Management of patients with dysphagia policy

Name of Policy Author & Title:	Kate Blick Operational Manager SLT
Name of Review / Development Body:	Speech & Language Therapy (SLT) Policy / Standard Operating Procedure development and review group
Ratification Body:	Quality, Safety, Effectiveness and Patient Experience Group
Date of Ratification/ effective from	August 2019
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Reviewing Officer:	Kate Blick

Please note

The Royal Surrey Foundation Trust Speech and Language Therapy (SLT) services have kindly agreed to share this with the Surrey Safeguarding Adults Board and their partner agencies for information only. Referrers will need to follow their own local Speech and Language Therapy service guidance on making referrals for their hospital/ community patients.

Version Control

Date	Review Type (please tick)		Version No.	Author of Review	Title of Author	Date Ratified	Ratification Body	Page Numbers (where amended)	Line Numbers (where amended)	Details of change	
	Minor amendment	Full Review								Inserted	Deleted
June 2015	✓		2	Gill Chapman	Head of SLT	June 2015		5	5.2.2	Regional Cancer Network	SWSH Cancer Network
October 2017		✓	3	Kate Blick	Operational Manager SLT	Nov 2017					
May 2019		✓	4	Kate Blick Charlotte Houghton	Operational Manager acute SLT SLT team lead, community	August 2022					

Contents

1. INTRODUCTION / BACKGROUND

Dysphagia (difficulty swallowing) describes eating and drinking disorders which may occur in the oral, pharyngeal and oesophageal stages of swallow. Contained in this definition are problems positioning food in the mouth and in oral movements, including sucking, mastication and the process of swallowing. The 'normal' swallow needs the respiratory, oral, pharyngeal, laryngeal and oesophageal anatomical structures to function in synchrony, which is dependent upon the motor and sensory nervous system being intact.

Dysphagia can result in aspiration, when food or fluids (including saliva) enter the airway and lungs, increasing the risk of chest infections and aspiration pneumonia. Dysphagia can also result in choking when an obstruction completely blocks the airway leading to an inability to breathe. Choking can also occur without the presence of a pre-existing dysphagia. Whilst it is not possible to prevent all episodes of choking, Speech and Language Therapists are able to provide specialist assessment and advice on the management of dysphagia, including reducing risk of aspiration pneumonia and choking.

Other consequences of dysphagia include malnutrition, dehydration, medication management difficulties and reduced quality of life.

Dysphagia can be caused by or exacerbated by the effects of neurological conditions, cognitive impairment, physical trauma, cancer such as head & neck or lung cancer, medication side effects, frailty and the normal aging process which can bring about changes in swallow mechanism impacting on function. Both aspiration and choking can be fatal.

The speech and language therapist (SLT) has a key role in assisting patients to make informed decisions when balancing the risks and benefits of treatment options.

- Speech and language therapists have a key role in educating/training others in identifying, assessing and managing dysphagia.

- Persons with long-term conditions, who have transient, intermittent, persistent or progressive dysphagia often remain at risk of the complications associated with dysphagia and require the SLT to monitor and review progress over time.

RCSLT website (accessed 16/10/17)

2. PURPOSE

To provide clear guidance on roles and responsibilities of The Royal Surrey County Hospital acute and community staff for the management of dysphagia. The aim of this policy is to ensure safe and effective management for patients with actual or suspected dysphagia. To outline the role of the Rapid Response SLT and Basic Swallow Screen Test (BSST) training coordinator (acute only) and referral guidelines to acute and community SLT services.

3. SCOPE OF POLICY

Inclusions

This policy applies to all RSCH SLT staff working with adults with dysphagia.

It also includes student SLTs during their clinical placements.

Newly qualified SLT staff must complete their post graduate training and dysphagia competencies before working independently. Student SLTs and SLT assistants/technicians will only work under supervision of the SLT. Student SLTs follow the guidance of their individual University curriculum. Clarification of their dysphagia specific course objectives needs to be considered when planning their clinical timetable.

Hospital patients will be seen either on the wards whilst inpatients or as an outpatient (head and neck or neuro-oncology patients only) at the RSCH or within the regional cancer alliance.

