

## Dysphagia Policy

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## Version Control Summary

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1.0	November 2013	Donna Power	Final	Applies to MHCOP and Community Health Newham
1.1	November 2013	Donna Power	Final	Name change from "Management of Oropharyngeal Dysphagia Policy to Dysphagia Policy"
1.2	March 2019	Paula Dougill	Final	<p>Updated with reference to new ELFT Policies, National Guidelines and RCSLT guidance.</p> <p>Inclusion of International Dysphagia Diet Standardisation Initiative (IDDSI).</p> <p>Applies to all Speech and Language Therapy Services within ELFT across Newham, Tower Hamlets and Bedfordshire and Luton.</p>
1.3	November 2019	Paula Dougill	Final	Inclusion of Dysphagia e-learning module available for all ELFT staff via OLM.
1.4	September 2020	Paula Dougill	Final	Updated with reference to RCSLT Guidelines in the context of COVID-19.

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## **1. Introduction**

This policy is relevant to all staff throughout East London NHS Foundation Trust who provide care to service users with dysphagia either directly or indirectly. The policy highlights the definitions of dysphagia, causes, prevalence, signs and consequences. It also highlights that the management of the individual with dysphagia must be a coordinated multidisciplinary approach. The policy also clarifies the role of speech & language therapists (SLTs) working in East London NHS Foundation Trust who provide assessment and intervention for children and adults with dysphagia and to make recommendations regarding good practice.

## **2. Purpose**

To outline the role of the multidisciplinary team who provide care to service users with dysphagia by:

1. Ensuring that relevant staff who provide care to service users with dysphagia are able to recognise the signs of dysphagia.
2. Ensuring that relevant staff who provide care to service users with dysphagia are able to make an appropriate referral to Speech and Language Therapy (SLT).
3. Outlining the respective roles and responsibilities of relevant staff who provide care to service users with dysphagia.
4. Ensuring that relevant staff who provide care to service users with dysphagia use the information outlined in this policy to ensure that the service user is able to eat and drink safely.

To outline the role of the speech and language therapist who provide care to service users with dysphagia by:

1. Providing information on key aspects of current SLT assessment and intervention in dysphagia, which is committed to sharing knowledge, skills, expertise and information with all those involved in the care of the service user.
2. Encouraging SLTs to plan, assess and provide intervention in partnership with other professionals and carers.
3. Delivering a safe, effective and efficient SLT service to the different dysphagic populations within Community Health Newham (evidence-based and/or accepted best practice).
4. Adhering to Communicating Quality Live (RCSLT, 2016) dysphagia guidelines.
5. Clarifying the training responsibilities and professional role of SLTs working in dysphagia.

## **3. Multidisciplinary management of oro-pharyngeal dysphagia**

### **3.1 What is dysphagia?**

Dysphagia is the term used to describe a swallowing disorder usually resulting from a neurological or physical impairment of the oral, pharyngeal and / or oesophageal mechanisms. The normal swallow has 4 phases:

1. Oral preparatory
2. Oral
3. Pharyngeal
4. Oesophageal

The first three of these together are termed the oropharyngeal phase. 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. Disorders of swallowing are associated with increased morbidity, mortality and

reduced quality of life. Pneumonia is a common sequelae of dysphagia and is associated with higher costs of care (Katzan et al 2007 in RCSLT 2009). The involvement of SLT's in the assessment and management of those with dysphagia is associated with better outcomes and advocated within national guidelines e.g. Scottish Intercollegiate Guidelines Network (SIGN 119), Royal College of Physicians National Clinical Guideline for stroke (2016).

### 3.2 How many people have dysphagia?

The prevalence of dysphagia varies with the aetiology and age of the individual. For some populations it is difficult to ascertain the prevalence rate because of the way dysphagia is reported, often forming part of other health conditions for which the patient is being treated. Dysphagia can be a transient, persistent or deteriorating symptom according to the underlying pathology.

**Table 1.**

<b>Client group</b>	<b>Incidence / Prevalence of condition</b>	<b>Incidence / Prevalence of dysphagia within condition</b>
Stroke	There are more than 100,00 strokes in the UK each year. There are over 1.2 million stroke survivors in the UK (Stroke Association State of the Nation, Stroke Statistics, 2017).	More than 900,000 people in England are living with the effects of stroke, with half of these being dependent on other people for help with everyday activities (NICE Stroke rehabilitation in adults, 2013). Up to 78% have dysphagia immediately post stroke (Martino et al 2005). Of all those with initial dysphagia following stroke 76% will remain with a moderate to severe dysphagia and 15% profound (Mann et al 1999).
Progressive neurological disease	Dysphagia can be an initial symptom in a small number of people with progressive diseases such as Parkinson's disease, multiple sclerosis and motor neurone disease, but the majority will develop dysphagia with progression of the disease.	200/100,000 UK population have dysphagia due to Parkinson's disease (Hartelius and Svensson 1994). More than 90% of those with motor neurone disease will develop dysphagia
Chronic Obstructive Pulmonary Disease	An estimated 1.2 million people are living with diagnosed COPD in the UK (British Lung Foundation).	27% of those with COPD have dysphagia (McKinstry et al 2009)
Dementia	850,000 people are living with dementia in the UK (Dementia UK, 2014).	68% of those with dementia in homes for the aged have dysphagia (Steele 1997)
Adults with Learning Disability	It is estimated that 930,400 adults in England have a learning disability (Public Health England, People with Learning Disabilities in England 2015).	5.27% of all adults with a learning disability were referred for advice regarding dysphagia (Chadwick et al 2003).

