and social services staff.

**Eating and Drinking Care Plan**

2.9 An individual and holistic plan, made following assessment and diagnosis of dysphagia by a specialist clinician. The plan will include recommendations for food and fluid texture modifications, levels of supervision required and other recommendations relating to dysphagia such as medications, postural advice and oral care etc.

1. **EQUALITY IMPACT ASSESSMENT (EIA)**

3.1 Dysphagia can affect people of all ages, genders, race, economic backgrounds and protected groups. This policy is intended to ensure that people with dysphagia from all groups in society have equal access to prompt assessment, diagnosis and treatment of their dysphagia.

1. **FLOW DIAGRAM**

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| --- |
| Person identified as having swallowing difficulties (dysphagia) |

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| --- |
| Referred to appropriate service for assessment and management |

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| --- |
| Assessment |

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| --- |
| Diagnosis |

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| Involvement of relevant people (MDT, carers etc) |

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| Onward referrals |

|  |
| --- |
| Individualised eating and drinking care plan |

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| --- |
| Following the care plan in various settings |

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| --- |
| Discharge |

**5. ROLES AND RESPONSBILITIES**

**Trust** **Chief Executive**

5.1 The Trust Chief Executive has overall accountability for the effective and safe operation of the Trust, ensuring the safety and well-being of service users and others are taken fully into account at all times.

**Managers**

5.2 Trust Managers and non-Trust Mangers working in partnership with the Trust are responsible for ensuring all their staff are fully aware of this policy and for making sure they follow it at all times.

5.3 Managers could include Community Hospital Matrons, Ward Sisters, Nursing Home / Care Home / Residential Home Managers, Mental Health Unit Managers, Hotel Service Mangers etc.

5.4 The above managers have a responsibility to ensure that the ward and nursing staff / care teams have in place the necessary systems and processes required to ensure the safe management of people diagnosed with dysphagia, and that eating and drinking care plans are followed in full.

5.5 Managers for people with Learning Disabilities (LD) living in their own homes should follow the escalation plan in the person’s eating and drinking care plan and contact 111 for advice or dial 999 in an emergency and also inform Speech and Language Therapy (SLT) via the following email address: [CTALDHealthReferrals@SomersetFT.nhs.uk](mailto:CTALDHealthReferrals@SomersetFT.nhs.uk).

5.6 Managers will ensure that any new advice or update to policy, procedure and change to operational policy is cascaded and implemented immediately.

5.7 Managers have a responsibility to ensure their staff have adequate awareness of dysphagia and competencies to manage dysphagia. This includes being aware of and compliance with IDDSI (descriptors for modifications to diet and fluids); and with safe eating and drinking procedures (Appendix B).

5.8 Managers should have full working knowledge of the Eating Drinking and Swallowing Competency Framework (RCSLT et al 2020). Managers should identify the level of dysphagia competence required by each team member and ensure they have the necessary training required and can demonstrate competence to the appropriate level.

5.9 Managers are responsible for ensuring that IDDSI compliant meals and snacks are available at all times to enable the eating and drinking care plan to be followed.

5.10 Managers are responsible for complying with the patient safety alert relating to the use of thickening powder (NHS England 2015) which outlines the risk of death from asphyxiation by accidental ingestion of fluid / food thickening powder.

5.11 If a person is identified as having a swallowing problem out of hours (currently Speech and Language Therapists work from Monday to Friday), the manager should discuss this with the doctor on call (acute hospital). For community hospitals and care homes, staff should contact 111 for advice or dial 999 in an emergency. The doctor or consultant in charge of the person’s care will need to make a decision whether the severity of the dysphagia warrants acute hospital admission, or if already on a ward whether they need to be ‘Nil By Mouth’ (NBM).

5.12 All persons identified as being unable to swallow (aphagia) or presenting with very high risk symptoms such as frequent coughing and choking episodes should be placed NBM until assessed by the relevant professional (see Appendix A).

