Government of JERSEY

Health and Community Services

Dysphagia Policy: Adult In-Patient JGH

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DOCUMENT PROFILE

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Author	Laura Flynn, Lead Adult Speech and Language Therapist
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Description	This policy aims to ensure the safe and effective management for any adult with dysphagia during their in-patient stay at the Jersey General Hospital
Linked policies	Dysphagia Policy: Adult Community FEES / Videofluoroscopy Nutrition and Dietetic Service Operational Policy and Referral Procedure Nutritional Screening and First Line Oral Nutritional Care Enteral Feeding Policy Transfer of Care Policy
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Contact details	l.flynn@health.gov.je

CONTENTS LIST:

1. INTRODUCTION

1.1 Rationale

The aim of the policy is to ensure the safe and effective management for any adult with dysphagia during their in-patient stay at the Jersey General Hospital.

Dysphagia is a complex condition which can be the consequence of a large number of different aetiologies. It impacts on nutritional and hydration status and can have serious consequences for quality of life including more frequent hospital admissions and increased length of stay in hospital.

1.2 Scope

This policy is written for any person working with a patient with dysphagia across the acute setting and may relate to a number of different client groups. It covers adults only.

1.3 Principles

Multi-disciplinary (MDT) working is crucial for the safe and effective management of patients with dysphagia.

2. POLICY PURPOSE

This policy is intended for use by any member of staff involved in the MDT assessment and management of disorders of swallowing (dysphagia) or in the provision of nutrition (food) and hydration (fluids) for adult in-patients with dysphagia. It outlines the roles and responsibilities of different professional groups to ensure co-ordinated MDT best practice.

This document has been produced by the Speech and Language Therapy as part of Jersey Health and Community Services Department. Consultation with other professional groups was undertaken and current best practice guidelines (1-7) were used in the development of the policy.

As highlighted in the Royal College of Physicians Report 2010 (4) (p. ix), patients with dysphagia require care tailored to their requirements. It should, as far as possible, preserve their oral intake. When this is impossible, short or long term tube feeding may be necessary, and less frequently, intravenous nutrition may be appropriate.

The policy sets out to achieve the following aims:

1. To promote awareness for all involved in the care of in patients with dysphagia
2. To provide best practice for in patients with dysphagia
3. To promote patient safety by minimising the complications arising from dysphagia (i.e. aspiration pneumonia, asphyxiation, dehydration and malnutrition)
4. To promote quality of life and achieve swallow safety balanced with preserving pleasure with adequate nutrition and hydration

3. CORPORATE PROCEDURE

See Appendix 1 for diagram of summary of multi-disciplinary pathway for managing dysphagia.

3.1 Clinical Issues of Relevance to Dysphagia

Dysphagia can manifest in several ways including dehydration, weight loss, frequent coughing and spluttering, prolonged mealtimes and loss of the pleasures and social aspects of eating and drinking. In severe cases it can leads to aspiration pneumonia.

3.2 Conditions associated with Dysphagia

Patients with established lung disease may be more susceptible to the development of respiratory complications following aspiration and the diseases themselves may reduce the effectiveness of coughing. Breathlessness itself makes oral feeding difficult.

Structural disease of the face, mouth and upper gastrointestinal tract, including the effects of recent or past surgery and radiotherapy, can preclude effective oral preparation of the bolus and swallowing, and compromise or preclude oral feeding.

Neurological problems which may affect the pre-oral phase, bolus control in the mouth, swallowing and respiratory function include:

- weakness
- loss of voluntary control
- apraxia of the face, lips, tongue and palate
- coma
- deleterious change in conscious level
- vigilance
- attention and concentration
- impairments of posture
- balance
- visual fixation
- spatial awareness
- poor coordination

People with Learning Disabilities will be at greater risk of having dysphagia. The NPSA (2004) (8) states that dysphagia is a significant health risk for people with learning disability. Aspiration pneumonia is a significant cause of death, and more likely to die due to choking/asphyxiation. Improvement management of dysphagia therefore increases quality of life and reduces hospital admissions.

Prevalence studies of dysphagia in people with dementia show that 68% of patients with dementia / in care home present with dysphagia (Steele et al 1997) (9). This is associated with an increased risk of choking incidents and aspiration due to problems with chewing, difficulty swallowing, effects of medication, and behavioural issues e.g. eating too fast.

Oropharyngeal dysphagia is an important factor leading to pneumonia in the elderly, with pneumonia being the leading cause of death among residents in nursing homes (Marik &

Kaplan 2003) (10). Those at highest risk of aspiration pneumonia are those who are reliant on others for both oral care and assistance with eating & drinking (Langmore et al 1998) (11).

Evidence from the literature suggests that dysphagia is a common problem in adults with mental health problems. Prevalence rates vary from 19% - 32% (Aldridge and Taylor 2011) (12). Choking is also prevalent with this client group. Ruschena et al (2003) (13) reported that the risk of death by choking was 30 times greater in people with schizophrenia than in the general population.

3.3 Environmental and Situational Considerations

The following factors all have the potential to impact mealtimes and safe eating and drinking. The availability of carers, the consistency, temperature and appearance of available food, the atmosphere in the ward or home including the number of distractions and interruptions, and a lack of appropriate seating.

These are of particular relevance to the pre-oral stage, and motivation to eat and drink. These are important considerations especially in those patients with conditions affecting cognition and behaviour.