Nursing Home residents	291,000 people over 65 are care home residents (Office for National Statistics 2011 census).	Between 50-75% of nursing home residents have dysphagia (O'Loughlin & Shanley 1998).
Acute hospitalised elderly		10% of acutely hospitalised elderly (Lugger 1994) have dysphagia.
Cerebral palsy	Affects approximately 1 in 400 children, i.e. approximately 1,800 children are diagnosed with CP in Britain each year. Incidence increases to 1 in 20 for babies with a birth weight under 1500g (NICE Cerebral Palsy, 2012).	Prevalence figures of dysphagia in cerebral palsy varies between 27% and 81% (Waterman et al, 1992).
Cardiac disorders	In the UK approximately 1 in 180 babies are born with congenital heart disease (British Heart Foundation Children and Young people statistics, 2013).	1 in a hundred children with a cardiac condition has a risk of concomitant feeding difficulties (Children's Heart Foundation, 2006).
Gastro-oesophageal reflux		Feeding problems affecting behaviour, swallowing, and food intake and mother-child interaction have been found to be common in infants with reflux (Mathisen et al, 1999).
Prematurity	It is estimated that around 60,000 babies are born prematurely in the UK each year (BLISS Prematurity Statistics in the UK).	Premature babies commonly have difficulties establishing feeding, and some may need ongoing support, particularly those with associated neurological difficulties (British Association of Prenatal Medicine (BAPM): Service Standards for Hospitals Providing Neonatal Care (2010).
Oesophageal atresia	Affects approximately 1 in 4000 births.	60-70% experience problems with dysphagia post-operatively (Munro, 2003).
Cleft lip and palate	Affects 1 in 6-700 births (WHO Expert Committee, 2002).	Feeding difficulties pre and post-surgery occur in a significant number of children.
Craniofacial conditions		No figures available, but by their very nature, craniofacial conditions are likely to impact.
Learning disabilities and congenital syndromes	There are approximately 1.4 million people with a learning disability in the UK (Public Health England 2016).	57% of people with learning disabilities are reported to have some level of nutritional difficulties (Kerr et al, 2003).

Autism	Over 695,000 people in the UK may be autistic (National Autistic Society, 2011 UK Census).	Some children with autism may have difficulties with food due to sensory disturbances with smell and texture (Bogdashina, 2004).
Trauma (e.g. tube-feeding, surgery, tracheostomy)		High incidence of clinical and behavioural feeding difficulties (Douglas & Harris, 2001).
Mental health	Approximately 1 in 4 people in the UK will experience a mental health problem each year (McManus et al 2009). 1 in 8 (12.8%) children and young people aged 5-19 have at least one mental disorder (NHS Digital 2017).	A high proportion of children and adults presenting to mental health services may have disturbances of swallowing which may be difficult to identify. These difficulties may be intrinsic to the mental health problem, may pre-date the mental health problem or may arise from it (RCSLT 2009). Approximately one third of people attending an acute or long term care setting for mental health conditions present with overt signs of oropharyngeal stage dysphagia (Regan et al 2006). Adults with organic mental illness are 43 times more likely to die of choking / asphyxiation (Aldridge & Taylor 2012).

Dysphagia is now recognised as a symptom of concern in many other conditions such as Chronic Obstructive Pulmonary Disease (McKinstry et al 2009 in RCSLT 2009), head and neck cancer (McCabe et al 2009 in RCSLT 2009), thermal burn injury (Ward et al 2001 in RCSLT 2009) and acquired brain injury (Ward et al 2007 in RCLST 2009).

A study of those having cervical discectomy and fusion indicated an incidence of dysphagia of 48% pre- operatively; and 67% post-operatively in those with a previously normal swallow study (Frempong-Boadu et al, 2002 in RCSLT 2009).

A study by Langmore et al (2002) in RCSLT 2009) examining elderly institutionalised individuals concluded that the prevalence of dysphagia and aspiration pneumonia was high when associated with impairment of oral structure, the respiratory or neurological system.

Dysphagia has also been recognised as an ongoing symptom following a COVID-19 diagnosis, secondary to increased coughing or shortness of breath impacting on swallow timing, long term intubation (> 72 hours) resulting in weakness of tongue/throat and damage to vocal folds, long ICU stays resulting in generalised critical illness weakness (Buckinghamshire Healthcare NHS Trust Dysphagia Guidance & COVID-19).

### 3.3 What causes dysphagia?

Oropharyngeal dysphagia can result from a number of factors. The causes may be:

- Neurological – including central nervous system (CNS), anterior horn cell, peripheral nervous system, and neuromuscular junction



- Physical – related to head and neck impairments or surgery e.g. glossectomy
- Respiratory
- Psychological

In adults dysphagia can present as acute or chronic, and within these categories, static or progressive in its presentation. It is frequently associated with the following disorders:

- Stroke
- Head and neck cancer
- Acquired Brain injury
- Brain or CNS Cancer
- Respiratory conditions (including COPD or post-polio syndromes)
- Following cervical spinal surgery
- Progressive neurological diseases, including Multiple Sclerosis, Parkinson's Disease
- Dementia
- Developmental disorders (carried on into adulthood)

The ability to swallow normally can be influenced by a number of factors which can include coordination and strength of the musculature, posture, bolus size, texture of bolus, disuse of swallow due to illness, ageing, cognition, respiratory, and cardiac problems.