**GPs, Doctors And Consultants**

5.13 GPs, Doctors and Consultants have overriding responsibility of individuals under their care.

5.14 When a person either in the community or on a ward setting is identified as having a difficulty swallowing, the GP, Doctor or Consultant in charge will need to consider the following:

* Whether the problem is new or existing.
* Whether there is an existing eating and drinking care plan in place (including potential eating and drinking with acknowledged risk care plan).
* The nature and severity of the problem.
* Whether the patient needs to be placed ‘Nil by Mouth’ pending further investigations.
* If the patient is placed ‘Nil by Mouth’, whether they require any non oral nutrition and / or hydration.
* If the patient is not placed ‘Nil by Mouth’, what they will eat and drink with reference to the IDDSI framework as well as the rationale for the decision.
* Whether the patient needs to be referred to SLT, ENT, or Gastroenterology (see Appendix A).

**Ears Nose And Throat (ENT)**

5.15 ENT are responsible for assessing and treating patients referred with ‘red flag’ dysphagia symptoms as part of the two week wait including progressive, persistent high (cervical) dysphagia which is worse with solids than liquids, weight loss, smoking history, history of excess alcohol intake, throat pain, hoarseness, neck lump, feeling of restriction in throat area, previous radiotherapy for head and neck cancer.

5.16 ENT will manage any surgical interventions required to treat dysphagia such as stapling of pharyngeal pouch, dilatations to manage high (hypopharyngeal / cervical oesophageal) strictures and cricopharyngeal spasm etc.

5.17 ENT will order any investigations required to support a medical diagnosis to account for the cause of dysphagia.

5.18 ENT will work closely with Speech and Language Therapists, Gastroenterologists, and GP’s to ensure holistic management of a person’s dysphagia.

**Gastroenterology**

5.19 Gastroenterology are responsible for assessing and treating swallowing symptoms arising from impairment of the oesophagus, stomach and bowel.

5.20 Gastroenterology are responsible for assessing and managing the following symptoms; dysphagia associated with pain or feeling of restriction in chest / behind breastbone, vomiting, nausea, regurgitation, reflux, food sticking in oesophagus, oesophageal dysmotility, hiatus hernia, gastritis etc.

5.21 Gastroenterologists will work closely with ENT, GPs and Speech and Language Therapy to ensure holistic management of a person’s dysphagia.

**Adult Speech And Language Therapy** **(Adult SLT)**

5.22 The Adult SLT team are responsible for the assessment, diagnosis and management of adults with acquired oral, pharyngeal and / or oropharyngeal dysphagia.

5.23 It is currently outside of the scope of Speech and Language Therapists to manage oesophageal dysphagia.

5.24 If patients present with a mixed presentation of oropharyngeal and oesophageal dysphagia, the Speech and Language Therapist will manage the oropharyngeal dysphagia symptoms but will recommend onward referral to Gastroenterology for management of the oesophageal symptoms.

5.25 Although a Speech and Language Therapy assessment considers how people with dysphagia are managing their medications and whether solid dose medications are safe, it is outside of the scope of practice of Speech and Language Therapists to give any advice relating to altering the form of a medication or taking medications with foods or thickened drinks (see section below on management of medications).

**Out Patients, Community Hospitals And Mental Health Units**

5.26 The Adult Speech and Language Therapy Service will carry out a prompt (aim within two working days) telephone triage assessment for all referrals into the service to ascertain whether the referral has been made to the appropriate service, the urgency of any intervention required and provision of interim advice to manage risk whilst a person is waiting for further assessment and / or investigations.

5.27 Following triage if further assessment is required, this will be carried out either face to face in clinic or the person’s home, or remotely using Attend Anywhere (AA).

5.28 Following assessment the person will be provided with an individualised eating and drinking care plan, made in agreement with them (if they have capacity) or in their best interests if they don’t have capacity.

5.29 Reasonable adjustment will be made with the advice given to take into account patient specific needs, also their cultural and religious preference.

5.30 Speech and Language Therapists will liaise with carers, other Allied Health Professionals, GPs and Consultants as required in order to facilitate a multi professional approach to managing the person’s dysphagia.

**In-Patients (Acute Settings And Stroke And Neuro Rehabilitation Units)**

5.31 The Adult Speech and Language Therapy Service will carry out a prompt (aim within two working days) face to face assessment.

5.32 Recommendations to manage the person’s dysphagia will be made in agreement with the person or in their best interests if they are deemed to not have capacity. The recommendations will be communicated verbally with nursing staff and recorded in the person’s medical notes. A yellow bedside poster will be displayed with a summary of any food / fluid modifications and supervision requirements.