In community, patients are seen either in their own place of residence (own homes or care homes), as out-patients at Milford or Haslemere, or as inpatient on the wards at Milford and Haslemere hospitals. Patients will be seen exceptionally at other sites as most suits their clinical need e.g. Beacon centre, day centre, other community locations

Exclusions

SLTs employed by RSCH do not have any skills or competencies to manage children or neonates with feeding difficulties or dysphagia as they work exclusively with adults.

4. DUTIES & RESPONSIBILITIES

a. Directors:

Have overall accountability for all aspects of patient safety including health and safety standards, within the Trust. Trust Directors are responsible for the implementation of all relevant policies and arrangements within their areas of control and to lead their managers and staff in proactive and effective risk management.

b. Director of Nursing (DON):

Is the Board member responsible for ensuring there are appropriate systems and processes in place for the management of dysphagia.

c. Department Manager

The Operational Managers in acute and community are responsible for distributing this document and ensuring that it is easily available to all staff (including bank, agency, contracted, locum and student SLTs).

The Operational Managers in acute and community are responsible for ensuring that all therapy staff involved with managing patients with dysphagia have received the appropriate training and supervision.

Is responsible for ratifying this Policy on a three-yearly basis and monitoring the effectiveness of this policy

d. Registered Speech & Language Therapists / Nurses

All staff involved in managing patients with dysphagia are responsible for:

- Ensuring that they follow the processes laid out within this policy.
- Maintaining their competencies through BSST updates, personal study and reflective practice, documenting evidence on their RCSLT CPD log (SLTs) and highlighting any training needs as part of the Trust's appraisal process.

5. MANAGING PATIENTS WITH DYSPHAGIA – IN THE ACUTE SETTING

Accepting referrals for inpatient dysphagia management

Inpatients should ideally have been assessed by a BSST competent nurse prior to being referred. If this has not been carried out, the ward should be asked to complete a BSST if feasible. If a patient has failed a BSST, the nurse should refer the patient directly to the Rapid Response SLT (for a formal dysphagia assessment. The target response times are within 4-6 hours during working hours (Mon-Fri 08.00-16.00).

When accepting 'phone referrals for a new patient, the following information should be collected and the Rapid Response SLT contacted:

- Ward, date and time of referral
- Brief clinical details (reason for admission, current status etc.)
- Outcome of BSST

If not available e.g. Rapid Response SLT on leave, the ward should be given an approximate time to expect an assessment and the referral prioritised

within the existing caseload. Current response times recommended by the RCSLT are within two working days. If the SLT department are experiencing staffing shortages and plan to work to the Business Continuity Plan, wards will be notified via the communications team. The MDT should be aware of, and complete, the Nil By Mouth flowchart for patients who are NBM for longer than 12 hours (see Nil by Mouth Policy).

Accepting patients for outpatient dysphagia management at RSFT

Referrals for outpatient video fluoroscopy are accepted as per the current policy for Video fluoroscopy.

Patients with head & neck cancer who are discharged from the RSFT/St Luke's Cancer centre will be seen by The Macmillan Aftercare Rehabilitation Service (MARS) as outpatients within the regional cancer network.

Patients with a neuro-oncology diagnosis will be seen by the neuro-oncology specialist SLT as an outpatient or, if necessary, in the community including the patient's home or hospice.

Any referrals from GPs or hospital consultants for outpatient assessments, with diagnoses other than those above, should be returned with a covering letter together with the contact details for the appropriate community SLT service. The exception is when the patient/GP is located within the RSFT community SLT catchment area, in which case they will be referred directly to this service.

Pre-assessment considerations

The following points are recommended to ensure a comprehensive assessment: however, there may be exclusions due to individual patient circumstances.

Background information on dysphagia - obtained from the patient's notes, patient or carer, nurses or other professionals involved. Specific information on past medical history (PMH), current oral intake and duration/type of symptoms should be included. If the patient is known to community SLT, they should be contacted for advice on current feeding regimes and any existing concerns.

Current status - relevant details on cognitive state, level of consciousness, fatigue, positioning issues, respiratory status, oral hygiene, co-operation, general medical condition

Tracheostomy Status – SLTs should have completed their RCSLT tracheostomy competencies prior to independent assessment of dysphagia in tracheostomised patients.

