**Clinical**

**Food, Fluid and Nutritional Care Policy (Adults)**

SECTION 6: DECISION MAKING IN THE MANAGEMENT OF ADULT PATIENTS WITH DYSPHAGIA

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This policy does / does not apply to Medical/Dental Staff
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## Policy Development, Review and Control Policy

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6. **DECISION MAKING IN THE MANAGEMENT OF ADULT PATIENTS WITH DYSPHAGIA**

1. **PURPOSE AND SCOPE**

   This document outlines the protocol for decision making in the management of adult in-patients with “acquired dysphagia” (difficulty in swallowing), and particularly relates to dysphagia affecting the oral and pharyngeal stage of swallow, but may be applied in principal to all “acquired” dysphagias.

   This document should be used in conjunction with other NHS Tayside policies and guidance: Dementia Policy, Oral Hygiene Policy, NHS Tayside Stroke Swallow Screening Test and Procedure, NHS Tayside Safe and Secure Handling of Medication Guidance and the Tayside Area Formulary.

   This policy excludes: paediatrics.

2. **RESPONSIBILITIES AND ORGANISATIONAL ARRANGEMENTS**

   General Managers/Assistant Directors (or equivalent) are responsible for the distribution of this protocol to staff within their area/directorate/business unit; ensuring staff have the opportunity to access the Food, Fluid & Nutritional Care Policy.

   **Clinical Directors & Senior Clinical Nurses** are responsible for ensuring this protocol is implemented within their area and to monitor compliance.

   **All clinical staff** are responsible for their own compliance with the guidance contained within this protocol, identifying their own training needs and attending appropriate training when provided.

3. **BACKGROUND**

   In May 2011, the Mental Welfare Commission published an independent report ‘Starved of Care’ which reported on the care and treatment of an 80 year old lady who died in hospital in December 2008. The recommendations included the need to ‘ensure that there is clear guidance on decision-making on nutrition for people who lose the ability to swallow.’

   As part of NHS Tayside’s’ Managed Clinical Network’s (MCN) Food, Fluid and Nutritional Care Service Improvement Plan, and in response to recommendations in the Mental Welfare Commission’s report, a multi-professional group of senior clinicians involved in the care of those with feeding difficulties were asked to develop a tool to help guide practitioners through the various considerations in managing those with feeding difficulties. This includes working with patients, families and carers to achieve clear individual care plans and communicating those decisions to staff at all levels.

   In order to design a NHS Tayside tool, national guidelines and published clinical evidence were examined. A key report was published by the Royal College of Physicians (RCP), in conjunction with the British Society of Gastroenterologists (Oral Feeding Difficulties and Dilemmas, A Guide to Practical Care, 2010) to provide practical advice to improve and facilitate this care, based on a sound legal and ethical foundation to prevent distress, disagreements and discord between healthcare professional, families and carers.
The report states:

“Patients with oral feeding difficulties require special care. The care must be tailored to their individual requirements, not the needs of others. It should, as far as is possible, preserve oral intake. If this is impossible, tube feeding may be necessary, short or long term. Very rarely intravenous nutrition may be appropriate” (RCP 2010).

While it refers to legislation within England and Wales, the practical guidance, and ethical discussions are applicable to NHS Scotland. However before decisions around the management of those with swallowing difficulties are made, a wide range of factors and a large amount of information needs to be considered, including the consequences of cessation of intake of nutrition (“Nil by Mouth”), and/or routes for non-oral nutritional and hydration support, including the risks, benefits and complications.

The NHS Tayside Dysphagia Decision Tree (Appendix 1) was designed to provide a simple guide to assist medical staff collate and manage all the complex information around each individual case, and make clear the need for documentation and review. It follows the principals of the RCP report, local and national guidelines and published clinical evidence and does not seek to replace it, merely to provide an aide memoir for those who perhaps do not meet those with feeding problems frequently.

4. USING THE DYSPHAGIA DECISION TREE (Appendix 1)

Once a swallowing problem has been detected by following the simple algorithm a decision should be made regarding the nature of the patient’s swallowing problem.