3.4 The Roles of the Multi-disciplinary Team in the Management of Dysphagia

Dysphagia requires expert and close collaborative MDT working in order to address the multifaceted nature of the difficulty [7]. The team members will vary depending on the particular needs of the person, the carers and the individual setting. The roles of different staff are summarised in table one below:

Table 1: The Roles of the Multi-disciplinary Team

Team member	Roles
Patient and Carers	Participation in assessment, decision-making, goal planning and implementation when appropriate.
Hospital Medical Teams	i) Referral to relevant other professionals if dysphagia is suspected. ii) Medical investigation into the cause of dysphagia and treatment if appropriate. iii) Consideration and implementation, when appropriate, of a plan for alternative nutrition or hydration when a patient is unable to achieve adequate oral nutrition or hydration. iv) Ensure appropriate training of staff.
Nurses	i) Initial screening for the signs of dysphagia if dysphagia-screening training has been completed. ii) Nutritional screening. iii) Initiation of referral to appropriate professionals. iv) Implementation of dysphagia recommendations through the development and review of care plans to maximise safe and adequate nutrition and hydration. v) Support to patient and carers to participate in care plans. vi) Recording of oral intake, tolerance and day-to-day difficulties and liaison with other members of the multi-disciplinary team. vii) Provision of alternative hydration and nutrition when required in liaison with the Department of Nutrition and Dietetics. viii) Maintenance of good oral hygiene. ix) Accurate information on discharge summaries.

Speech and Language Therapists	i) Assessment, diagnosis and monitoring of oro-pharyngeal swallowing problems within appropriate time scales. ii) Taking into consideration risks, patient choice, best interests and quality of life. iii) Therapy, support and advice to patient, carer and team regarding appropriate consistencies and compensatory strategies and positioning. iv) Multi-disciplinary training on the management of dysphagia. v) Videofluoroscopic examinations of swallow with Radiology. vi) FEES assessments of swallow in ENT. vii) Documentation in correct systems. viii) Follow up in community and onward management if required of the patient with dysphagia.
Dietitians	i) Assessment and monitoring of nutritional requirements with consideration of S&LT recommendations. ii) Provision and monitoring of tube feeding regimes for those who need enteral tube feeding. iii) Recommend and prescribe enteral feeds and dietary supplements. iv) Multi-disciplinary training on adequate nutrition for patients with dysphagia.
Nutrition Nurse Specialist	i) Assessing suitability for enteral and parenteral nutrition. ii) Facilitating placement of enteral feeding devices. iii) Collaborative working with MDT for best patient outcomes. iv) Provide education and support for patients and families.
Pharmacists	Advise on appropriate administration of medication for patients with dysphagia.
Physiotherapists	i) Assessment, treatment and management of the respiratory system. ii) Advice on positioning when eating and drinking. iii) Head control management.
Occupational Therapist	i) Assessment and management of the impact of physical, environmental, social, behavioural and cognitive/ perceptual factors associated with dysphagia. ii) Advice regarding adaptive equipment and positioning at mealtimes.
Psychologist	Assessment and management of the socio-emotional, behavioural and psychological components of dysphagia.
Catering staff	Provision of attractive, nutritious and suitably fortified foods of suitable consistencies.

3.5 Identification and Screening for Dysphagia

All members of the MDT will be aware of the indicators of dysphagia summarised in table 2. When dysphagia is suspected, a referral for assessment will be made to the appropriate professional. Symptoms of oesophageal dysphagia requires medical management.

Table 2: Indicators of Dysphagia

Indicators of dysphagia	**Oro-pharyngeal stages**	**Oesophageal stage**
Difficult, painful chewing or swallowing at level of larynx	✓	
Regurgitation of undigested food		✓
Nausea/vomiting		✓
Difficulty controlling food or liquid in the mouth	✓	
Drooling	✓	
Pooling of food, or food residue in the mouth.	✓	
Hoarse voice	✓	
Coughing or choking before, during or after swallowing	✓	✓
Globus sensation	✓	✓

Nasal regurgitation	✓	
Feeling of obstruction below laryngeal level		✓
Unintentional weight loss	✓	✓
Change in respiration pattern	✓	✓
Unexplained temperature spikes	✓	✓
Wet voice quality	✓	
Xerostomia (dry mouth)	✓	
Heartburn		✓
Change in eating habits, e.g. eating slowly	✓	✓
Frequent throat clearing	✓	✓
Recurrent chest infections	✓	✓

Factors which may increase the risk for those at risk of aspiration:

- reduced dentition
- psychotropic medication
- polypharmacy
- lack on interest of attention when eating and drinking
- overloading food into the mouth
- speed of eating
- pace / agitation whilst eating
- holding food in the mouth
- swallowing without chewing
- mood levels
- levels of alertness
- poor insight into difficulties
- poor oral hygiene

3.6 Screening of Dysphagia for Adult In-patients at the Jersey General Hospital

Junior Doctors, Middle Grade Doctors, and Nurses at the Jersey General Hospital who have undertaken the dysphagia training for nurse's course will screen adult in-patients using the Dysphagia Screening Test protocol (Appendix 2). This has been updated for the Covid 19 pandemic.

Patients with CVA will be screened within four hours of admission in line with the Royal College of Physicians Stroke Guidelines (2016) (14). The completed protocol form will be kept in the patient's nursing notes and a sticker with the outcome will be placed into their medical notes. If a patient fails screening, or requires a communication assessment, the team will alert the Speech & Language Therapy service via referral process outlined below.

3.7 Referral to Speech and Language Therapy

Patients with oro-pharyngeal difficulties will be referred for Speech and Language Therapy assessment. The service has an open referral policy and will accept referrals from anybody involved in the patient's care.

For an adult patient in the Jersey General Hospital the responsible nurse will leave a message on the Adult S&LT hospital voicemail (45601) and a swallow screen will have been completed if appropriate. The message will detail the patient's name, URN or date of birth, and the reason for referral. One of the Adult S&LT team will respond within 2 working days. This in line with the guidelines set out by the Royal College of Speech and Language Therapists on response times. This process will be subject to change with the roll out of the Electronic Patient Record (EPR) planned for mid 2023.

3.8 Speech and Language Therapy Assessment of Swallowing

Assessment will be undertaken with the consent of the patient, and where this is not possible assessment may be undertaken in their best interest with agreement of the multi-disciplinary team.