Consent – verbal explanation of the assessment **must** be given prior to dysphagia assessment to enable the patient to give their informed consent. Consent should be obtained verbally (if possible): otherwise, it may be

considered in the patient's best interests if the patient is cooperative, accepts the bolus or doesn't seem distressed by the SLT's presence. Consent should be documented in the patient's notes. If consent is not given or in the patient's best interests, further assessment should **not** be carried out, the medical team informed and the patient assessed at a future date. If the patient is deemed to have capacity and refuses SLT input, this should be discussed with the patient, the medical team and SLT before agreeing on any further management decisions.

During the assessment

Assessment of dysphagia will vary greatly between patients according to individual differences in mood, fatigue, cooperation and functional ability. A comprehensive assessment may take more than one session to complete and therefore, initial recommendations may need to be revised at a later stage. Reduction of aspiration risk and optimal, safe oral intake are the primary goals. These should be considered in line with the patient's diagnosis, prognosis and views. Each SLT will have their own preferred order and style of conducting an assessment but it should include the areas outlined below.

The SLT should introduce themselves to the patient and explain the purpose and format of the assessment.

The patient must give their consent for the assessment (see 5.3.3)

The patient should be positioned in the bed/chair, ideally at 90^{o}. Staff must have attended their Manual Handling training before moving patients, otherwise, nursing staff will need to reposition the patient prior to assessment.

Personal Protective Equipment must be used during any assessment due to the potential contact with saliva or secretions which are considered a Biological hazard under Control Of Substances Harmful to Health (COSHH) regulations. Disposable latex free gloves should be worn for all patient contact plus an apron if they are in an isolation room and eye shield if deemed necessary.

Appropriate supplies of food and/or drink should be obtained for the assessment. The patient may have their own suitable snacks which can be used with their consent. The SLT should provide thickener and a variety of foods for the assessment (if needed) from stocks held in the kitchen.

A neurological examination should be carried out to include oro-motor examination looking at cranial nerve function and voluntary reflexes. General comments on unilateral weakness, hand dominance or possible neglect/inattention are also useful to document.

If oral suction is required during the assessment, this should only be carried out by SLT staff who have been trained and assessed as competent. Physiotherapy or nursing staff may be needed if deep suction is required. Management of choking is included in the annual update session on Basic Life

Support, but emergency call bells should be used if staff need assistance with the patient's airway management.

The recommendation for non-oral feeding (temporary or long-term) should be discussed with the medical team as soon as possible. Patients should continue to be reviewed whilst awaiting a decision from the team. The current Trust Percutaneous Endoscopic Gastrostomy (PEG) guidelines may be consulted to aid decision making.
Advice on suitable routes for medication should be discussed with the medical team e.g. liquid format. The ward or on-call pharmacist may also give valuable information if needed.

The current Trust Medicines Management Policy should be consulted for guidelines on enteral administration or mixing medicines with food.

If a video fluoroscopy is felt to be appropriate, this should be discussed with the patient and the medical team and the current policy for Video fluoroscopy followed.

After the assessment

Details of the assessment findings should be discussed with the patient and recommendations made in line the International Dysphagia Diet Standardisation Initiative https://iddsi.org/framework/.

The outcome should be documented in the patient's notes and discussed with the nursing and medical teams where possible.

Approved signs indicating the recommended oral intake should be placed over the bed space.

The ward receptionist should be informed and any changes to oral intake recorded in the ward diary/ward grid. A supply of thickener and a shaker should be provided or requested from the kitchen if required.

Used equipment should be disposed of in line with the current Trust policy.

Referral to a Dietician should be recommended if the patient requires either non-oral feeding or assessment for nutritional supplements.

For outpatients: a written report outlining any significant changes in management should be sent to the Consultant and the GP. Alternatively, if the medical notes are available e.g. at MDT clinic, a summary of assessment findings should be written, and the Medical team advised.

If it is not considered that the patient can eat or drink safely, without a risk of aspiration or choking, and the patient is not appropriate for any form of non-oral feeding, then a decision will need to be made by the medical team, in conjunction with the patient if they are deemed to have capacity for this

decision, regarding 'feeding at risk'. If it is decided that a patient is for 'feeding at risk' then this should be clearly documented by the medical team in the notes. This decision should also be made clear in the medical discharge summary. No further SLT input is usually indicated at his point.