Acquired problems with swallowing can arise from a range of underlying causes and diseases. Oral, pharyngeal and oesophageal stages of swallow may be effected in any combination. Problems may be due to a structural alteration, underlying neurological disease, cognitive problems, or may be functional. There may be mixed causes, for example an elderly person with a pharyngeal pouch and dementia, or a stroke patient with a long standing oesophageal dysmotility. In addition respiratory difficulties will often impact on swallow ability.

Based on underlying cause, problems may be chronic or acute; stable, improving or deteriorating and this will effect management decisions. Management of problems with vary according to underlying cause, stage of swallow affected and whether this is a static or deteriorating condition.

4.1 “Nil by Mouth”

“Nil by Mouth” will be considered as a last resort. Whilst it is recognised that decisions are unique to an individual and their circumstances, patients who are too ill to eat and drink must be reviewed, and this review documented, at minimum of daily by medical staff. Oral feeding is assumed unless there is clear contrary evidence.

“Nil by Mouth", with or without non-oral nutritional support, may well be considered where feeding difficulties are attributable to an acute and potentially reversible cause, or while assessment is being carried out. Clear timescales for review must be recorded.

Consideration must be given to the aim /benefit of oral, non oral or mixed feeding, and what the burdens and drawbacks would be. Timescales for likely change, and a clear view of what a successful outcome for the individual would be, are important. The impact on the individual and their carers must also be considered.
4.2 Stroke

If the patient has had a Stroke then condition specific tools such as the NHS Tayside Stroke Swallow Screening Test and Procedure can be used. However, this is not suitable for generalisation to other patients groups, as it assumes an acute event affecting swallow from which recovery can be expected.

4.3 End of Life

Many patients with swallowing difficulties, particularly towards the end of life will have several different disease processes impacting on their abilities, some of which may be progressive, and response to treatment may be unclear. If the patient is in the end stage of life then discuss with or refer to the Palliative Care Team. Out of hours follow departmental guidelines or discuss with local senior medical staff.

4.4 Medical Decision Making (Appendix 1)

Step 1: Collect information

It is the role of the medical practitioner to collect and collate the information from all sources, to consult with the individual, their family and others involved, including other staff, and to clearly document this process.

Information to inform assessment can come from a range of sources, including:
- Past medical history
- Medications review
- Nursing Assessment
- Medical records
- Observation
- Information from family, carers and the patient and other health care professionals

It should be acknowledged that respiratory problems and situational factors can lead to feeding difficulties, so the assessment and considerations go beyond swallowing difficulties alone.

Steps 2 – 5: Consider, Consult, Collate, and Decide

Additional consultation, and or assessment, by speech and language therapy, nutrition and dietetics and others including nurse specialists, specialist services, and clinical pharmacists may also be appropriate.

Following this a clear nutrition and hydration plan for the patient should be documented and implemented, supported by an oral care plan, medication review/reconciliation and monitoring arrangements.

Treatment choices listed below may be used individually or in combination of the above, however this list is not exhaustive and “Nil by Mouth” should be the last resort.

Treatment may include:
- Managing Oral Texture Modified Diet/Thickened Fluids
- “Nil by Mouth”, Intravenous/ Subcutaneous Fluids
- Allow the patient to eat and drink with knowledge of aspiration
- Patient declines food/ fluid
- Artificial Nutritional Support
Ethical and legal considerations, particularly around the Adults with Incapacity Act (2008), Scotland, will also be crucial. All patients within NHS Tayside with feeding difficulties can expect to be managed sympathetically and individually.

**Step 6: Review**

At review, changes in the individual’s condition, new information and altered expectations may lead to changes to these care plans, which must be documented and review date set.

**5. CONSENT**

There is a duty for all clinical staff to provide best care to an individual, which includes assumed consent for oral feeding. However the context of consent can take many different forms, ranging from the active request by a patient for a particular treatment to the passive acceptance of a health professional’s advice. In many cases, ‘seeking consent’ is better described as ‘joint decision making’: the patient and the health professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the health professional’s clinical knowledge.