On the basis of the findings of this preliminary assessment, the therapist will give oral trials of food and drink, observing all phases of the swallowing process. Compensatory strategies may be employed during the oral trials which may include modification of consistencies, bolus size and positioning and use of airway protection techniques. The Speech and Language Therapist may request videofluoroscopy or FEES assessment to contribute to the assessment and management process if required (15, 16).

Assessment may also highlight the need for onward referrals to Occupational Therapy, Dietetics, Physiotherapy or Psychology for their support in managing the patient with dysphagia from the perspectives outlined in table 1. The assessing Speech Therapist or medical team can make these onward referrals (see Appendix 3).

Assessment results will be documented in the patient's Speech and Language Therapy Care Partner notes. In addition, recommendations will be documented in the patient's medical notes. 'PIPA' signage above the patient's bed will indicate IDDSI levels recommended by the Speech and Language Therapist.

Swallowing assessments for patients with a tracheostomy will only be undertaken by a Speech and Language Therapist with appropriate skills in this area. A Physiotherapist or Nurse trained in suctioning will be present. Assessment will be undertaken with the cuff deflated, and only when it is considered medically safe to do so.

If the medical team deem it necessary to asses with the cuff inflated, a multi-disciplinary discussion will take place to consider whether the benefits of oral trials outweigh the risks of aspiration. The outcome of the discussion will be documented in the medical notes.

3.9 Recommendation of Nil by Mouth

When the Speech and Language Therapist's assessment indicates that a patient is at high risk of aspiration from oral intake, this will be documented in the medical notes for in-patients or communicated with the patient's Doctor. A patient-centred decision will be made about artificial nutrition and hydration and the means of delivery. The final decision as to whether a patient is to remain nil by mouth is the responsibility of the patient's Doctor. In some feeding at risk is appropriate, if alternative feeding is not deemed the appropriate option. See section 3.15 for further information on best practice when risk feeding.

"Nil by mouth" should be the last resort, not the initial default option, and the least restrictive option.

When the Doctor decides to make an in-patient nil by mouth, a nil by mouth (NBM) sign will be placed above the patient's bed. The medical team will consider:

- the need for alternative hydration and nutrition
- the need for non-oral administration of drugs.

In some cases the Speech and Language Therapist may recommend that the patient is trialled with small quantities of oral intake. If the Dietetic assessment indicates this is insufficient to meet nutritional requirements, alternative hydration and nutrition will also be considered.

3.10 Intravenous (IV) Fluids

The medical team will assess the need for and prescribe intravenous (IV) fluids when required. Nursing staff trained in IV administration will administer the fluids. Electrolytes will be monitored regularly by the medical team. The Dietitian will look at fluid intake as a whole, including IV fluids and any oral intake when planning tube feeding regimes.

3.11 Alternative Feeding

If a patient is deemed to have unsafe swallow, and placed nil by mouth (NBM), then alternative feeding should be considered. The type and route for artificial feeding will be decided by the patient's medical team and multi-disciplinary team. This must be considered as soon as possible to avoid nutritional compromise, a patient must not be left NBM without alternative feeding for more than 72 hours with no decision on tube feeding, and/or risk feeding. Please refer to Appendix 1.

See 'The safe insertion and ongoing care of a Nasogastric (NG) feeding tube in adults' (17) for full guidance on indications for enteral feeding and management of enteral feeding tubes.

For patients with progressive conditions, the MDT will provide timely information about the potential for increasing severity of dysphagia and the range of management options for the future. This may include discussion about long term alternative nutrition and hydration so that patients are able to make timely and informed decisions. This may also include advanced decision making.

3.12 Management of Dysphagia

The key outcome from the multi-disciplinary assessment process will be a co-ordinated management plan devised by the MDT in partnership with the patient and carer. This will take into consideration prognosis, quality of life and ethical issues.

3.13 End of Life Considerations

At the end of life, even if the patient is deemed to have "an unsafe swallow", a risk management approach will offer the patient the best quality of life. This will raise ethical

and moral questions regarding the appropriateness of non-oral feeding vs. the risks of aspiration and this must always be individually assessed. Those imminently dying should be supported to pursue comfortable oral intake for QoL and following their wishes (see references below).

3.14 Risk feeding

CHOICES is a tool developed by Hazel Ferreira, Speech and Language Therapist and is used in areas of the NHS (18). It guides the principles of decision making should there be a risk with continued oral intake due to dysphagia, when alternative feeding is not appropriate. It is guided by the principles in 'Supporting people who have eating and drinking difficulties: A guide to practical care and clinical assistance, particularly towards the end of life RCP (2021) (19) and eating and drinking difficulties with acknowledged risk: MDT guidance for the shared decision making process – adults (RCSLT 2021) (20).

Risk feeding may be appropriate in the following situations:

- the benefits of oral intake out weight the risk (consider QoL, chest infections, weight loss)
- alternative feeding is not appropriate e.g. given nature of patient's condition, and will not improve QoL or outcomes
- approaching end of life, but not imminently dying
- patient wishes to continue with oral intake despite the risk of aspiration, and decides not to have any alternative feeding

Appendix 4 outlines the main factors to be considered when making the decision with a patient associated with continued oral intake in the context of dysphagia. It provides a process for the decision making and appropriate documentation.

C – Centred around the patient
H – Holistic
O – Options
I – In the best interests
C - Communicated
E – Evidenced
S – Shared

Best practice is that the Consultant, Nurse, Speech and Language Therapist, Dietitian and Nutrition Nurse are the core members of the team supporting the patient and their family with these complex decisions (see Appendix 4). All decisions are documented and shared with patient and their family.

3.15 Capacity

Every individual should be deemed to have capacity unless proven otherwise. Please see the Capacity and Self Determination (Jersey) Law Jersey 2016 (21).