Emergency procedures to complete if required

As many patients with dysphagia are at risk of choking or aspirating food/drink, it is advisable to check that any bedside suction and oxygen equipment is working prior to assessing the patient.

If a patient is already requiring regular deep suction e.g. tracheostomy in situ, a nurse or Physiotherapist should be available during the assessment as, at the present time, RSFT SLT staff are not trained in performing deep suction.

The emergency bell should be used if a patient chokes or becomes unresponsive and requires resuscitation.

6. MANAGING PATIENTS WITH DYSPHAGIA – IN THE COMMUNITY SETTING

Accepting referrals for dysphagia management

Community and out-patient referrals are received by post and email directly to the SLT department at Milford or through the community coordination centre. Ward referrals are received by phone.

The service has developed a referrals pack for care homes, which has been distributed to all Guildford and Waverley care homes and is sent again on request. This includes information on identifying symptoms of dysphagia, when and how to refer to SLT, as well as guidance on immediate risk management that can be taken by care staff prior to referring for specialist dysphagia assessment – including reducing choking and aspiration risk.

Clinically appropriate referrals are accepted from anyone including GPs, care home staff, community and hospital health care staff, social care and direct from patients.

All referrals are processed, triaged and prioritised, contacting the referrers or patients/carers for additional clinical information if required to progress triage. The service has developed triage guidelines to be used to inform SLTs decision making when prioritising and accepting referrals.

Once the referral has been accepted, patients/carers are sent letters to advise them that they are on the SLT waiting list and requesting they contact the

department if there is any change that could impact on urgency of their appointment.

There is no rapid response service for community SLT

Referrals for Video fluoroscopy (out-patient service at RSCH)

When clinically required, referrals can be made for objective assessment of swallowing – video fluoroscopy at RSCH. These referrals have to come from the GP and will be requested by the SLT as needed.

Dysphagia assessment

Assessment of swallowing including history, symptoms and observation of eating and drinking is carried out using a SLT Dysphagia Assessment as a guide, to ensure a comprehensive assessment. This is documented using an EMIS template. Not all areas are completed for every patient – there may be exclusions depending on patient circumstances.

A comprehensive assessment may require more than one visit to complete. It may be beneficial to assess the patient at different times of day or in different situations to get a full picture on which to base recommendations. Carers may be asked to complete a swallow diary over several days as part of the assessment.

Consent for dysphagia assessment is documented in the patient record: including whether the patient was able to consent themselves or the assessment was carried out in best interests.

All SLT staff attend annual manual handling training but are not able to use equipment to move patients e.g. slide sheets, hoists. SLTs will liaise with and require assistance from suitably trained care/nursing staff as relevant to optimise the patient's positioning for assessment.

Choice of food and drink to use in assessment is based on the patient's history and reports of their current eating and drinking difficulties. Risk of choking is evaluated before proceeding with any oral intake during assessment.

Personal Protective Equipment when appropriate will be used during assessment due to the potential contact with saliva or secretions. This might include disposable latex free gloves, aprons, eye cover and masks as required for the clinical situation.

The required infection control measure for equipment and hand washing are carried out before and after assessment.

The first aid management of choking is included in induction and annual update session on Basic Life Support which all SLT staff attend. In care homes, emergency call bells and care staff can be used to assist. In domiciliary settings, staff will follow the guidelines from their basic life support

training and call the emergency services as needed. Suction is not routinely available in community.

Dysphagia management

Management will involve a range of techniques including advice on food and fluid texture modification, mouth care, feeding technique, posture, and use of specialist eating and drinking equipment. Emphasis is put on the 24-hour nature of dysphagia management to reduce risk, including swallowing of sections, medications, snacks and oral care.

Dysphagia management planning will require the clinician to balance the risk of airway penetration, aspiration and choking, the patient's nutrition and hydration, quality of life and the patient's wishes – including next of kin and carers where appropriate.

Clinical decisions and reasons for recommendations will be clearly documented in the patient's SLT consultation on EMIS.

Risk feeding: The SLT may set up an 'Eating and Drinking at Risk' plan when:

- Following SLT assessment, a patient with capacity makes a fully informed decision to eat and drink in such a way which may leave them at increased risk of aspiration or choking.
- The severity of a patient's dysphagia is such that risk cannot be reduced further, and non-oral feeding is not clinically appropriate or in the patient's best interests.