In children dysphagia can present as acute or chronic, and within these categories, static or progressive in its presentation similar to adults. The causes of dysphagia in paediatric populations can be different to the adult population. Unlike adults, children have rapidly developing body systems and even short-term problems with swallowing can interrupt normal development and cause serious long-term sequelae (Dodrill & Gosa, 2015). Dysphagia in children is frequently associated with the following disorders:

- Developmental disorders
- Prematurity
- Respiratory and cardiac disorders
- Gastrointestinal disorders (including NEC and GORD)
- Neurological disorders
- Congenital abnormalities (including tongue tie and cleft lip/palate)
- Maternal and perinatal issues
- Iatrogenic complications (including tracheostomy and tube feeding)
- Ingestational injuries
- Stroke
- Acquired brain injury
- Brain or CNS cancer

### **3.4 Signs and consequences of dysphagia**

The intake of adequate food and drink is essential for life. Difficulty with swallowing normally not only has potentially life threatening consequences, but can also lead to an impaired quality of life. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences. Aspiration of food, drink and saliva is frequently caused by oropharyngeal dysphagia and can lead to aspiration pneumonia.

Dysphagia can present in many ways, and the patient may demonstrate one or several of the following symptoms:

- Food spillage from lips
- Dry mouth
- Drooling

- Food remaining in the mouth
- Nasal regurgitation
- Food sticking in the throat
- Poor oral hygiene
- Coughing and choking
- Regurgitation
- Weight loss
- Aversion to food
- Taking a long time to finish a meal

If untreated, dysphagia can lead to further problems including:

- Choking
- Dehydration
- Malnutrition
- Aspiration pneumonia
- Asphyxiation
- Chronic pain
- Adverse socio-emotional effects
- Death

### **3.5 Roles and responsibilities of MDT**

The team members will vary according to the client's needs and the environment they live in. Key team members and their roles and responsibilities are described below.

#### **3.5.1 Client / Carer**

The client must be involved at each stage of dysphagia management (e.g. consent to assessment and subsequent management decisions). Sometimes regardless of the potential risks explained to the adult client by the team they may choose to continue with oral food and fluid, and / or unmodified consistencies, for pleasure and quality of life purposes. In this situation it is important to document the fact that the risks of aspiration, airway obstruction and pulmonary infection have been explained and discussed with the client and that they understand the implications of the risk of continuing eating and / or drinking.

If an adult is assessed not to have capacity in relation to a feeding management decision a best interest meeting may be convened as outlined in the Mental Capacity Act (2005). If the client is unsafe to eat and drink, but alternative nutrition and hydration has been deemed unsuitable it may be appropriate for risk feeding documentation to be completed with the relevant professionals, addressing capacity, ethics, and quality of life issues (Communicating Quality Live, RCSLT, 2016).

The carer can also play a significant role in providing information to gain history and inform assessment and if appropriate to support the client with feeding and encourage safe swallowing.

When supporting children and adults with learning disabilities with feeding and / or swallowing difficulties, and their family members / carers do not comply with guidelines and the client is deemed to be at 'significant risk', a safeguarding referral should be considered, and MDT colleagues and social care providers informed (Trust Safeguarding Children Policy, 2016, Safeguarding Adults Policy, 2016).

### **3.5.2 Medical team**

The overall responsibility for the management of the patient's medical care rests with the client's medical practitioner. However Kennedy (1992) in Rainbow and Marks (2001) states that the decision regarding the management of the client should not be the responsibility of one professional alone. Instead the multidisciplinary team should reach a joint decision regarding future management based on factors such as assessment findings, medical condition and the wishes of the client and/or family.

In "Collaborative Practice in Dysphagia" guidelines which are designed to promote multidisciplinary team working (Royal College of Speech and Language Therapists 1995 in Rainbow and Marks 2001) the following are proposed:

- The development of coordinated assessment protocols.
- The setting and recording of joint goals to ensure timely intervention.
- Joint treatment plans with written documentation in line with local policies.
- Adopting a common approach to the involvement of the client, relatives and carers.

### **3.5.3 Speech and Language Therapist**

Speech and language therapists have a unique registered role in identifying and managing oropharyngeal dysphagia associated with a broad range of developmental, neurological and physical / head and neck disorders. The key roles of the speech and language therapist include:

- To assess oral motor structure and function.
- To assess the efficiency and safety of the swallow.
- To implement objective assessments when indicated (e.g. videofluoroscopy).
- To determine safe feeding regimens and whether modified food and fluid consistencies are required.
- To identify and communicate the risk factors to the client, family and team members.
- To advise the client, their family, carers, nursing staff and relevant MDT regarding management strategies.
- To monitor and check whether the regimen is being carried out.
- To provide appropriate education and training for a range of professional staff to recognise dysphagia and the client's needs (e.g. food and fluid consistencies).
- To ensure safety, psychological and physical well-being of the client with regard to their swallowing.
- To ensure the catering staff receive information and training to comply with feeding and swallowing guidelines.
- To be sensitive to the client's economic, educational and employment background and cultural beliefs.
- To establish links with appropriate members of the MDT and to facilitate team communication.