**Adults With Learning Disabilities (ALD) Speech And Language Therapy**

5.33 The Specialist Health Learning Disabilities (LD) Team, Speech and Language Therapists are responsible for the assessment, diagnosis and management of adults with learning disabilities with eating, drinking and swallowing difficulties.

**Acute Hospital Support**

5.34 When a person with learning disabilities is admitted to an acute hospital, Musgrove Park Hospital (MPH) or Yeovil District Hospital (YDH), their eating and drinking care plan should be followed by nursing staff. If there are concerns about the person’s swallowing then a referral can be made to the Adult Speech and Language Therapy in-patient team in the usual way. The Adult Speech and Language Therapy team will liaise with the treating Learning Disabilities Therapist to ensure the person receives the most appropriate care and support.

**Community Hospital Support**

5.35 When a person with learning disabilities is an in-patient in a community hospital, their eating and drinking care plan should be followed by nursing staff. If there are concerns about the person’s swallowing, the LD team should be contacted for advice.

**Children and Young People’s Therapy Service (CYPTS)**

5.36 The paediatric dysphagia Speech and Language Therapists are responsible for the specialist assessment, diagnosis and management of children and young people with eating, drinking and swallowing difficulties.

**Paediatric Support for Acute Hospitals**

5.37 The (CYPTS) provides an in-reach service to the children’s wards and Neonatal Intensive Care Unit (NICU) at MPH and YDH. All referrals are seen promptly (aim within two working days). Following assessment the child / young person will be provided with an individualised eating and drinking care plan. Speech and Language Therapists will liaise with carers, ward staff, other AHPs and Consultants in order to facilitate a multi-professional approach to managing the child’s / young person’s feeding and swallowing. After discharge from hospital, Speech and Language Therapists will follow-up the child / young person in the community if needed with no new referral required.

**Multi-Disciplinary Feeding Clinic**

5.38 Clinical Lead Speech and Language Therapist will provide input to MDT Feeding clinic which is held six times annually and attended by Paediatrician, Paediatric Dietitian, Clinical Lead Paediatric Occupational Therapist and Clinical Lead Paediatric Speech and Language Therapist.

**Dietetic Services**

5.39 Dietitians will complete a nutritional assessment to determine whether the service user is meeting their nutrition and hydration requirements.

5.40 Dietitians are responsible for developing a nutritional care plan, considering service users’ current clinical status, symptoms, past medical history, dietary requirements, cultural and / or religious beliefs, ability to eat and drink, ability to chew and swallow (documented in dysphagia care plan), cognitive and communication abilities.

5.41 Dietitians will make onward referrals to Speech and Language Therapy, ENT or gastroenterology when a person reports swallowing difficulties during their assessment.

5.42 Dietitians will adhere to advice given by Speech and Language therapists in relation to texture modification when providing service users with advice and in developing a nutritional plan. This includes ensuring that any oral nutritional supplements they prescribe are of a suitable IDDSI level.

5.43 Dietitians will work closely with Speech and Language Therapists to manage a person with dysphagia’s nutrition provision, especially in relation to texture modified meals and/or snacks requiring fortification.

5.44 For those who are identified as not meeting their nutritional requirements orally, dietitians will support decision making in relation to artificial nutritional.

**6. REFERRALS**

**Flow Chart**

6.1Who Should I Refer To? (see Appendix A).

**Referral To ENT Department**

6.2 Out patient referrals can be emailed to: [entsecretaries@somersetft.nhs.uk](mailto:entsecretaries@somersetft.nhs.uk).

6.3 In-patients requiring an ENT review, a redtop referral should be sent via: <http://intranet.tsft.nhs.uk/a-z/red-top-referral-form-(electronic)/>.

**Referral To Gastroenterology Department**

6.4 Out patient referrals can be emailed to: [gastroenterologysecretaries@somersetft.nhs.uk](mailto:gastroenterologysecretaries@somersetft.nhs.uk).

6.5 In-patients requiring a gastro review, a redtop referral should be sent via: <http://intranet.tsft.nhs.uk/a-z/red-top-referral-form-(electronic)/>.