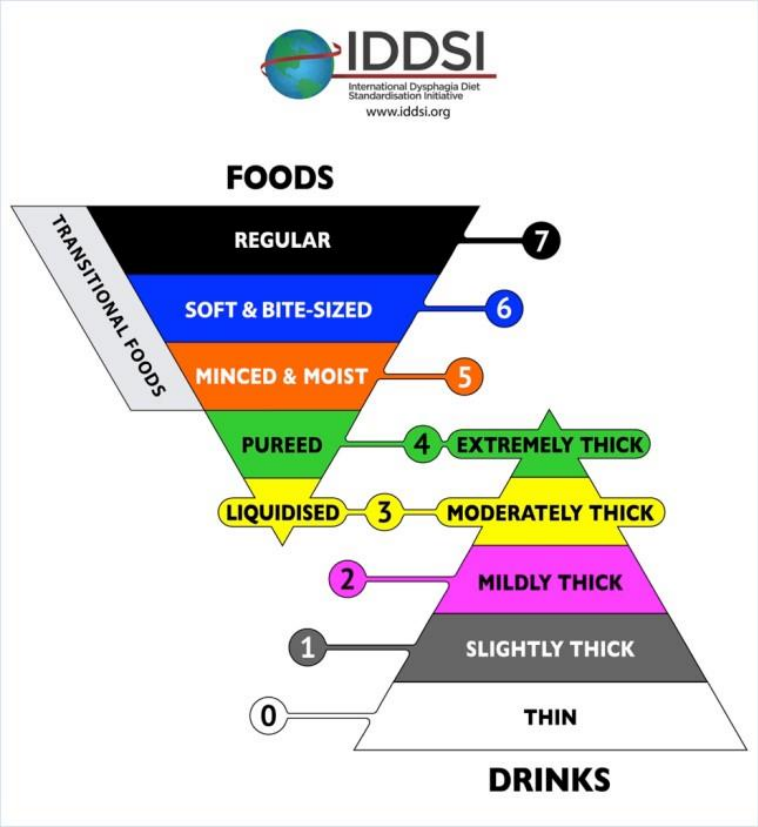
A patient may choose not to follow the recommendations made by the Speech and Language Therapist, and choose to feed orally 'at or with risk'. In these instances the patient should be supported to eat and drink as they wish, ensuring that they have all the information required to make an informed decision. All discussions will be documented

on the differences and the advice given by the Speech Therapist, and communicated to the medical team responsible for the patient. CHOICES is an appropriate approach in this situation (see Appendix 4).

If a person is deemed not to have capacity to make this decision, then a best interest meeting will be held with all the relevant individuals involved. Any relevant advanced decisions to refuse treatment are legally binding. Otherwise, in situations without an advanced directive, the wishes and beliefs of the patient when competent, their current wishes, their general wellbeing and their spiritual and religious beliefs will be taken into consideration. People close to the patient (relatives, carers and friends) may be able to give information on some of these factors and will be consulted to contribute to decisions about management. CHOICES is an appropriate approach in this situation (see Appendix 4).

3.16 International Dysphagia Diet Standardisation Initiative (IDDSI)

IDDSI (22) was rolled out in Jersey in April 2019 following the international development of the food and fluid levels detailed in the chart below.



All staff who serve food to patients with dysphagia will have undertaken training to understand the food and fluid consistencies that may be recommended. Information can be accessed on the resources page on the IDDSI website www.iddsi.org. Each setting should familiarise themselves with the IDDSI information when managing clients requiring modified diets.

3.17 Ensuring Appropriate Consistencies of Food

Health and Community Services have adopted the IDDSI standards for food and fluid textures. This has led to Jersey adopting Nutilis Clear as thickening agent except in rare circumstances (e.g. a patient wishes to use Nutilis powder, or the Nutilis powder provides a safer consistency).

For in-patients at the Jersey General Hospital 'PIPA' signage with recommended dietary texture and fluid consistency will be placed by nursing staff above the patient's bed to ensure that all staff are aware of appropriate consistencies. Please note that ICU/HDU and Robin Ward do not use these signs.

Nursing staff will also liaise with families to ensure that they understand the recommendations and the importance of food brought from home complying with these recommendations.

The Hospital Catering Department provides a daily choice for patients needing modified texture diets. Puree (IDDSI level 4), minced and moist (IDDSI level 5) and soft and bite sized (IDDSI level 6) diet options are available for patients who have been assessed by a Speech and Language Therapist or are already known to be on modified diets on admission. The diets have to be ordered on an individual basis on the form (Appendix 5). On the private wards, the diet chefs will provide modified textures as requested. Please note level 7 food choices can be made easier to chew by cutting the food up and avoiding 'high risk foods and / or adding sauces and gravies, this is on a needs basis.

IDDSI compliant diets are available to order for Samares Ward, St Saviour's Hospital, and Sandybrook Residential Homes and Day Centres from the General Hospital Catering Department. These meals will be regenerated at ward level by domestic staff. Nursing staff will ensure meals are presented in an appropriate and safe way.

3.18 Ensuring Appropriate Consistencies of Fluids

The manager of the ward will be responsible for ensuring that all staff working with patients with dysphagia are trained in thickening fluids to the appropriate consistency.

As set out in IDDSI, all drinks are to be made up to 200ml with the thickener added before the fluid.

- 1 scoop of Nutilis clear for level 1 (slightly) thick
- 2 scoops of Nutilis clear for level 2 (mildly) thick
- 3 scoops of Nutilis clear for level 3 (moderately) thick
- 7 scoops of Nutilis clear for level 4 (extremely) thick

Each ward has an information pack detailing the guidance on thickening fluids. Nutilis clear thickener is to be stored in the kitchens on each ward.

3.19 Recommendations for Adequate Nutrition

Following the Speech and Language Therapy recommendations on safe food and fluid consistencies, the Dietitian will advise on methods to ensure that the patient achieves

adequate levels of nutrition. Whenever possible, a “food first approach” will be taken with increased nutrition provided by additional ‘normal high calorie foods’. When required the Dietitian may prescribe oral nutritional supplements (ONS).

All in-patient settings will ensure that there is sufficient time given to patients who take a long time to eat an adequate meal. In addition there will be sufficient staff at mealtimes to assist and, when necessary, feed patients who require support.