### **3.5.4 Nursing**

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997 in Rainbow and Marks 2001) states that "nurses have a clear responsibility for ensuring the nutritional needs of patients... nurses have an implicit responsibility for ensuring patients are fed...Nurses may delegate the task of feeding patients, for example to unregistered practitioners, but...overall responsibility remains with the registered nurse". This role is applicable to both nurses from a health and mental health background.

The key roles of the nursing staff include:

- To recognise the signs and symptoms of dysphagia and make appropriate onward

referrals for their assessment and management.

- To monitor for signs of dehydration and malnutrition.
- To complete oral hygiene in accordance with nursing guidelines.
- To ensure patients receive the appropriate level of assistance with feeding (e.g. hand over hand assistance, partial assistance, full assistance).
- To ensure clients receive the correct consistency fluids and solids as per Speech and Language Therapy guidelines (e.g. ordering foods from menus, preparing correct fluid consistencies) and to follow a complete swallowing care plan which offers additional guidelines regarding positioning, environment, levels of assistance, equipment and communication.
- In appropriate settings to ensure that swallowing recommendations are accessible to relevant members of the team (e.g. displaying/ filing swallowing care plans).
- To monitor oral intake by keeping food and fluid charts.
- In appropriate settings to pass a nasogastric tube and to confirm it is sited in the stomach rather than the lungs.
- To attend education and training sessions led by the speech and language therapist as appropriate.
- To be competent in emergency procedures if choking / obstruction of the airway occurs. Nursing staff to follow nursing procedures.

### **3.5.5 Dietitian**

Part of the dietitian's role is to calculate the nutritional requirements of clients and participate in selecting the route of administration of non-oral feeding tubes (e.g. Fine bore nasogastric or NG tubes, fine bore nasoduodenal / jejunal tubes, percutaneous endoscopic gastrostomy feeding tubes or PEG's, Percutaneous jejuna feeding tubes or PEJ's and parenteral nutrition). They monitor the client's intake against their requirements using food and feed record charts, biochemistry, fluid input and output charts, visual observation and the client's weight. From this they modify intake and advise on a change in the route of administration if required. They work closely with the nursing staff, carers, catering, pharmacy and medical staff. For those clients discharged home on a feed they arrange for the appropriate feed and pump to be delivered to the client's home.

### **3.5.6 Physiotherapist**

The physiotherapist's role includes:

- Ensuring optimal positioning of the client and use of appropriate seating and other postural support to facilitate safe and effective feeding and swallowing.
- Preparation of the client for feeding by ensuring tone is as normal as possible and the chest is clear.
- Maintenance of the client's respiratory system.
- The use of suction and humidification.
- Monitoring of the client's chest.

### **3.5.7 Occupational Therapist**

The Occupational Therapist should consider the impact of physical, environmental, social and behavioural factors involved in the assessment and management of clients with dysphagia. This may include:

- Joint working to facilitate positioning which may involve use of appropriate seating.
- Facilitating independence through positioning or the use of adaptive equipment.
- Assessing the impact of cognitive, perceptual and behavioural impairments and other social factors and facilitating effective management.

### **3.5.8 Pharmacy**

During assessment and intervention, Speech and language therapists may recommend modification to the texture of food or the thickness of drinks. This advice may also have a potential impact on the format of medication the client is currently receiving. Speech and language therapists will always seek advice from a pharmacist and request that the format of medication is reviewed by the GP/consultant. Speech and language therapists will not advise any change to the format of medication.

### **3.5.9 Oral health promotions / Dentist**

Inadequate oral hygiene can lead to:

- A loss of dignity
- Reduced and unpleasant oral sensation
- A coated tongue, causing reduced range of movement
- Food residue from pocketing increasing the number of bacteria present causing a bad taste in the mouth and reducing others' interactions with the affected person.
- Increased bacteria presenting a high risk of chest infection / pneumonia if saliva is aspirated.

The Speech and Language Therapist may be involved in administering mouth care at the start of an assessment or treatment session but responsibility and regular implementation of oral hygiene rests with the nursing team as part of a client's personal hygiene (refer to 7.2). The oral hygienist can offer specialist advice on oral hygiene practises. Dentists diagnose and treat problems involving teeth, gums and mouth. They may also assess and recommend the need for dentures and manage ongoing needs e.g. resizing if appropriate.

## **4 Speech and Language Therapy management of oro-pharyngeal dysphagia**

### **4.1 Dysphagia Management in context of COVID-19**

COVID-19 is an infectious disease caused by the most recently discovered coronavirus. COVID-19 is now a global pandemic. Anyone can catch COVID-19, and symptoms range in severity. However, older people and those with underlying medical conditions are at higher risk of developing serious illness.

The main symptoms are recognised as a new, continuous cough, a high temperature, and / or a loss or change to sense of smell or taste. Other symptoms reported include shortness of breath, difficulty breathing, fatigue, muscle aches, headache, sore throat, congestion or running nose, gastrointestinal problems (WHO 2020).

The transmission of COVID-19 is primarily through respiratory droplets and contact routes. Respiratory droplet emissions when coughing or sneezing have been considered important routes of COVID-19 transmission. Aerosols generated by speech are also proposed to be a potential source for transmission.

Swallowing assessments are typically undertaken by SLTs in close proximity to clients (<1m) and last at least 10 minutes. Coughing is commonly generated during dysphagia assessment, and it can be an unpredictable risk, for example reflexive coughing secondary to aspiration. Clients can also experience difficulty managing oral secretions. Therefore due to direct prolonged contact, focus on the upper airway, and risk of contact with saliva and secretions as well as aspiration related coughing, the RCSLT and expert consensus considers dysphagia assessment to be an aerosol generating procedure. Thus SLTs are likely to be at high level of risk of COVID-19 infection (RCSLT 2020 Aerosol generating procedures, dysphagia assessment and COVID-19).