**Referral To Adult Speech and Language Therapy Service**

6.6 Referrals for in-patients and out patients can be made by completing the form on the internet / intranet: <http://intranet.sompar.nhs.uk/operational-services/community-services/speech-and-language-therapy-adult/>.

**Referral To Paediatric Speech and Language Therapy Service**

6.7Children and young people with eating, drinking and swallowing difficulties should be referred using the CYPTS Referral Form and Additional Information Form – both available on the Somerset NHS Foundation Trust Website –CYPTS or an Early Help Assessment Form (EHA). Referrals should be sent to: [CYPTSReferrals@somersetft.nhs.uk](mailto:CYPTSReferrals@somersetft.nhs.uk) where they will be triaged. Patients referred from community will be seen within 15 working days. We aim to see ward referrals within two working days.

**Referral To ALD Speech and Language Therapy Service**

6.8 The Specialist Learning Disability Health Team has an open referral policy. All referrals are received via the Single Point of Access email address: [CTALDHealthReferrals@SomersetFT.nhs.uk](mailto:CTALDHealthReferrals@SomersetFT.nhs.uk).

6.9 Dysphagia referrals are triaged within 24 hours of receipt. Referrals can be submitted by email or by completing and emailing the Specialist Learning Disability Health Team referral form to the above email address. Dysphagia response times within the Learning Disability Speech and Language Therapy Service are currently:

* **High Risk** – within two working days.
* **Moderate Risk** – within ten working days.
* **Low / Mild Risk** – within three to six weeks.

**Referral To Dietitian**

6.10 The Community Dietetic Team has an open referral policy. The team covers community hospitals, mental health units as well as community services. All referrals are received via the Single Point of Access email address: [DieteticsReferrals@SomersetFT.NHS.uk](mailto:DieteticsReferrals@SomersetFT.NHS.uk).

6.11 For community referrals, the referral form can be accessed from the public website: <https://www.somersetft.nhs.uk/dietetics/referring-to-community-dietetic-services/>.

6.12 Alternatively a clinic letter will also be accepted as a referral to the Service. Any urgent referrals should be marked appropriately. All referrals are triaged and prioritized according to clinical need with the Community Dietetic Team aiming to review patients requiring urgent intervention within two weeks.

6.13 For adult in-patients at Musgrove Park Hospital, referrals should be made using the online referral form which can be found on the former acute services intranet under A-Z (Nutrition and Dietetics). Patients will be triaged based on information provided in the referral form, with the aim that patients requiring tube feeding are seen within one working day, and others who require oral nutritional support are seen within two to three working days.

6.14 Referrals for adult oncology dietetic out patient services at MPH should be made using the referral form under A-Z (Nutrition and Dietetics). Alternatively, referrals can be made by letter at uploaded to Maxims. Referrals will be triaged with patients requiring urgent dietetic advice being seen within two weeks.

**7. ASSESSMENTS**

7.1 Once referred to the appropriate service, people with dysphagia will be triaged and booked for any relevant diagnostic assessments, which could include the following:

* **ENT** - Direct visualisation with flexible nasendoscope, followed by CT Scan or MRI if indicated.
* **Gastroenterology** - Oesophageal Gastro Duodenoscopy (OGD).
* **Barium Swallow** - Dynamic Xray of the swallow using fluids.
* **Barium Swallow with solid bolus** - ENT Consultants may request a solid bolus trial with a marshmallow providing the patient is not at risk of choking.
* **Speech and Language Therapy** - Bedside Specialist Dysphagia Assessment followed by Videofluoroscopy (VF) – where appropriate (dynamic Xray of the swallow using fluids and solids).

Note - separate Trust SOPS are available for each of these procedures.

7.2 Children and young people requiring videofluoroscopy will be referred to the Speech and Language Therapy team at the Bristol Royal Hospital for Children (BRHC). They are required to have a BRHC Consultant to access this service. Any young person with adult anatomy can access videofluoroscopy through the Somerset Foundation Trust Adult Speech and Language Therapy Service.

1. **DIAGNOSIS**

8.1 Following assessment, once a diagnosis has been made, the person with dysphagia will receive an individual eating and drinking care plan to support the management of their difficulties. They will also receive any relevant advice leaflets, signposting to relevant websites and / or support groups.

