# Dysphagia Policy

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# Version Control Summary

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<td>Donna Power</td>
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<td>November 2013</td>
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<td>References</td>
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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. This policy aims to reflect the management of swallowing difficulties within the Community Health Newham Directorate and across the wider ELFT organisation.

The policy also clarifies the role of speech & language therapists (SLT’s) 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 patient 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 client.
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).
5. Clarifying the training responsibilities and professional role of SLTs working in dysphagia.
3. Multidisciplinary management of oro-pharyngeal dysphagia

3.0 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 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 sequela 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 78 and 90), Royal College of Physicians 2008.

3.1 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>
<thead>
<tr>
<th>Table1: Client group</th>
<th>Incidence/Prevalence of condition</th>
<th>Incidence/Prevalence of dysphagia within condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stroke</strong></td>
<td>Each year in England, approximately 110,000 people have a first or recurrent stroke and a further 20,000 people have a TIA. NICE 2008. Up to 78% have dysphagia immediately post stroke (Martino et al 2005).</td>
<td>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 2008). Of all those with initial dysphagia following stroke 76% will remain with a moderate to severe dysphagia and 15% profound (Mann et al 1999)</td>
</tr>
<tr>
<td><strong>Progressive neurological disease</strong></td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Condition</td>
<td>Prevalence/Details</td>
<td></td>
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<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>27% of those with COPD (McKinstry et al 2009)</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>68% of those with dementia in homes for the aged have dysphagia (Steele 1997)</td>
<td></td>
</tr>
<tr>
<td>Adults with Learning Disability</td>
<td>It is estimated that 985,000 people in England have a learning disability (2% of the general population) <a href="http://www.bild.org.uk">www.bild.org.uk</a> (Steele 1997)</td>
<td></td>
</tr>
<tr>
<td>Nursing Home residents</td>
<td>5.27% of all adults with a learning disability were referred for advice regarding dysphagia (Chadwick et al 2003)</td>
<td></td>
</tr>
<tr>
<td>Acute hospitalised elderly</td>
<td>Between 50-75% of nursing home residents (O’Loughlin&amp;Shanley 1998)</td>
<td></td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>Affects approx.. 1 in 400 children, ie approx. 1,800 diagnosed with CP in Britain each year. Incidence increases to 1 in 20 for babies with a birth weight under 1500g (SCOPE, 2012). Prevalence figures of dysphagia in cerebral palsy varies between 27% (Waterman et al, 1992) and 81%.</td>
<td></td>
</tr>
<tr>
<td>Cardiac disorders</td>
<td>1 in a hundred children with a cardiac condition has a risk of concomitant feeding difficulties (Children’s Heart Foundation, 2006)</td>
<td></td>
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<tr>
<td>Gastro-oesophageal reflux</td>
<td>Feeding problems affecting behaviour, swallowing, and food intake and mother-child interaction have been found to be common in infants with GOR (Mathisen et al, 1999)</td>
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<tr>
<td>Prematurity</td>
<td>80,000 babies are born prematurely in the UK each year (BLISS, 2011)</td>
<td></td>
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<tr>
<td>Prematurity</td>
<td>Premature babies commonly have difficulties establishing feeding, and some may need ongoing support, particularly those with associated neurological difficulties.</td>
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<tr>
<td>Oesophageal atresia</td>
<td>Affects approximately 1 in 4000 births</td>
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<tr>
<td>Oesophageal atresia</td>
<td>60-70% experience problems with dysphagia post-operatively (Munro, 2003)</td>
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<tr>
<td>Cleft lip and palate</td>
<td>Affects 1 in 6-700 births (WHO Expert Committee, 2002)</td>
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<tr>
<td>Cleft lip and palate</td>
<td>Feeding difficulties pre and post surgery occur in a significant number of children.</td>
<td></td>
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<tr>
<td>Craniofacial conditions</td>
<td>No figures available, but by their very nature, craniofacial conditions are likely to impact</td>
<td></td>
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</table>
Learning disabilities and congenital syndromes

57% of people with LD reported to have some level of nutritional difficulties (Kerr et al, 2003).

Autism

Approximately 1 in 100 children (NAS, 2011)

Some children with autism may have difficulties with food due to sensory disturbances with smell and texture (Bogdashina, 2004)

Trauma (eg tube-feeding, surgery, tracheostomy)

High incidence of clinical and behavioural feeding difficulties (Douglas & Harris, 2001)

Mental health

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)

Reference for paeds working with neonates: British Association of Prenatal Medicine (BAPM): Service Standards for Hospitals Providing Neonatal Care, 2010

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 RCSLT 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 being associated with impairment of oral structure, the respiratory or neurological system.

3.3 What causes dysphagia?

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

- Neurological – including central nervous system, anterior horn cell, peripheral nervous system, 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/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 and Dementia
- Developmental disorder (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.

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

If untreated, dysphagia can lead to further problems including:

- Choking
- Dehydration
- Malnutrition
- Aspiration Pneumonia
- Asphyxiation
- Chronic pain
- Adverse socioemotional 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 management decisions). Sometimes regardless of the potential risks explained to the adult client by the team the client chooses to continue with oral food and fluid for quality of life. In this situation it is important to document the fact that the risks of 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 (DOH 2005).

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 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, Community Health Newham Child Protection Policy, 2009).

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 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.
- To identify and communicate the risk factors to the client, family and team members.
- To advise the client, their family, carers and nursing staff 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.
- 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 dehydration and malnutrition.
- To complete oral hygiene in accordance with nursing guidelines.
- Ensuring patients receive the appropriate level of assistance with feeding (e.g. hand over hand assistance, partial assistance, full assistance).
- Ensuring 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 keep 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 (e.g. Fine bore nasogastric or NG tubes, fine bore nasoduodenal/ jejunal tubes, percutaneous endoscopic gastrostomy feeding tubes or PEG’s, Percutaneous jejun a 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:

- Positioning the client/ recommendations 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
- Increased bacteria presenting a high risk of chest infection/ pneumonia if this saliva is aspirated.
- 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.

