Clinical

Food, Fluid and Nutritional Care Policy

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
(delete as appropriate)

UNCONTROLLED WHEN PRINTED

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: Informed Consent Policy 2014, 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/ swallowing difficulties were asked to develop a tool to help guide practitioners through the various considerations in managing these patients. 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 an NHS Tayside Dysphagia Decision Tree 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 not possible, 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 feeding/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 patient, 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 affected 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

such as Stroke, 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 specific tools such as the NHS Tayside Stroke Swallow Screening Test and Procedure can be used (Appendix 2). **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 (if family, member , carer, friend etc hold welfare power of attorney/ legal guardianship they are legally entitled to all and any information and be involved in decision making) 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 Plan

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: Evaluation

At review, evaluate treatment plan if 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 codes 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/ swallowing 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

Adults with Incapacity Act Scotland,
http://www.sehd.scot.nhs.uk/mels/CEL2008_11.pdf

MWC (2011) "Starved of Care" Report: Investigation into the care and treatment of "Mrs V", Mental Welfare Commission for Scotland.

Royal College of Physicians (2010), Report of a Working Party, Oral Feeding Difficulties and Dilemmas. A guide to practical care, particularly towards the end of life, RCS ISBN: 9781860163715

SIGN Guidelines 119 (2010) - Management of patients with stroke: identification and management of dysphagia,

10. ADDITIONAL READING

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

Mental Capacity Act 2005.
http://www.legislation.gov.uk/ukpga/2005/9/contents

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

NICE Guideline CG68- Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) (2008)

NHS Tayside (2011) Stroke Treatment Protocol.

NHS Tayside (2011) Stroke Swallow Screening Test and Procedure.

Palliative Performance Scale Version 2 (PPSv2) Medical Care of the Dying.
4th edition.

Regnard, C.Leslie, P, Crawford, H., Matthews, D., &; Gibson, D. (2010). Gastrostomies in dementia: Bad practice or bad evidence? Age and Ageing, 39(3).

Royal College of Physicians & British Society of Gastroenterologists (2010) Oral Feeding Difficulties and Dilemmas, a guide to practical care, particularly towards the end of life. Report of a Working Party.

Scottish Government (2010) Scotland's National Dementia Strategy.
Scottish Government - Scotland's National Dementia Strategy

Scottish Government (2000) The Adults with Incapacity (Scotland) Act.
http://www.scotland.gov.uk/Topics/Justice/law/awi

SIGN Guidelines 119- Management of patients with stroke:
identification and management of dysphagia (2010): SIGN Guidelines

Smith, HA, Kindell, J, Baldwin, RC, Waterman D and Makin-Smith AJ (2009) Swallowing problems and Dementia in Acute Hospital Settings: practical guidance for the management of dysphagia. Clinical Medicine, Volume 9, Number 6, 544-8.

6.1 STANDARD OPERATING PROCEDURE - The provision of Consistency Modified liquids

Policy: Food, Fluid and Nutritional Care	**Policy Reference:** 6.1	**Originator:** Victoria Hampson and Janet Brodie

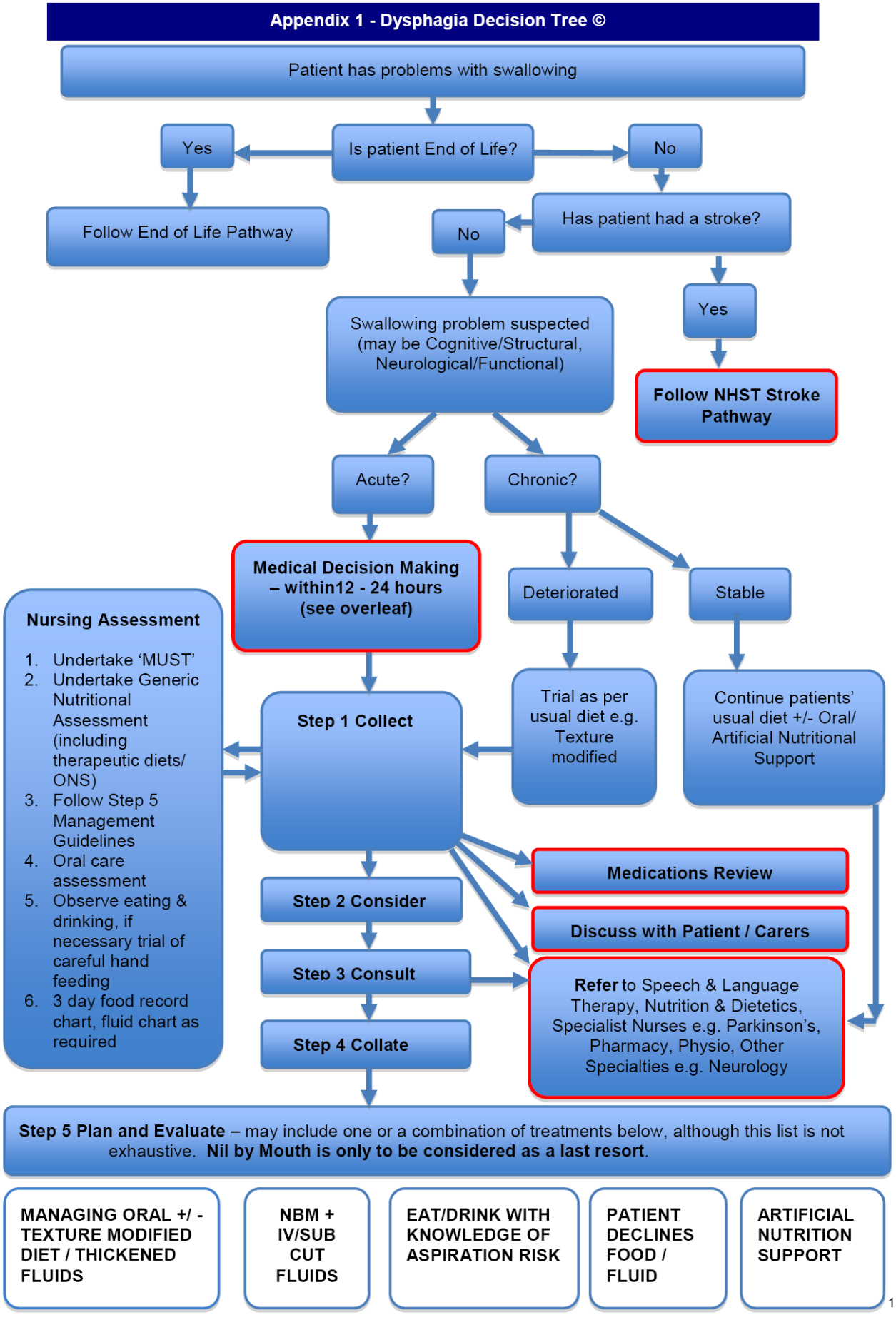
Operation	The provision of Consistency Modified liquids (see NHS Tayside Thickened Fluids - fluid modification stages 1, 2 & 3 - Appendix 4)
Part Number/ Name	This standard operating procedure is for the provision of modified liquid consistency for adult in-patients being undertaken by registered clinical staff
Safety Tools/ Clothing	Universal precautions Products not licensed for use in children under 3 years of age*
Tools/ Equipment	Thickening agents/powders/fluid shakers/measuring spoons or jugs