With this in mind it is essential for all SLTs working across the Trust to use professional

guidance and clinical judgement to assess and carry out safe and effective practice for themselves and others when working with clients during this pandemic (RCSLT 2020 RCSLT guidance on reducing risk of transmission, use of personal protective equipment in the context of COVID-19).

Since the pandemic began services have had to work flexibly and consider new ways of working, therefore new approaches to the delivery of care and management of clients with dysphagia will have been developed within all SLT services appropriate to their setting. This may include undertaking consultation, assessment and intervention remotely via telehealth systems, use of uniforms for face to face contact, use of personal protective equipment (PPE) for face to face contact, carrying out remote or e-learning training / upskilling of others. This may be an extension of previous practice, or a novel aspect of the service.

The RCSLT has published extensive guidance regarding new ways of working, and practical and operational considerations for both adult and children's services (RCSLT 2020 Restoring services and keeping everyone safe: Framework to support decision-making). It is the responsibility of the Clinical Manager of each service with senior SLTs to write and review local policies / standard operating procedures for dysphagia management during this time, according to the setting (e.g. inpatient, outpatient, community). All clinicians are to ensure that they are aware of the new guidance regarding service delivery.

#### **4.1.1 Telephone / video consultation vs face-to-face consultation in context of COVID-19**

The type of assessment and intervention provided i.e. face to face or telehealth, needs to be considered carefully, using clinical judgement and a risk assessment framework to determine what is most appropriate to meet the needs of the individual, as well as ensuring safe practice. The RCSLT has developed a decision making flowchart and risk assessment to support decisions regarding working with any individual in any setting (RCSLT 2020 RCSLT Guidance on reducing the risk of transmission and use of personal protective equipment PPE in the context of COVID-19).

Factors that should be considered include client access to digital technologies, Trust IT department recommendations, support available for client, risks and benefits to clients and service, COVID-19 status and vulnerability, level of personal protective equipment (PPE) required, consent, risk of transmission. The RCSLT have developed a number of resources and guidance to support dysphagia telehealth service (RCSLT 2020 Telehealth Guidance, Teleswallowing).

#### **4.1.2 Use of personal protective equipment (PPE) in context of COVID-19**

PPE is an essential element of infection prevention and control, and it is important for SLTs to understand the different types of PPE, undertake a full risk assessment to identify appropriate level of PPE required for face to face dysphagia management, and to strictly follow Government, Trust and RCSLT guidance on appropriate use. It is essential that SLTs working within the Trust are fit tested for face masks such as the FFP3, and complete available online training /webinars regarding hand hygiene, donning and doffing of PPE.

Types of PPE include:

- Filtering Face Piece class 3 (FFP3) respirator (fit testing required)
- Fluid-resistant surgical mask (FRSM)
- Surgical mask
- Eye and face protection – full face shield, safety goggles, surgical mask with integrated Visor
- Fluid-repellant long-sleeved gown
- Disposable plastic apron
- Disposable gloves

## 4.2 Access to the service – referral criteria / response times

SLT Professional Guidelines (Communicating Quality Live, RCSLT 2016) state; “Referrals are made in writing by any member of the multidisciplinary team or by the individual’s GP.”

All response times start from the time an **appropriate** referral is **received** by the therapist, not from the time the referral is made. Response times will inevitably be affected by staff vacancies & capacity. SLT services reserve the right to screen and prioritise referrals in line with clinical guidelines, for example choking risk guidance for adults with a learning disability (Hampshire Review 2012), and professional judgement, according to the information received. Referrals may not be accepted if the client is not suitable for an assessment.

East London NHS Foundation Trust Speech and Language Therapists are based in a number of Directorates and Services:

**Table 2.**

Directorate	Service
Bedfordshire and Luton	Adult Speech and Language Therapy Service.
	Learning Disabilities Specialist Community Healthcare.
City and Hackney	Integrated Learning Disability Service.
Forensic Service	John Howard Centre.
Newham Community Health	Adult Speech and Language Therapy Service.
	Community Neuro Service.
	Newham Health Team for Adults with Learning Disabilities.
Specialist Services	Speech and Language Therapy – Early Years.
	Speech and Language Therapy – Service for Schools.
Tower Hamlets	Tower Hamlets Community Learning Disabilities Services.

## 4.3 Assessment of dysphagia

### 4.3.1 Aims:

The aims of dysphagia assessment are to:

- Assess the physiology of the swallow and determine the safety of oral food/fluid intake and risk of aspiration.
- Assess for the presence of delayed/disordered eating and drinking skills where present.
- Make recommendations as to the safest oral intake e.g. modified food and fluid consistencies, with accompanying strategies as appropriate.
- Provide verbal and / or written feedback to all those involved, including written swallow care plan.
- To support carers and reduce potential anxiety surrounding the feeding difficulties.

- Clients and / or their carers will be assessed in their first/preferred language with the use of interpreters as appropriate.