The Eating and Drinking at Risk plan (also referred to as 'risk feeding') will clearly outline the patient's decision making, the consistencies that they are currently eating and drinking, and what advanced care planning is required by the patient's GP should health consequences occur such as aspiration pneumonia.

Non-oral feeding: Where a patient in community is found at assessment to be at high risk of aspiration/choking on all consistencies, the SLT will contact the patient's GP to discuss hospital admission or care at home as appropriate for their clinical situation.
If the potential need for non-oral feeding is identified, the SLT will discuss this with the patient and GP and request the GP refer to gastroenterology and dietetics at RSCH. SLTs are able to refer direct to dietetics for advice about nutritional support.

Texture modification recommendations are made using the International Dysphagia Diet Standardisation Initiative https://iddsi.org/framework/. The patient and any individuals caring for the patient will be given sufficient information on how to prepare food and drink in accordance with these descriptors as relevant for that patient.

If appropriate, prescription of fluid thickeners will be requested from the GP. To reduce risk of errors in thickening practice, the same thickener brand is used across the acute and community services – see Guildford and Waverley CCG prescribing guidelines (see associated documentation at end of policy).

Medication management: Where needed to reduce choking and aspiration risk, the GP may be requested to review medications, and alter prescriptions to easier to swallow preparations.

Multi-disciplinary management: Assessment and management of dysphagia is carried out within the multi-disciplinary care of the patient, and may require liaison and clinical discussion with a range of different professionals, including, but not restricted to : physiotherapy, occupational therapy, dietetics, gastroenterology, ENT, GP, Community Nursing, Specialist nursing, hospice care, neurology, dentistry, respiratory care.

SLT recommendations and care planning: All patients who have had a dysphagia assessment by the service will be given a Speech and Language Therapy Recommendations sheet, and/or it will be written into their care plan, covering any texture modifications and all other advice given to reduce the risk of aspiration, choking and other health consequences of dysphagia. The document is shared with the patient and any carers. The patients and carers are advised that these recommendations are taken with them if they are admitted to hospital or other care facility (see associated documentation at end of policy).
If a patient with an open episode of care in the community SLT service goes into hospital or moves to a care facility, the SLT will liaise with the acute service and/or new care staff to ensure the dysphagia management plan is carried over.

In circumstances where a patient who does not have capacity may be at risk by helping themselves to food which is not of a safe consistency for them, the SLT can work with staff and carers to identify the level of risk and a best interests meeting would be required to establish a management plan.

Discharge

Patients are discharged when recommendations are in place, and they have been reviewed to ensure they are effective, meet the patient's needs and are being carried out appropriately by the patient and/or carers.

At discharge, reports are written to the GP responsible for the patients care to inform them of any on-going recommendations, risks and potential for future health consequences e.g. chest infections. Referrers need to refer back to the service if there is a change in the patient's condition which has affected their swallowing, or the recommendations are no longer effective in managing the patient's dysphagia and risk.

7 TRAINING

Acute setting

Training required by SLT staff

As outlined in the introduction, newly qualified SLT staff must complete their post graduate training and dysphagia competencies before working independently. Support for developing competencies will be given by senior colleagues alongside personal study and attendance at relevant study days.

SLTs should have completed their RCSLT tracheostomy competencies prior to independent assessment of dysphagia on tracheostomised patients.

On-going training needs e.g. Developing advanced competencies should be highlighted during the annual appraisal process.

Training given by SLT staff on dysphagia management

Regular training sessions are given to nursing staff and health care assistants in conjunction with the practice development nursing team.

Informal training sessions for other professions are carried out as requested.

The rapid response SLT and BSST training co-ordinator holds regular training sessions for qualified nurses wishing to gain competencies in BSST administration. Training comprises of 2 elements: a 30-minute theory session (held quarterly for groups of nurses) and a number of individual sessions to assess competencies in BSST administration (an exact number is not given because of the recognised difference in speed of competency acquisition). Nurses must complete both elements and be deemed competent before using the BSST independently. An annual review, consisting of an observed assessment or a written reflection is required to ensure maintenance of competencies.