For in-patients at high risk of malnutrition, all meals will be served on a red tray, which highlights to nursing and health care assistants that the patient needs support and assistance with feeding.

3.20 Monitoring and Review

All members of the MDT team have a responsibility to monitor the patient’s swallowing to ensure that adequate nutrition and hydration is maintained. Any change in status will be recorded and liaison with the Speech and Language Therapist will take place before changes to existing recommendations are made. Health Care Assistants will report any deterioration or improvement in the patient’s swallowing to their supervising nurse.

All professional members of the MDT will request a Speech and Language Therapy review if a change in status in the patient’s swallowing function is observed. For in-patients, the staff nurse will be responsible for ensuring timely referral.

Once a patient’s dysphagia has resolved or reached a maximum potential and recommendations have been implemented to achieve safe and adequate nutrition and hydration, the patient will be discharged from Speech and Language Therapy. If they require community follow up, this will be arranged by the Speech and Language therapy Team following discharge from the hospital. Please refer to Dysphagia Policy for Community Settings (23).

It is the responsibility of the discharging Nurse to write the current recommendations on the discharge summary, and to provide a tin of Nutilis Clear on discharge if this is required. Please refer to Transfer of Care Policy (24). The Speech and Language Therapy Team will support with on-going prescriptions of Nutilis Clear in the community, and alert the patient’s GP via a letter if the patient’s swallowing has changed during this admission.

3.21 Staff Competency and Training

Speech and Language Therapists

Speech and Language Therapists managing patients with dysphagia will have completed their dysphagia competencies approved by Royal College of Speech and Language Therapists as a minimum requirement. Speech and Language Therapists who have not undertaken this training may work under the close supervision of a senior colleague.

Senior Therapists with responsibility for specialist areas of dysphagia will have undertaken further appropriate professional development to ensure they are competent in their specialist area.

All Speech and Language Therapists must be aware of the extent and limits of their role and understand that they may not always have a contribution to make, e.g. with patients who refuse to eat and drink or patients with oesophageal problems.

Registered Nurses

For Registered Nurses interested in developing their knowledge and skills in the management of dysphagia, the Speech and Language Therapy department support training in swallow screening (see below).

All nursing staff working with feeding pumps will have the opportunity to attend training either from Dietetic team or via annual training events. Nutricia also have on line training programme.

All nursing staff administering intravenous fluids will undertake training through the intravenous drug administration study day run by the Education Centre four times per year.

Swallow Screen Training

Speech and Language Therapy will arrange 3 face to face training sessions per year for nursing staff. Following this session the nurses will arrange supervised screens to be signed off as competent.

For those who cannot make the training sessions, or wish to do the training in their own time, the Speech and Language Therapy Department also recommend using the managing dysphagia training session on https://www.nutricia.co.uk/hcp/profile/my-account.html

- To do this, create an account with Nutricia and then go to e-learning to find '**managing dysphagia'** session
- Complete the on line training and download your certificate
- email Laura Flynn with your certificate and then we will arrange a practical swallow screening session with you

This training is applicable for all nurses on medical wards who manage patients with dysphagia, and for Junior Doctors and Middle Grade Doctors working on the medical wards. The Deanery has supported the training and their competencies will be managed within their own teams.

Doctors and Nurses undertaking this training are required to undertake assessment of competency including the completion of a minimum of 1 supervised water swallow screening test with a member of the Speech and Language Therapy Team. When this training has been successfully completed, dysphagia trained Nurses and Doctors are competent to undertake swallow screening.

The Speech and Language Therapy Department maintain a list of staff who have been assessed as currently competent for swallow screening. This is circulated to relevant ward managers to enable identification of staff competent to undertake a swallow screen.

To remain competent the staff are required to meet an average of 1 swallow screen per month, and are requested to forward all screens they undertake to the Speech Therapy Department via fax on 443031 or scanned via e mail to evidence this standard.

4. DEVELOPMENT AND CONSULTATION PROCESS

A record of who is involved in the development of this document. This may include HCS committees, service users and other agencies.

4.1 Consultation Schedule

Name and Title of Individual	Date Consulted
Dr Marion Croft	January 2023
Dr Kiran Bangalore	January 2023
Debbie Hill, Lead Physiotherapist	January 2023
Samantha McManus, Therapies Lead	January 2023
Wendy Baugh & Valter Fernandes, Lead Nurses	January 2023
Dr Ng and Dr Duku, Gastroenterology	January 2023
Tim Hill, Practice Development Nurse	January 2023
Laura Foster, Head of Dietetics	January 2023
Neil Giaonni, Catering Manager	January 2023
Toby Farlan, Capacity Assessor	January 2023

Name of Committee/Group	Date of Committee / Group meeting
PPRG	Sept 2021
	Reviewed Jan 2023

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15. Videofluoroscopy Policy (Jersey)

16. FEES Policy (Jersey)

17. The safe insertion and ongoing care of a Nasogastric (NG) feeding tube in adults

18. CHOICES: Guideline for supporting and documenting complex decision making in those with eating, drinking and/or swallowing difficulties. North West Anglia Foundation Trust (2022)

19. Supporting people who have eating and drinking difficulties: A guide to practical care and clinical assistance, particularly towards the end of life RCP (2021)

20. Eating and drinking difficulties with acknowledged risk: Multipdisciplicary team guidance for the shared decision making process – adults (RCSLT 2021)

21. Capacity and Self Determination (Jersey) Law Jersey 2016

22. www.iddsi.org

23. Dysphagia Policy for Community Settings (Jersey)

24. Transfer of Care Policy (Jersey)

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7. GLOSSARY OF TERMS / KEYWORDS AND PHRASES

DTN: Dysphagia Trained Nurse
FEES: Fiberoptic Endoscopic Evaluation of Swallowing
IDDSI: International Dysphagia Diet Standardisation Initiative
IV fluids: Intravenous Fluids
MDT: Multi-Disciplinary Team
NBM: Nil By Mouth
S&LT: Speech and Language Therapist
QoL: Quality of life