#### **4.3.2 Information gathering:**

Gather information pertaining to:

- Client's nutrition and hydration.
- Client's respiratory status.
- Gastro-oesophageal conditions.
- Current medication.
- Oral hygiene.
- Dental health.
- Dietary preferences.
- Individual's ability to participate.
- Individual's cognitive level and developmental history, where appropriate.
- Information on current and past feeding pattern.
- Effects of emotional state, mood and behaviour.
- Involvement and participation of other professionals.
- Eating, drinking and swallowing history including birth, early and subsequent development.
- Technique of feeder.
- Environment for feeding.

#### **4.3.3 Assessment process:**

An assessment will always commence with the gathering of information from appropriate sources to inform further assessment methods and determine whether assessment and/or intervention is appropriate. An assessment of the client's ability to eat, drink and swallow will be carried out in order to determine the safety and efficiency of this process. All assessments will be specific to the age, needs and difficulties of the client. Assessment may involve members of the multi-disciplinary team.

The SLT will, as required, assess the following:

- Observation of the client eating and drinking.
- Oro-facial examination.
- Vocal tract function.
- Gross and fine motor skills/posture and use.
- Assessment of sensory abilities including vision, hearing, processing and integration.
- Client's management of secretions.
- Client's cognitive level.
- Levels of alertness.

#### **4.3.4 Holistic factors**

The SLT will place the eating, drinking and swallowing disorder within the context of the client's overall:

- Development.
- Emotional, psychological and behavioural well-being.
- Medical and surgical status.
- Medical diagnosis.
- Respiratory and nutritional status.



- Prognosis.
- Physical environment and social setting.

After consideration of the above factors, it may become apparent that further SLT intervention for dysphagia is not appropriate.

#### 4.4 Clinical procedures

At times it may be necessary to use additional clinical procedures to assess swallowing.

##### 4.4.1 Videofluoroscopy

**Aim of procedure:** Provide additional information to the overall dysphagia assessment in cases where recommendations cannot be made on bedside assessment alone.

**Indications:** Videofluoroscopy is always used in conjunction with specific clinical observations, clinical history taking, swallow trials and other subjective and objective assessments where appropriate.

**Definitions:** Videofluoroscopy is a dynamic X-ray of the swallowing sequence using a contrast medium, conducted in the presence of a consultant radiologist.

**Training:** All SLTs using videofluoroscopy must have received training and / or undergone supervised practise and be deemed competent by a senior therapist.

For additional information please refer to the Local Acute Hospital Trust Videofluoroscopy Policy and RCSLT Videofluoroscopy Policy.

##### 4.4.2 Pulse Oximetry

**Aim of procedure:** The procedure is intended to guide speech and language therapists who are using pulse oximetry as part of the assessment of dysphagia to ensure consistent, evidence-based practice.

**Indications:** Pulse oximetry is an assessment measure used as part of a dysphagia assessment. It is always used in conjunction with specific clinical observations, clinical history taking, swallow trials and other subjective and objective assessments where appropriate and never used as a measure on its own.

**Definitions:** Pulse oximetry is the measurement of the ratio of oxygenated haemoglobin to the total haemoglobin in arterial blood (Hibberd 2003).

A pulse oximeter is a device that clips onto the finger, toe or earlobe and uses red and infra-red light to measure the arterial oxygen saturation of the blood (Marks and Rainbow 2001).

**Training:** All SLTs using pulse oximetry must have received training in using the equipment and carrying out the assessment from a recognised expert or regional specialist. Ongoing supervision is also required from another SLT experienced in using pulse oximetry.

##### 4.4.3 Cervical Auscultation

**Aim of procedure:** The procedure is intended to guide SLTs who are using cervical auscultation in the assessment of dysphagia to ensure consistent, evidence-based practice.

**Indications:** Cervical auscultation is an assessment measure, which is sometimes, but not always used by SLTs in the assessment of dysphagia. It is always used in conjunction with specific clinical observations, clinical history taking, swallow trials and other subjective and objective assessments. Information from auscultation is never used alone to make treatment

decisions.

**Definitions:** Cervical auscultation is the use of a stethoscope placed on the neck to listen to the sounds that are generated during a swallow (Cichero and Murdoch 1998).

**Training:** All SLTs using cervical auscultation must have received training and supervised practice in using the equipment and carrying out the assessment from a dysphagia specialist with specific knowledge of cervical auscultation. Ongoing supervision is also required from another SLT experienced in using cervical auscultation.

#### **4.5 Management of dysphagia**

Attempts should be made to provide treatment in their first/preferred language, with the use of interpreters as appropriate.

##### **4.5.1 Aims of intervention:**

- Allow clients to maximise swallowing and feeding potential
- Enable clients to maintain or develop skills or function
- Reduce the risks associated with dysphagia

##### **4.5.2 Types of intervention:**

Intervention may be **direct** or **indirect** depending on the findings of the assessment. Intervention programmes will be presented in an accessible format for the client and / or carers.

###### **Direct**

The SLT will provide therapy to maintain and/or improve oro-motor function as appropriate. This may include:

- Exercises to improve speed, range of movement and coordination of all muscles involved in the swallowing process
- Exercises to improve or counteract abnormal oral motor patterns

###### **Indirect**

The SLT will consider and potentially modify the following aspects of eating and drinking as part of the intervention in conjunction with other multi-disciplinary findings and recommendations:

- Presentation of food and fluids
- Consistency of food and fluids (see page 17 for more information on descriptors).
- Environment, including utensils.
- Interest in food/appetite.
- Posture/position for oral intake.
- Reducing oral aversions and hypersensitivity.
- Frequency, timing of meals.