Community setting

The SLT service will provide sufficient training to carers, including community hospital ward staff, to manage the patient and carry out SLT recommendations. The service can also provide information on dysphagia management through the Care Home Forum. One-off information sessions can be provided for community health care staff who support patients with dysphagia. Training for individual/small groups of care homes or agencies can be provided on request and is costed.

When the capacity of both services allows, community staff will work with RSCH acute SLT service to complete video fluoroscopy training competencies and be able to work in the VF clinic at RSCH assessing community patients.

8. IMPLEMENTATION

No action plan applicable as systems already in place.

9 MONITORING

Minimum requirement	Monitoring Process	Monitoring/ implementing Job title(s)	frequency of the monitoring	Name of responsible committee	Monitoring/ implementing committee (s)
that is to be monitored	e.g. review of incidents/ audit/ performance management	of individual(s) responsible for the monitoring and for developing action plan	(Minimum)	(that is responsible for review of the results and of the action plan)	of individual(s)/ committee responsible for monitoring implementation of the action plan
Title					

10 REVIEW, RATIFICATION AND ARCHIVING

This policy will be reviewed every 3 years or earlier if national policy or guidance changes are required to be considered. The review will then be subject to approval and re–ratification.

11 DISSEMINATION AND PUBLICATION

Dissemination of the final policy is the responsibility of the author. They must ensure the policy is uploaded on Trust Net via the Central Policy Officer. The Central Policy Officer is responsible for informing the Communications team to issue a trust-wide notification of the existence of the Policy.

Clinical Directors, DMDs, DDOs Speciality Business Unit (SBU) or supporting services management teams, ward managers and heads of department are responsible for ensuring that all relevant staff under their management (including bank, agency, contracted, locum and volunteers) are made aware of the Policy.

12 ASSOCIATED DOCUMENTS

All existing Trust policies, procedures & plans will be adhered to.

This policy should also be used in conjunction with the following policies and guidelines:

- Speech and Language Therapy recommendations sheet for community settings
- G&W CCG prescribing guidelines
- Infection Control Personal Protective Equipment
- Policy and Procedure for the Control Of Substances Hazardous to Health (COSHH)
- Incidents and Serious Incidents Management Policy
- RCSLT Clinical Guidelines
- RCSLT Dysphagia Training and Competency Framework
- Enteral Feeding Policy
- Nil by Mouth Policy
- Nutrition and Hydration policy
- Guidelines for gastrostomy feeding
- Medicines management Policy
- Handbook of drug administration via Enteral feeding Tubes
- Video fluoroscopy policy
- Safe Management of Healthcare Waste policy
- Safeguarding of Adults at Risk Policy
- Community referrals pack:

11 REFERENCES

https://www.rcslt.org/

https://iddsi.org/framework/

12 EQUALITY IMPACT ANALYSIS

The author of this policy has undertaken an Equality Impact Analysis and has concluded there is no impact identified. The analysis is available via the Central Policy Officer.

13 APPENDIX A

Complete Dysphagia Pack for Care Homes

This person's health is at risk if these recommendations are not followed. THIS FORM MUST ONLY BE COMPLETED BY A SPEECH AND LANGUAGE THERAPIST.

NHS Royal Surrey NHS Foundation Trust

Name: **NHS no.** **DOB:**

SPEECH AND LANGUAGE THERAPY RECOMMENDATIONS:

Food

- ❑ IDDSI level 7 **NORMAL**
- ❑ IDDSI level 6 **SOFT & BITE SIZED**

If one of the following textures has been advised, the form of tablet medications MUST be reviewed by a pharmacist or GP:-

- ❑ IDDSI level 5 **MINCED & MOIST**
- ❑ IDDSI level 4 **PUREED**
- ❑ IDDSI level 3 **LIQUIDISED**
- ❑ Nil By Mouth ❑ On oral trials

Fluids

- ❑ Normal fluids
- ❑ IDDSI Level _____ thickened fluids
- ❑ Avoid Beaker lids / straws

If thickener is required, this applies to ALL FLUIDS not just drinks e.g. LIQUID MEDICATIONS must be thickened as must sauces.

It is important to follow the thickener powder manufacturer's instructions when mixing drinks and before serving **check the consistency against the IDDSI descriptors** www.iddsi.org.