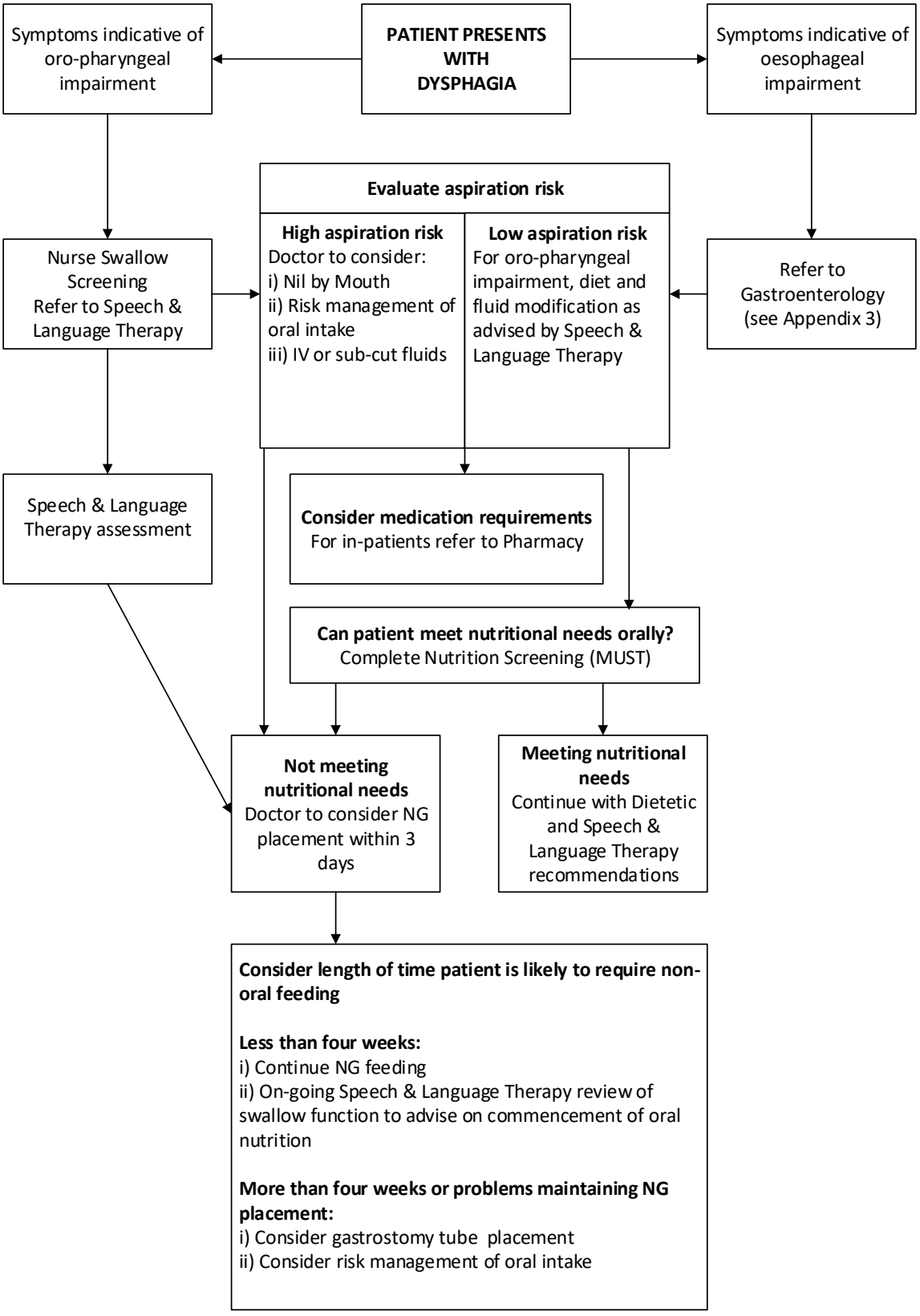
8. IMPLEMENTATION PLAN

A summary of how this document will be implemented.

Action	Responsible Officer	Timeframe
Ensure all Ward Managers and Medical Consultants are alerted to policy to share with their teams	Laura Flynn	Immediately following ratification
CHOICES training sessions	Laura Flynn	To be implemented in training sessions throughout 2023

9. APPENDICES

Appendix 1: Summary of Multi-disciplinary Pathway for Managing Dysphagia



Appendix 2: Dysphagia screening form

DYSPHAGIA SCREENING Record sheet

Assessment criteria
The DST should be administered by a dysphagia trained nurse (DTN) if:

- A patient is showing signs and symptoms of dysphagia, or is nil by mouth (NBM) and awaiting S&LT assessment. **PLEASE ENSURE MAINTAIN GOOD ORAL HYGIENE.**

Patient's name:		Hospital no:	
Assessment discussed with medical staff:		Y/N	
Date:	Time:	Glasgow Coma Score> 11	Y/N
Current oxygen requirements:			

The DST: Initial assessment of function

Voice	Cough –	'Dry swallow' of secretions	Respiratory rate	Other
Normal Hoarse Weak Wet Unable to assess	**Normal** Weak Not observed	**Able to initiate** Unable to initiate **Managing secretions** Not managing secretions	**Stable RR** Increased SoB	**No facial weakness** Facial weakness L/R **Tongue protrusion** Normal Limited Deviates L/R

Speech: normal
Or disturbance: dysarthria (slurred)/dysphasia (language impaired)/Confused or ICU related delirium/no functional speech OR unable to assess/ESL
Any other comments…….

The water swallow test – with patient consent.
Stage 1: Give the patient three teaspoons of water. Circle all signs that apply.