1. **INVOLVEMENT OF RELEVANT HEALTH PROFESSIONALS AND CARERS**

9.1 The person with dysphagia will be at the centre of the management plan for the dysphagia and will need to consent (if they have capacity to do so) to any further involvement from other health professionals and / or onward referrals.

9.2 Other Health Professionals who can support people with dysphagia could include (but not limited to the following):

* **Occupational Therapists** (to support with specific feeding utensils, food textures, sensory advice etc).
* **Physiotherapists** (to support with posture, head positioning etc).
* **Dietitians** (to optimise nutritional and hydrational intake).
* **Pharmacy** or **GP** (to support with potential side effects from medications that could be exacerbating dysphagia and / or reviewing solid dose medications that are difficult to swallow).
* **Mental Health**, **Psychological** or **Counselling Services** (to support with either psychogenic or functional disorders and / or support with the psychological impact of living with dysphagia).

9.3 Carers should be involved (with the person’s consent) in order to support with the provision of specific modified food and fluids textures and / or supervision requirements.

9.4 When professional advice is given to a person with dysphagia, they do not have to follow the plan (regardless of the setting they are in) if they have the capacity to understand the risks of not following the advice. If they do not have capacity, then a decision is made in their best interests.

1. **FOLLOWING A DYSPHAGIA CARE PLAN (IN-PATIENT AND CARE HOME SETTINGS)**

10.1 All in-patient and care home settings have a responsibility to carry out patient care for a patient with dysphagia as advised by the Speech and Language Therapist, ENT Consultant or Gastroenterologist. In in-patient settings the eating and drinking care plan recommendations are summarised on a yellow poster displayed at the bedside. Care Homes are provided with written care plans.

10.2 On admission to an in-patient ward or care home, nursing staff should check with the patient (or carer if they lack capacity) whether they have any difficulty swallowing and whether they currently have an eating and drinking care plan. If they have a care plan, nurses need a copy of this, so that the recommendations can be followed during the admission. If they don’t have swallowing care plan but are reporting difficulties, they should be referred to the appropriate service.

10.3 Prior to giving a patient a meal, the ward nurse or care home nurse / carer should check the meal is the correct IDDSI level recommended in the eating and drinking care plan (or yellow poster for in-patients) and check that the meal itself is compliant with the IDDSI descriptors.

10.4 Texture modified meals required in Musgrove Park Hospital can be ordered using the form on the intranet (under Catering).

10.5 All care given to the patient relating to dysphagia must be clearly documented in the multi-disciplinary evaluation record.

10.6 Ward and care home nurses and health care assistants have a responsibility to act upon any concerns from carers or relatives about a patient’s swallowing and pass on these concerns to the treating Speech and Language Therapist or activate a new dysphagia referral as appropriate.

* 1. On discharge from an in-patient ward, nurses should ensure that any swallowing recommendations, or care plan are handed over in full. Details should be documented on the discharge summary.

* 1. If a person with dysphagia is not managing the diet and fluid texture modifications as detailed in their eating and drinking care plan, the Speech and Language Therapy team should be notified immediately by ringing 01823 617464. Nursing staff with appropriate knowledge of the IDDSI framework and dysphagia competence should liaise with the medic in charge of the person’s care to discuss and decide whether the person should be placed Nil By Mouth or whether it is safe to downgrade (i.e. trial the next Level down as per the IDDSI framework) in order to help minimise risk, pending further advice and assessment from Speech and Language Therapy. All such decisions and rationales should be fully recorded in the person’s medical notes.

1. SUPERVISION

11.1 If supervised eating and drinking is required for person diagnosed with dysphagia and associated nutritional difficulties, it will be documented in the eating and drinking care plan (or yellow poster for in-patients) and the multi-disciplinary health progress / medical notes following the Speech and Language assessment. Supervision will be discussed with the named nurse for the patient, or the person’s carer.

Levels Of Supervision

11.2 Full Supervision - The person with dysphagia should not be left alone with food or drinks. Supervision requirement is one to one. The person may also require support and assistance to eat and drink.