The SLT will observe and consider the ability of the key carers who support the client. Advice and training, in the following areas, may be given as appropriate:

- Food and fluid consistency (see page 17 for more information on descriptors).
- Feeding techniques.
- Mealtime interaction.
- Positioning.

- Environment, including reducing distractions.
- Strategies, including cues.

The SLT will provide information to the clients and all significant others on:

- The actual swallowing problem.
- Best treatment and management.

The GP will be informed of the need for a prescription of thickener for fluids for clients in the community.

The SLT may review the individual for any change in ability in conjunction with key carers and the multidisciplinary team and amend, update, advise and make recommendations as appropriate.

### **Food and Fluid Consistencies – IDDSI Framework**

Previously Speech and Language Therapy Services within ELFT used the UK National Descriptors to describe texture modifications to food and fluids for patients with dysphagia (fluids: Stage 1 / syrup, Stage 2 / custard, Stage 3 / pudding; foods: E soft/fork-mashable, D pre-mash, C puree). These descriptors are based on a consensus of expert opinion, and not clinical evidence.

However, the International Dysphagia Diet Standardisation Initiative (IDDSI) has developed a new global framework to standardise the terminology and definitions used to describe texture modified foods and thickened liquids. The IDDSI framework is based on clinical evidence and consists of a continuum of 8 levels combining food and fluids, identified by numbers, text labels and colour codes. Thus aiming to improve safety and the identification of appropriate consistencies for clients with dysphagia in all care settings, as well as eliminate use of “imprecise” and “inconsistent” terminology raised within recent patient safety alerts.

The implementation of the new IDDSI framework has received formal support from the Royal College of Speech and Language Therapists and the British Dietetic Association. The Patient Safety Alert: Resources to support safer modification of food and drink (27<sup>th</sup> June 2018 Reference Number NHS/PSA/RE/2018/004), referring to significant harm caused to patients by imprecise dysphagia diet terminology, has also stated that NHS services providing care for patients who have dysphagia or need texture modifications for other reasons are to transition to IDDSI framework as soon and as safely as possible.

Full implementation of IDDSI framework was to be completed by April 2019 across the UK. Therefore Speech and Language Therapy Services within ELFT should have transitioned from UK descriptors to IDDSI diet and fluid descriptors for all patients with dysphagia, within the recommended timeframe.

Table 3



The International Dysphagia Diet Standardisation Initiative 2016 @<http://iddsi.org/framework/>.

Attribution is NOT PERMITTED for derivative works incorporating any alterations to the IDDSI Framework that extend beyond language translation. Supplementary Notice: Modification of the diagrams or descriptors within the IDDSI Framework is DISCOURAGED and NOT RECOMMENDED. Alterations to elements of the IDDSI framework may lead to confusion and errors in diet texture or drink selection for patients with dysphagia. Such errors have previously been associated with adverse events including choking and death.

### 4.5.3 Non-compliance or disagreement

When working with adults with feeding and / or swallowing difficulties there may be occasions when variances occur such as non-compliance or the client / carers / MDT members disagree with the recommendations made or intervention plan. Details of this non-compliance / disagreement will be documented in departmental case records and the named GP / Consultant will be notified. For issues regarding capacity please refer to 4.16 Mental Capacity.

When working with children with feeding/ swallowing difficulties if a parent / carer does not comply with guidelines and a child is deemed to be at 'significant risk', a safeguarding referral should be considered (ELFT Safeguarding Children Policy 2016).

### 4.5.4 Non-oral feeding and Eating and Drinking at Risk

Where the client is at risk of aspiration on all oral trials, the GP / Consultant will be informed in order for further management decisions to be made regarding feeding and / or nutritional status.

The SLT is able to contribute to the multidisciplinary decision regarding the potential need for non-oral nutrition and hydration vs. eating and drinking at risk but this is ultimately a

medical decision.

Please refer to the Royal College of Physicians and British Society of Gastroenterology. Oral feeding difficulties and dilemmas. A guide to practical care, particularly towards the end of life, NICE Enteral (tube) feeding for people living with severe dementia, as well as relevant Local Acute Trust policies for further information / advice regarding non-oral feeding.

#### **4.6 Assessment and management of dysphagia in tracheostomies**

A tracheostomy is a surgical opening in the anterior wall of the trachea to facilitate ventilation; the opening is usually maintained by use of a tracheostomy tube. The procedure may be performed either surgically or by a percutaneous method. Patients who have a tracheostomy and present with swallowing difficulties should be seen by a Speech and Language Therapist with relevant competencies, and alongside competent MDT. St George's Healthcare NHS Trust Tracheostomy guidelines are adhered to in NUH and ELFT.

#### **4.7 Legal issues**

##### **4.7.1 Documentation**

The full details of each SLT assessment, intervention and interaction with carers and multi-agency staff must be recorded in the client's case notes or on electronic systems (e.g. RIO, EMIS) as per the departmental case notes guidelines. This will include all relevant information and the client's medical history. Details of seeking consent for assessment and treatment in dysphagia must also be detailed in the case notes or on the appropriate consent forms as per the SLT consent guidelines, and all written documentation provided to patients and carers will be filed / uploaded. Regular case note audits are completed to ensure that documentation is in line with East London NHS Foundation Trust policies and standards.

##### **4.7.2 Legal liability**

The employing authority is vicariously liable for the clinician within the scope of their duties. This means that they will support the clinician in litigation, provided the charge is not criminal. Registered members of RCSLT have professional indemnity insurance that specifically sites dysphagia as an area of work.