Laryngeal elevation	Voice	Breathing	Cough	Patient Reports
Normal Absent Incomplete Delayed Multiple swallows Unable to assess	**Normal** Increased hoarseness/weakness Wet/'gurgly' Unable to assess	**No change in breathing** Increased SoB	**Absent** Coughing Throat clearing	**Swallow feels normal** Swallow feels different

- DO NOT PROCEED WITH TEST IF ABNORMAL SIGNS PRESENT
- Maintain NBM and refer to speech and language therapist (SLT).
- Repeat the screen in 24 hours if S&LT unavailable

If no abnormal signs present, proceed to stage 2 below.

Stage 2: Give the patient 90 ml water by glass. Circle all signs that apply.

Voice	Cough	Difficulties coordinating breath/swallow	Time taken	Patient reports

Normal/no change Increased hoarseness/weakness Wet/'gurgly'	**Absent** Coughing/Choking Shortness of breath	**No** Yes	<**1 minute** > 1 minute	**Swallow feels normal** Swallow feels different

If any of the above abnormal signs are present at stage 2:

- Maintain NBM and refer to SLT. Repeat the screen in 24 hours if S&LT unavailable.

If *NO abnormal signs present*, the patient has passed the screen:

- Trial of supervised oral intake on L0 (thin) fluids and L7 (regular) diet for 24 hours.
- OBSERVE CLOSELY FOR FATIGUE.
- Refer to S&LT with any further concerns.

Record sheet:

Patient:……..has been assessed and failed/passed the

Dysphagia Screening Test on…….(enter time and date)

Assessed by:……(accountable DTN signature)

- The patient who fails should be kept nil by mouth and the testing procedure repeated after 24 hours.
- The patient who passes will be put on a trial of L0 (thin) fluids and L7 (regular) diet over an initial 24 hour period. Unless known baseline to already be on modified diet, or staff have concerns that this patient won't manage regular diet textures. Please refer to S&LT in this instance.
- Complete observation checklist to inform patient management during oral intake.
- Oral medications can be provided in suspension form or tablets crushed into a purée/yogurt, provided that this is pharmacologically viable.
- This document must be placed in the medical notes with a brief summary of outcome in medical and nursing notes.

The observation checklist and action plan

Observation	**Action**
Ensure patient is fully alert, if patient is likely to fatigue. ☐	Monitor fatigue. Consider 'little and often' and consider refer to Dietitians if unlikely to meet needs orally.
Patient distractible ☐	Supervised feeding, with verbal prompts, and minimize distractions
Patient nutritionally at risk – according to local nutrition protocol ☐	Refer to dietitian
Poor sitting position ☐	Seek advice from physiotherapist – patient must be sat at 90 degrees.
Oral hygiene poor ☐	Mouth care every…….hours
Pocketing of food. ☐	Ensure mouthcare post feeding.
Patient has spouted lid ☐	Avoid spouted lids, as these increase risk of aspiration.
Patient feeds themselves ☐	Encourage self feeding.
NONE OF THE ABOVE APPLIES	