11.3 Distant Supervision - The person with dysphagia can eat independently but is at higher risk of choking so should not be left completely alone to eat and drink. The person does not require one to one supervision, but the person supervising is available close by and within sight / hearing distance to support if the person gets into difficulties.

11.4 The following are reasons why a person might require supervision:

* 1. **Poor Nutritional Intake**

If not specifically associated with dysphagia the patient may need prompting to eat and be encouraged to increase their food intake, or may have physical difficulties associated with self-feeding.

* 1. **Difficulties With The** **Oral Phase Of Swallowing**

The patient may need reminding to chew their food, to take smaller mouthfuls, or to be assisted with their feeding due to weak oral musculature.

* 1. **Risk Of Aspiration And Choking**

If not supervised due to cognitive issues or other, the patient may be able to feed themselves but needs supervision to ensure they follow the advice given by the Speech and Language Therapy Service, such as using a repeat swallow to clear all food residues prior to taking another mouthful of food or eating more slowly.

11.5 When working in supervision situations it is essential that the following points are adhered to:

* 1. If someone needs assistance / supervision whilst eating, it is important that the person supervising them is focussed on what they are doing and can give the patient their undivided attention.
  2. When supervising, the carer encourages the patient to follow the strategies as advised by the Speech and Language Therapist, e.g. encourage repeat swallows, head turns, use of upright posture.
  3. Should relatives / carers wish to supervise a patient during mealtimes, this should be encouraged and supported by the ward staff and be in accordance with their management plan (with the patient’s consent).

1. **SPECIFIC GUIDANCE**

Mental Capacity Act

12.1 All staff supporting adults with dysphagia are required to adhere to the following:

* Somerset Foundation Trust Consent and Capacity to Consent to Treatment Policy.
* The Mental Capacity Act (2005).

**Management Of Medications for Persons With Dysphagia**

12.2 Following a diagnosis of dysphagia it may be necessary to change the form in which medications are given. A pharmacist or prescriber should always be consulted as changes to the amount of medicine or how often it is given may need to be made.

12.3 A pharmacist or prescriber should be consulted before crushing medications or opening capsules as this can affect the way the medication works. Some medications should never be crushed or opened such as modified release (slow or extended release) tablets or capsules, enteric coated tablets or capsules, hormone steroid antibiotic or chemotherapy medicines.

12.4 When solid dose medications are unsafe (but the medication is essential) the prescriber or pharmacist should review whether it is available in an easier / safer to swallow version. For example, dispersible / soluble tablets, liquid preparations, patches which can be applied to the skin, suppositories or injections. This information can be found in the British National Formulary (BNF), but a pharmacist or prescriber should always be consulted as changes to the amount of medicine or how often it is given may need to be made. In certain circumstances when an alternative is not available and it is not suitable to open capsules or crush tablets, liquid medicines can be ordered from specialist manufacturers.

12.5 When solid dose medications are unsafe and no alternatives are available a Medical Prescriber should review whether the medication is necessary. It might, in some instances, be more appropriate to stop the treatment, either temporarily or long term.

**Hospital Admissions**

12.6During the clerking in process, nursing staff should routinely establish whether a patient has any swallowing difficulties and whether they have either a hospital passport, an eating and drinking care plan or an eating and drinking with acknowledged risk care plan.

12.7 Nursing staff will need to follow any care plan, and ensure that food and drink provided are offered in compliance with the IDDSI framework.

12.8 For patients who lack capacity to discuss their swallowing difficulties or care plans, nursing staff should discuss their eating and drinking requirements with either their POA for Health, next of kin or carer.

12.9 Where there are concerns that a person’s swallowing has deteriorated and that the care plan is not relevant, up-to-date or effective then the Doctor or Consultant in charge of the person’s care needs to be consulted so they can make a decision in line with their responsibility outlined in 5.13.

**Hospital Discharges**

12.10On discharge from hospital, the person in charge of the discharge summary should ensure that recommendations made during the admission regarding eating and drinking, food and fluids modifications, supervision etc are included.

12.11 If a person with dysphagia is being discharged to another NHS setting or Care Home then a verbal hand over in addition to the discharge summary should be made.

12.12 If a person with dysphagia is prescribed thickener during their admission, the discharging ward should ensure this is available to the person taking over the care as well as ensuring it is added to the GP prescription.