If it is not the expected consistency it may be necessary to stir, shake or leave it to stand for a longer period, then check it again.

IDDSI Level	The number of green scoops per 200ml required for Nutilis Clear:
Mixing instructions provide guidelines based on thickening water. **More or less thickener** may be required to achieve the same consistency in other drinks Please note the below guidelines are for Nutilis clear only. For **other thickener brands** see manufacturer's instructions	
Level 1	**1** (1.25g)
Level 2	**2** (2.5g)
Level 3	**3** (3.75g)
Level 4	**7** (8.75g)

Position

- ❑ Must be upright and alert – (sat in a chair and up to a table is ideal)
- ❑ Carer assisting must be sat down (to same level) rather than stand to assist.

Teeth cleaning / oral care

- ❑ Must be done at least twice a day
- ❑ Needs assistance for mouth cleaning.

Assistance required

- ❑ Independent with eating and drinking
- ❑ Direct supervision
- ❑ Needs assistance
- ❑ Slow pace required
- ❑ Small individual mouthfuls
- ❑ Specialist equipment required

Medication

Check with Pharmacist or GP that forms of medication are suitable

- ❑ No problems reported
- ❑ Need for liquid meds seen on assessment/ tablets/capsules likely to be unsafe
- ❑ Need for Pharmacist/GP advice re: easy to swallow forms of medication. May manage smaller or crushed tablets, for example.

Things to look out for:

Coughing, choking, wet sounding voice, chest infection, unintentional weight loss.

GUIDE TO PRESCRIBING THICKENERS FOR DYSPHAGIA IN ADULTS

Thickeners are used to modify liquids and foods to a thicker consistency. Thickening fluid is used as a strategy to slow the transit time of fluid through the mouth and throat which can help some people with dysphagia swallow more safely and so reduce the risk of aspiration.

Thickeners should be prescribed by a clinician able to take clinical responsibility for the ongoing management of the patient, e.g. General Practitioner (GP) or a Speech and Language Therapist (SLT), to ensure their correct use and to reduce potential risks to patients from their incorrect use.

Advice to thicken fluids will depend on an individual's type of dysphagia and the required consistency and is described using the new International Dysphagia Standardisation Initiative (IDDSI) terminology.

Which Thickener to Prescribe

Nutilis Clear® is the preferred choice thickener in Surrey Heartlands. This is a clear gum-based thickener and is more palatable and stable than starch-based thickeners, is enzyme resistant and does not change the appearance of clear fluids.

How Much Thickener to Prescribe

Adults should be encouraged to drink at least 2000mL fluid per day, (although this can vary depending on age, gender and weight). The amounts of thickener advised in the table below are the minimum quantities required for 28 days to thicken 2000mL fluid per day to the correct consistency.

Thickener	Tin Size (g)	IDDSI level (see table overleaf for description)	No. of 1.25g Scoops per 200ml fluid	No. of Tins / Total Weight (g) Required per 28 days	Cost per Month
Nutilis Clear®	175	Level 1 (slightly thick)	1	2 / 350	£16.92
		Level 2 (mildly thick)	2	4 / 700	£33.84
		Level 3 (moderately thick)	3	5 / 875	£42.30
		Level 4 (extremely thick)	7	12 / 2100	£101.52

(Costs calculated based on prices published February 2019)

Recommendations	
✓ Patients with swallowing difficulties may need to be assessed by SLT, after discussion with GP, where there are on-going concerns around the safety of food and drink consistencies being consumed	× Avoid prescribing thickeners in sachets (unless advised by SLT), prescribe tins – check prescribing volume when selecting product
✓ Good oral care is particularly important in people with swallowing difficulties and this should be encouraged	× Where possible convert existing prescriptions of sachets to their equivalent in tins
✓ While waiting for SLT assessment thickened fluids can be started by GPs at Level 1, monitor for warning signs and increase to level 2 if the thicker level reduces symptoms further.	× Thickener stock in care homes should not be automatically disposed of each month, stock should be carried forward
✓ **Include consistency directions on the**	× Avoid prescription of pre-thickened drinks e.g. Slo-drinks, Fresubin