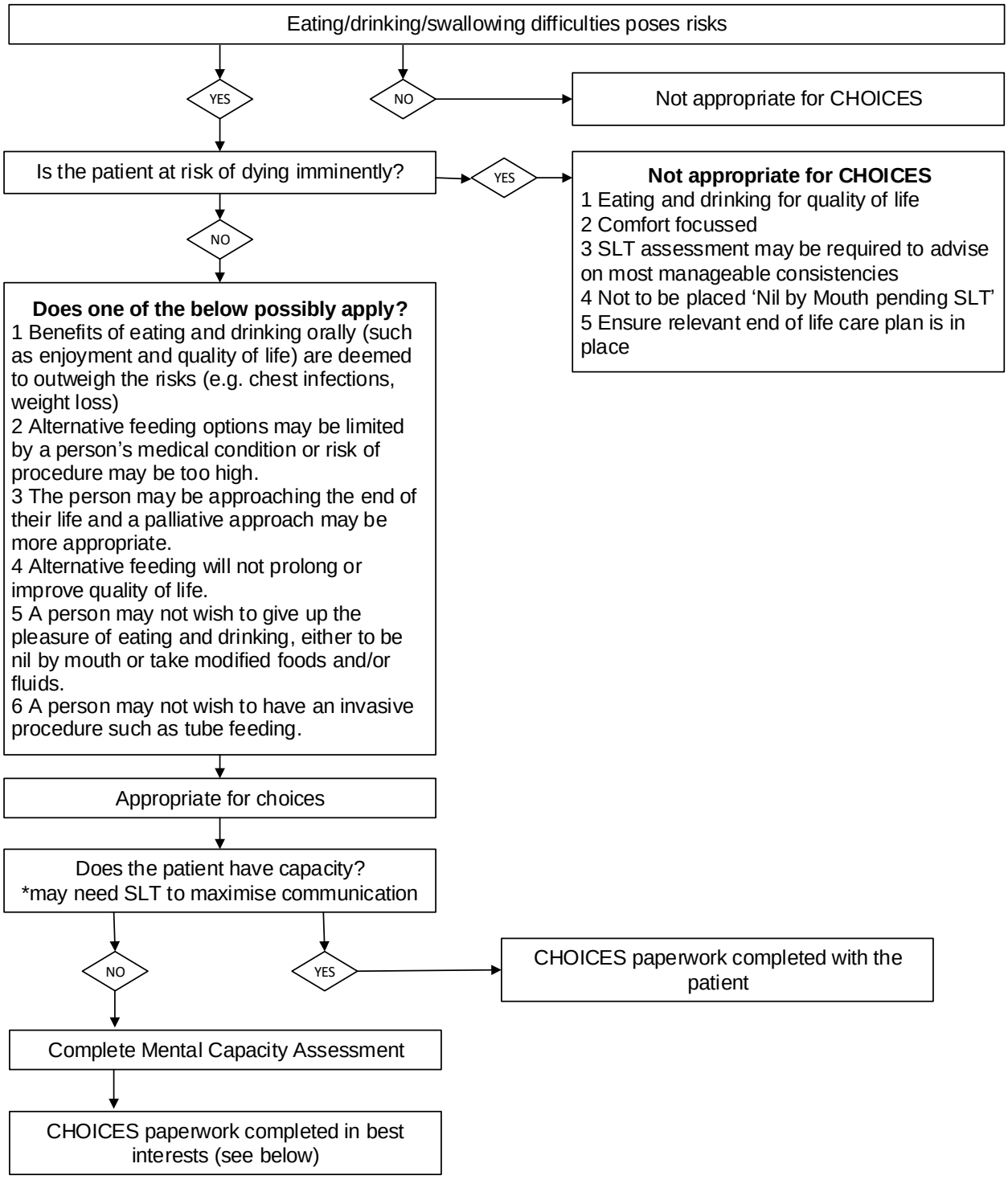
☐ **-** tick if applicable

Appendix 3: Potential onward referrals

Department	When	Policy/Referral
Nutrition and Dietetics	All adults admitted to Jersey General Hospital should be screened for malnutrition within 24 hours of admission. Screen all in-patients using MUST.	See Nutrition & Dietetic Service Operational Policy and Referral Procedure for full guidance and information on inpatient and how to refer to the Nutrition & Dietetic Service.
Gastroenterolgy	When dysphagia is suspected to be oesophageal in origin, S&LT will suggest a referral to the Gastroenterology Medical Team requesting their assessment and advice.	For in-patients, the managing Medical team make this referral if they are in agreement with the S&LT advice.
Physiotherapy	Patients should be referred to physiotherapy when dysphagia is suspected to have resulted in aspiration with respiratory compromise, or when respiratory impairments are affecting the efficacy of swallowing. In addition, physiotherapy opinion should be sought in relation to movement and postural control and alignment, particularly with reference to positioning for eating and drinking and to optimise respiratory function.	For inpatients, referral to physio can be made by any member of the MDT at ward specific daily ward handover meetings, or by liaising with the relevant ward physiotherapist directly. Standard physiotherapy cover is available on the wards at JGH between 08:30-16:30 Mon-Fri. Should referral be necessary for patients with respiratory compromise outside these hours, the on-call physiotherapist can be contacted via switchboard.
Occupational Therapy	Patients who have physical, perceptual, or cognitive impairments impacting on their ability to eat and drink may benefit from Occupational Therapy support for assessment for environmental, positional or	All referrals to the Occupational Therapy department are made via SPOR.

	adaptive equipment to support when eating and drinking and/or at mealtimes.	
Pharmacy	In-patients on medication who are nil by mouth or who are unable to swallow their medication safely will be referred to the Ward Pharmacist or Medicines Information Pharmacist, who will provide advice and supply alternative forms of medications if available.	The Ward Pharmacist visits each ward daily or can be contacted via bleep; the Medicines Information Pharmacist is available on 442628. Pharmacy opening times are Monday to Friday from 08:00 til 17:30 and on Saturdays and Sundays 10am til 13:30. If any advice on alternative preparations is needed outside of those hours then the on-call pharmacist can be bleeped via switchboard.
Videofluorscopy	Referral is made by the Medical Team to Radiology Request form	See Videofluoroscopy Policy
FEES	FEES will be arranged by S&LT Team and ENT	See FEES Policy.

Appendix 4: CHOICES



Name		DOB		URN		Date	

Centred around the Person: (Past/present wishes and beliefs, implications for the individual – QoL, future recovery potential)
Holistic: (Consider in context of other co-morbidities, prognosis, reversible causes, frailty score, previous level of function)
Options: (List the choices in this case? Texture modification? Alternative feeding? Pros and cons of options? Advanced care planning options? How will future infections be managed?)
In best Interests: Presumed mental capacity? Yes ☐ No ☐ If no = Mental Capacity Assessment ☐ IMCA needed? Yes ☐ No ☐ LPA Health and Welfare? Yes ☐ No ☐ (if yes- who. Place copy in notes). Advance Directive? Yes ☐ No ☐ (if yes- Place copy in notes).
Communicated: Who have the choices been discussed with (name, relationship to person), how and when? When (date): How: Who:
Evidenced: (What are the risks? How do we know they exist? How frequent /severe are they? S&LT assessment +/- instrumental assessment, frequency of chest infections, weight loss history etc)
Shared: (Which professionals have been involved in this decision making process? Name and profession): Who needs to know for the future?
CHOICE: (including wishes for future management of infections +/- hospital readmission)

Supporting Team Members

Team Member	Name	Involved yes/no
Lead Consultant*		
Ward Nurse*		
Speech and Language Therapist *		
Dietitian*		
Nutrition Nurse*		
Pharmacist		
Palliative Care Nurse / Consultant		
Gastroenterologist		
Physiotherapist		
Safeguarding Team		
Learning Difficulties Specialist Nurse		
Other Specialist Nurses, e.g. MS		
IMCA		
Family member		
Representative from nursing home		

*Core members

Appendix 5: Special diet request form for IDDSI compliant diets levels 4-6

SPECIAL DIET REQUEST FORM FOR IDDSI COMPLIANT DIETS LEVELS 4-6					
Date & day of meals required.					
Patients Name					
Ward				**Contact Number**	
	Please tick texture required				
Soft and Bitesized (level 6)					
Minced and Moist (level 5)					
Pureed diet (level 4)					
	LUNCH please tick		**EVENING please tick**		
Turkey		Turkey			
Beef		Beef			
Pork		Pork			
Fish		Fish			
Vegetarian		Vegetarian			
Chicken		Chicken			
Pureed Fruit pudding		Pureed Fruit pudding			
NB smooth Yoghurts, jelly and ice cream will also be suitable (but check if patient is on thickened fluids)					
Options for lighter diets	**Please contact ward prep to request**				
Fish					
Chicken					
Plain omelette					
Low Potassium Vegetable Broth also available from ward prep					
Contact Ward prep for					
Soya Milk					
Milk free spread					
Gluten free bread					
Vegan Meal					
Any queries please call Ward Prep: 42361 (or office number: 42327)					