**Oral Care**

12.13 People with dysphagia are at higher risk of aspiration from pathogenic material in the oral cavity. Therefore, stringent oral care is essential (see Separate Trust Policy on Oral Care).

**Eating and Drinking With Acknowledged Risk**

12.14 See Separate Trust Policy on Eating and Drinking with Acknowledged Risk.

**Incident Reporting On Radar**

12.15 All adverse events should be reported on the Trust’s Radar system. Such events could include (but are not limited to):

* SLT care plan / recommendations not being followed.
* Incidents relating to poor oral care.
* Choking / significant aspiration incidents which could have been avoided.
* Incidents relating to poor hand over of care across settings.
* Incidents relating to lack of dysphagia awareness and training.

**13. DISCHARGE**

13.1 The treating clinician will decide with the patient when it is appropriate to discharge them from the service.

13.2 Decisions will be made using the Trust’s Patient Initiated Follow Up (PIFU) guidance and adapted as per the individual service SOP for PIFU.

**14.** **TRANSITION**

14.1 If a young person will require ongoing support within Adult Services or the Adult Learning Disability Team, the CYPTS Speech and Language Therapist will contact the relevant team before the young person’s seventeenth birthday to discuss this transition and any ongoing needs that the young person has. As in paediatric services, the adult teams work in episodes of care so the young person will be assessed and offered interventions as and when needed.

14.2 The Adult Speech and Language Therapy team will occasionally accept a referral for a young person with dysphagia under the age of 18. Such referrals will be considered on a case by case basis.

**15. TRAINING / COMPETENCE REQUIREMENTS***.*

* 1. All Managers, line managers and clinical staff working with people with dysphagia should be aware of the Eating, Drinking and Swallowing Framework (RCSLT RCN RCP BDA NACC 2020).
  2. Managers should identify each staff member, their role with dysphagia and plan their training needs in accordance with the Competency Framework.
  3. IDDSI (bite-sized) training is available on OWL. All catering staff, hospitality staff, and direct facing clinical staff should complete this training.
  4. Free Dysphagia Training is available via NHS England <https://www.e-lfh.org.uk/programmes/dysphagia/> (the module is called Dysphagia Essentials).
  5. Trust wards / departments can request bespoke training from the Adult Speech and Language Therapy Service.

15.6 Paediatric Speech and Language Therapists will provide training for carers and care staff to whom the responsibility for supporting eating and drinking difficulties has been delegated, in order to increase their awareness and understanding of eating and drinking difficulties. It is expected that schools and other organisations accessing the service will provide the opportunity for regular training and updates for staff by the designated therapist, to ensure safe and appropriate continuity of care.

* 1. All Speech and Language Therapist’s involved in the management of eating, drinking and swallowing will have this stated in their job description and will have completed appropriate post graduate dysphagia competences.
  2. Learning Disability Speech and Language Therapist’s can provide in-house training for carers when the person with learning disabilities dysphagia needs are complex and require careful management.
  3. Learning Disability Speech and Language Therapist’s offer two levels of dysphagia training via e-Learning and face to face.

**16. MONITORING**

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| --- | --- | --- | --- | --- | --- |
| **Element of policy for monitoring** | **Section** | **Monitoring method -**  **Information source (e.g. audit)/ Measure / performance standard** | **Item Lead** | **Monitoring frequency /**  **reporting frequency and route** | **Arrangements for responding to shortcomings and tracking delivery of planned actions** |
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**17. REFERENCES**

8.1 Eating And Drinking With Acknowledged Risks: Multidisciplinary Team Guidance For The Shared Decision-Making Process (Adults) (RCSLT 2021). <https://rcslt.org>.

8.2 Eating, Drinking Swallowing Competency Framework (RCSLT 2019). <https://www.rcslt.org/speech-and-language-therapy/clinical-information/dysphagia#section-4>

8.3 International Dysphagia Diet Standardisation Initiative (IDDSI) (online @ <https://iddsi.org>)

8.4 The Mental Capacity Act (2005) Guidance available (online @ [Mental Capacity Act - NHS (www.nhs.uk)](https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/)

Diagram

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**APPENDIX A**

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**APPENDIX B**