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 the teeth, gums and mouth. They may also assess and recommend the need of dentures and manage ongoing needs (e.g., resizing if appropriate).
4.0 Speech and Language Therapy management of oro-pharyngeal dysphagia

4.1 Access to the service – referral criteria/response times

SLT Professional Guidelines (Communicating Quality 3, RCSLT 2006) 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. SLTs reserve the right to prioritise referrals in line with their professional judgement, according to the information received and may not accept the referral if the client is not yet suitable for an assessment.

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

<table>
<thead>
<tr>
<th>TEAM NAME</th>
<th>REFERRAL CRITERIA</th>
<th>RESPONSE TIMES</th>
</tr>
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<tbody>
<tr>
<td>Virtual Wards/ Extended Primary Care</td>
<td>Adults (16+) with an acquired swallowing difficulty.</td>
<td>Virtual Wards: 2 working days</td>
</tr>
<tr>
<td></td>
<td>*This service is also currently piloting a non urgent SLT service to Tower Hamlets Inpatient’s Mental Health wards The Green, Leadenhall Ward and Columbia Ward.</td>
<td>Extended Primary Care: 2 weeks</td>
</tr>
<tr>
<td>Community Neuro Service- Newham</td>
<td>Adults (16+) with a neurological diagnosis with an acquired swallowing difficulty.</td>
<td>2 weeks</td>
</tr>
<tr>
<td>(formerly Community Disability Service and Community Stroke Team).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newham Community Health Team for People with Learning Disabilities</td>
<td>Adults (16+) with a learning disability and a swallowing difficulty.</td>
<td>5 working days</td>
</tr>
<tr>
<td>Child Development Centre</td>
<td>0-5 years with a swallowing difficulty.</td>
<td>2 working days- acute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 working days- community</td>
</tr>
<tr>
<td>School’s Team Service</td>
<td>5-16 years with a swallowing difficulty.</td>
<td>2 working days- acute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 working days- community</td>
</tr>
</tbody>
</table>
4.2 Assessment of dysphagia

4.2.1 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 with accompanying strategies as appropriate
- Provide verbal and/or written feedback to all those involved
- 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.

4.2.1 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
- Information on current and past feeding pattern
- Effects of emotional state, mood and behaviour
- Participation of other professionals
- Eating, drinking and swallowing history including birth, early and subsequent development
- Technique of feeder
- Environment for feeding

4.2.3 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 assessment 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
- Oro-facial examination
- Vocal tract function
- Gross and fine motor skills/posture and use
- Assessment of sensory abilities including vision, hearing, processing and integration.
- The clients' management of secretions
- The clients' cognitive level
- Levels of alertness

4.2.4 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.

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

4.3.2 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 refer to NUHT Videofluoroscopy Policy and RCSLT Videofluoroscopy Policy.

4.3.2 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 (J. 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.

4.3.3 CERVICAL AUSCULATION

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.

4.4 Management of dysphagia

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

4.4.1 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

4.4.2 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. In East London NHS Foundation Trust the following descriptors are used:
  - Fluids: thin, syrup, custard and pudding
  - Solids: normal, soft easy chew, soft mashed, pureed
- 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:

- Meal and drink consistency
- 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.

4.4.3 Non compliance or disagreement

When working with adults with feeding/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, Community Health Newham Child Protection Policy, 2009).
4.4.4 Non oral feeding

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. feeding orally at risk but this is ultimately a medical decision.

Please refer to the Newham University Hospital Clinically assisted nutrition for patients with a confirmed diagnosis of advanced dementia (2011) policy for further information on the role of the Speech and Language Therapist within the MDT regarding alternative feeding in people with a confirmed diagnosis of Advanced Dementia.

4.5 Assessment and management 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. St George’s Healthcare NHS Trust Tracheostomy guidelines are adhered to in NUH and ELFT.

4.6 Legal issues

4.6.1 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) 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. Regular case note audits are completed to ensure that documentation is in line with East London NHS Foundation Trust policies and standards.

4.6.2 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.

4.6.3 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.

4.7 Confidentiality

4.8 Staff competencies

- Job descriptions - any staff working (i.e. screening, assessing, managing, implementing care plans) with service users with dysphagia should have this role reflected in the job description and Knowledge and Skills Framework profile.

- Speech and Language Therapists - 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 the Kings College guidelines 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 speciality.
  - 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 Therapist colleagues.
  - Clinical Lead Speech and Language Therapist (AFC 8) 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.

4.9 Education and training

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

- Identifying aspiration risks
- Referral and re-referral to SLT
- Best feeding practise
- Carrying out recommendations

This should be tailored to the feeding environment of the client and specific client needs.

4.10 Rehab support worker’s

RSWs 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.
4.11 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.

4.12 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.

4.13 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.

4.14 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 rerefer if necessary. Potential reasons for discharge are listed below (Scottish Intercollegiate Guidelines Network 1997):

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

(In Marks and Rainbow 2001)

4.15 Referrals to other agencies

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

4.16 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.).

References

RCSLT (2009) Royal College of Speech and Language Therapist’s resource manual for commissioning and planning services for SLCN.


Oxleas NHS Trust Dysphagia Policy.

Sandwell NHS Dysphagia Policy.


RCSLT (2005) RCSLT Clinical Guidelines, Speechmark Publishing Ltd.

RCSLT (2009) Resource manual for commissioning and planning services for SLCN: Mental Health