prescription information, e.g. 'thicken all fluids to IDDSI level 2' ✓ Review quantities prescribed to avoid waste and over prescribing ✓ For care homes, use the same thickener product for all residents to avoid errors. If there are several residents with dysphagia requiring thickener Bulk Prescribing could be considered ✓ Only prescribe alternative thickeners at SLT request ✓ Always follow the manufacturers advice for thickening fluids, e.g. for gum-based thickeners, start with the desired quantity of thickener before adding fluid	Thickened, Nutilis Complete unless on the recommendation of a dietitian or SLT. × Store thickeners safely and out of reach to avoid accidental ingestion (see patient safety alert)
Review medications to ensure they are suitable for a patient with dysphagia. Liquid formulations may not always be appropriate (especially if they are thin fluids). Consider alternative formulations or other routes of administration and seek advice from manufacturers, hospital medicine information services or a pharmacist as required. Consideration should also be given that thickener products can affect the absorption and bioavailability of oral medications. Note: thickeners are not licensed for mixing with medications so decisions on medication administration should be made on an individual patient basis and clearly documented.	

GUIDELINES FOR PATIENTS WHO ARE PLACED NIL BY MOUTH (NBM) FOR LONGER THAN 12 HOURS

These guidelines should be used for all patients who are NBM for longer than 12 hours. It should not, therefore, include patients whose surgery is completed within the planned timeframe without any post-operative restrictions on their oral intake or concerns re. swallow safety.

Completion of the flowchart

- The flowchart should be used for all patients who will be NBM for over 12 hours either due to their clinical condition, prior to a complex procedure or due to swallowing difficulties (suspected or pre-existing dysphagia)
- Patients should have the date and time when they were placed NBM written on the form together with any recommendations for intravenous infusion (IVI) or medication administration
- The time when the patient is allowed to eat and drink following the procedure should be documented together with any special instructions e.g. clear fluids only etc.
- If the procedure/operation cannot take place, the medical team should decide whether the patient can eat and drink or to remain NBM pending re-scheduling of the procedure/operation
- If the patient is NBM due to suspected swallowing difficulties, the medical/nursing staff should try to establish if this is a new or existing difficulty and the diet/fluid consistency the patient was managing prior to admission
- The nursing team should assess the malnutrition universal screening tool (MUST) score and refer to Dietetics if indicated.
- A Basic Swallow Screen Test (BSST) should be conducted (see note below) and if necessary, the patient should be referred to Speech and Language Therapy (SLT)
- The medical team should consider IVI, nasogastric tube (NGT) for diet/fluids/medication and alternative medication routes if necessary

Basic Swallow Screen Test (BSST)

- ***A BSST can only be carried out by staff who have been assessed as competent by SLT***
- If the patient fails the first section of the pre-assessment information section, keep them NBM and re-assess when alert or within 24 hours. If still NBM after 48 hours, discuss with medical team re. Nutrition **and** refer to SLT. If they fail the fluid or diet screen due to adverse signs, follow the instructions on the form and refer for a Speech and Language Therapy assessment

Medication

- If medication cannot be given orally, by an alternative route or at the designated time, the current Trust Medicine Management policy **must** be followed, and all documentation completed as required

Patients who are placed Nil By Mouth for longer than 12 hours

NBM for Procedure

Details of procedure:
Date/ time:
NBM a) food from (time):
NBM b) fluids from (time):
Special instructions:

Outcome

Date/ time oral intake recommenced:

Other comments/ actions:

NBM due to clinical condition

NBM date/ time:
IVI: Y/N
Medication Route:
Oral Intake:
Additional Information:

NBM due to dysphagia (swallow problem)

NBM date/ time:
☐ New Symptoms
☐ Existing dysphagia
Baseline oral intake:
Diet
Fluids

Date/ time referred for BSST:

BSST Completed: Date/ time

Outcome: ☐ Pass ☐ Fail
Date/ Time referred to SLT:

SLT Ax Date/ time:

Outcome:
Diet:
Fluids:

Nutrition/ Hydration issues

IVI: Y/ N Referred?
(date) …….
BGT Y/N Referred?
(date) ……..
Medication: oral/ NGT/ Other:
Action if unable to give medication:

Date/ time referred to nutrition support team:

Date/ time referred to dietitian:

All patients regardless of the reason for NBM status should be given **REGULAR ORAL CARE**

Completed by…….

Designation…….