Issues of capacity and competence around consent for non-oral nutritional support are complex. Where an adult patient is judged to lack the mental capacity to give or withhold consent for themselves, this must be assessed under the terms of the Adults with Incapacity (Scotland) Act 2000 (see Section 3.6 of NHS Tayside’s Informed Consent policy 2011). Welfare proxies (power of attorneys or welfare guardians) may be consulted with if the patient lacks capacity and has activated power of attorney.

**6. AUTHORISED PROFESSIONALS**

All staff within NHS Tayside that are involved in assessing and managing feeding difficulties must at all times act in accordance with their professional code of practice and within the remit of their professional registration.

**7. EDUCATION AND TRAINING**

Staff should have appropriate professional undergraduate and post graduate training to allow them to fulfil their professional role with regard to the management of people with feeding difficulties. This may vary from attendance at local training days such as the Dysphagia and Oral Health Study Day for all grades of nursing staff, to specific post-graduate Royal College of Speech and Language Therapist qualifications in dysphagia assessment and management, depending on the professional and their individual role.

**8. LEGAL LIABILITY**

NHS Tayside as an employer will assume vicarious liability for the actions of all staff, including those on honorary contracts, providing that:

- Staff have undergone any training identified as necessary
- The member of staff is authorised by NHS Tayside to undertake the procedure
- The provision of this Policy and the supporting procedure has been followed by the member of staff at all times
9. REFERENCES


10. ADDITIONAL READING

Dysphagia Diet Food Texture Descriptors http://www.rcslt.org/members/publications/dysphagia_diet_texture_descriptions

Kindell, J (2002) Stockport Old Age Psychiatry Service, Tube feeding in Dementia, a framework for decision making, Speechmark Publishing Ltd., UK


National Patient Safety Agency, Royal College of Speech and Language Therapists, National Association of Care Catering, British Dietetic Association, National Nurses Nutrition group, Hospital Caterers Association (2012) Dysphagia Diet Food Texture Descriptors


SIGN Guidelines (as appropriate to condition)


Tayside Area Formulary, Available at http://www.nhstaysideadtc.scot.nhs.uk/TAPG%20html/MAIN/Front%20page.htm
Medical Decision Making

Step 1 Collect Information

**Medical Staff**
- **History**
  - Acute or chronic?
  - Reversible?
  - Past Medical History
  - Prognosis?
  - Medication review Examination
- **Evidence of aspiration**
- **Cognitive assessment**
- **Reversible factors**

**Nursing Assessment**
- Undertake ‘MUST’
- Follow Step 5 Management Guidelines
- Oral assessment
- Observe eating & drinking; if necessary trial of careful hand feeding
- 3 day food record/fluid chart as required

**Patients/Carers**
- Previous difficulties
- Previous management
- Patient's wishes
- Advanced directive

**Other Specialists**
- Is patient currently being seen or new referral required?
  - SLT
  - Nutrition & Dietetics
  - Specialist Nurses
  - Pharmacy
  - Physiotherapy
  - Occupational Therapy
  - Other specialties

Step 2 Consider
- What are the aims/ benefits of oral/nh oral/mixed feeding?
- What are the burdens/ drawbacks?
- Is more information needed?
- What are the likely timescales for change?
- What is causing distress?
- What would be a successful outcome?

Step 3 Consult
- Has the person and their family been given adequate information and support?
- Have effects on staff been considered and managed appropriately?
- Consult with MDT as necessary/
- Onward referral to acute care (if required)

Step 4 Collate
- Collate all the information from Multidisciplinary Team, family, individual.
- Document if not already clearly available in medical notes.

Step 5 Decide
- Nutrition and Hydration Plan
- Medication Plan (consider alternative routes of administration)
- Oral Care Plan
- Monitoring / review arrangements
- Review dates and individual responsibilities
- Document and share

Step 6 Review Steps 1-5
- Correct any assumptions made.
- Consider new information and consult with others.
- Assess expectations of patient, carer, multi-disciplinary team.
- Document management changes and review times and responsibilities and communicate new decisions

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