##### **4.7.3 Duty of care**

This occurs from the moment the clinician sees the client and not from the date of referral. It continues until the clinician closes the case.

#### **4.8 Confidentiality**

Clinicians in the UK need to be aware of the Data Protection Act 1998, the European Directive for Data Protection 1988, The Computer Misuse Act 1990 and the Access to Medical Records Act 1990. Speech and Language Therapists employed by ELFT will comply with local policies.

#### **4.9 Staff competencies**

- Job descriptions – any staff working with service users with dysphagia (i.e. screening, assessing, managing, implementing care plans) should have this role reflected in the job description and Knowledge and Skills Framework profile
- Experience and Training – Speech and Language Therapists have specific training in dysphagia to different levels of expertise:

- **SLT students** on placement in the Trust may work with dysphagic clients under the direction of their supervising clinician. All decisions re; swallow safety and management must be made in consultation with the client's therapist and responsibility for the client's management remains with the client's therapist. Students will be expected to use a well-known dysphagia competency framework e.g. the Kings College Dysphagia schedule, or RCSLT Dysphagia Training and Competency Framework, to ensure that they are learning appropriate skills and discussing these with their supervising clinician.
- **Speech and Language Therapists completing their probationary year (AFC Band 5)** will have completed basic dysphagia training as part of their undergraduate training. They are expected to manage non-complex dysphagia cases as part of the multi-disciplinary team, with supervision from senior Specialist Speech and Language Therapy colleagues. They will be required to undertake post-basic dysphagia training appropriate to their specialty.
- **Specialist and Highly Specialist Speech and Language Therapist (AFC Band 6 & 7)** will have completed post-basic dysphagia training. They will be expected to manage complex dysphagia cases as part of the multi-disciplinary team with supervision from senior Specialist Speech and Language Therapy colleagues.
- **Clinical Lead Speech and Language Therapist (AFC Band 8a)** will have significant training and experience managing very complex dysphagia cases as a lead practitioner within the multidisciplinary team. They will supervise other Speech and Language Therapy colleagues.

#### 4.10 Education and training

SLTs have a responsibility to train other carers and professionals in:

- Identifying signs of dysphagia.
- Identifying aspiration risks.
- Referral and re-referral to SLT.
- Best feeding practice.
- Carrying out recommendations.

This should be tailored to the feeding environment of the client and specific client needs. Please contact your local Speech and Language Therapy Service regarding training.

The Newham Adult Speech and Language Therapy Service have developed an online training module providing an introduction to dysphagia (feeding, eating, drinking and swallowing difficulties) for all ELFT staff working with adults, including nurses, healthcare assistants, rehab support workers, catering staff. This is available via OLM, please search for "363 Dysphagia and Swallowing Difficulties (e-Learning)".

#### 4.11 Rehab support workers

Rehab Support Workers will only carry out delegated dysphagia intervention programmes following an assessment by a qualified, competent SLT. Their competence to carry out such activities will have been assessed by the SLT using the work-based competencies available. The worker will be closely supervised by the SLT during the delivery of the treatment programme. At no point will the worker make assessment or management decisions regarding the client's care.

#### **4.12 Infection control**

Current infection control guidelines will be followed as per the relevant NHS trust policies and departmental procedures. Annual infection control training is a requirement for all therapists covered by this policy, including MRSA and decontamination training. Please see section for further details regarding use of PPE in context of COVID-19.

#### **4.13 Storage of food**

Any food/drink supplied by the SLT department for use in dysphagia assessment and intervention will be kept and used as per the Statutory Health & Safety Food Hygiene Policy. Liquid thickener will be used by the expiry date and will be dated and signed when opened and used within the specified use by date.

#### **4.14 Medicine format**

During assessment and intervention, SLTs may recommend modification to the texture of food or the thickness of drinks. This advice may also have a potential impact on the format of medication the client is currently receiving. SLTs will always seek advice from a pharmacist and request that the format of medication is reviewed by the GP / consultant. SLTs will not advise any change to the format of medication.

#### **4.15 Discharge criteria**

Discharge planning occurs continually throughout assessment and management. These plans depend on factors such as severity, diagnosis and outcome. They are made in agreement with the client and multidisciplinary team and are documented. The client, carers and team are given information on how to contact the speech and language therapy department in the future and re refer if necessary. Potential reasons for discharge are listed below (Marks and Rainbow, 2001):

- No abnormality detected.
- Assessment and advice.
- Problem resolved.
- Modified regime established and / or present potential realised.
- Deteriorating medically.
- Non- compliance.
- Transferred (including to other therapist).
- Failure / unable to attend.
- Died.
- Therapist withdrawal.

#### **4.16 Referrals to other agencies**

At any time the SLT may refer on to relevant specialties and agencies as appropriate.

#### **4.17 Mental capacity**

The Mental Capacity Act (2005) is an Act of the Parliament of the United Kingdom which applies in England and Wales and came into force in April 2007. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Speech and Language Therapist may be involved in contributing towards an assessment to determine if a person with feeding / swallowing difficulties has the capacity to make a decision regarding their feeding / swallowing (e.g. assessment of understanding of language, making information accessible, exploring AAC options to facilitate communication, etc). The Trust's MCA policy and further information

regarding the MCA and Code of Practice can be found on the intranet; alternatively please seek advice from your local mental health law office.



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