No	**Main Operating Steps**	**Rationale**	**Evidence/support**
1	Registered nursing staff must undertake a complete Dietary assessment within 24 hours of admission of all patients Consider allergies before using any product	To assess the patients dietary needs To prevent harm/ patient safety	BAPEN 2011
2 (i)	Patient admitted with a previously diagnosed dysphagia/swallowing difficulty and requires texture modified meals/fluids Establish current recommendations via carers/patient documentation Texture modified meals may be obtained through catering using the texture modified menu Notify SLT if any concerns or changes to underlying swallowing problem	The modification of food/liquids is common practice in dysphagia management to avoid aspiration of material into the patient airway, and improve oral intake.	For ordering texture modified meals see the Protocol for the Provision of Food and Fluid in Hospital - Section 3 of the Food, Fluid and Nutritional Care policy (2014)
2 (ii)	Patient identified on admission/ during admission with new dysphagia New Stroke? use Tayside Screening Form for Swallowing Difficulties in Stroke New dysphagia? follow Algorithm (Appendix 1 Management of Adults with dysphagia policy)	The modification of food/liquids is common practice in dysphagia management to avoid aspiration of material into the patient airway and improve oral nutrition Patient safety, person centredness	Management of Adults with dysphagia, Section 6 of the Food, Fluid and Nutritional Care policy (2014) Tayside Screening Form for Swallowing Difficulties in Stroke (Appendix 2)

			NICE Guideline CG68 - Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) (2008) SIGN Guidelines 119- Management of patients with stroke: identification and management of dysphagia (2010)
3	To provide the correct fluid texture follow local fluid recommend thickening guidelines as per Summary of Swallow Assessment from SLT (local variants)	To provide the correct consistency of liquids as recommended by SLT	SLT Therapy Management forms (Appendix 5)
4	Decision must be made by Senior Charge Nurse / Nurse in charge regarding storage in wards / clinical areas and patient beside lockers/ tables of thickening powders should be made following individual risk assessment of each patient / ward environment (e.g. patients with dementia/ cognitive impairment/ learning disability) to prevent accidental ingestion of dry powders Store in cool / dry place	Thickening powders/ agent whilst remaining accessible, should be stored to mitigate the potential risks of accidental ingestion of the powder/thickening agent - all staff should be aware of this risk As per manufacturer's instructions	Patient Safety Alert 05/02/2015 (Appendix 3)
5	To make up and administered thickened fluids all clinical staff must follow instruction on the packaging Using only the measuring spoon provided with the product follow instructions on the product label. Measure liquid using measuring jug/shaker Staff must date when tin opened using a sticky label on the side and lid of tin - keep tin tightly sealed after opening and do not refrigerate	To provide the correct consistency Shakers in general provide the best mixture/ texture of the product Caution must be used with hot or carbonated liquids which may need to be mixed with a fork Identify when product required to be discarded/use by date	Patient Safety Alert 05/02/2015 (Appendix 3) As per manufacturer's instructions As per manufacturer's instructions As per manufacturer's instructions

	Ensure the drink is of the correct consistency as per Summary of Initial Swallow Assessment from SLT Once drink is prepared it should be left to stand for 1-5 minutes to complete thickening process Discuss with pharmacy/pharmacist regarding alternative modes of medicine administration for patient with new dysphagia/ newly prescribed medicines	Product left open for a greater length of time absorbs moisture from the environment and does not thicken according to recipe If liquid is not of the correct consistency discard and do not add extra powder To ensure liquid achieves the correct consistency before ingestion Alternative modes of medication may need to be given to ensure that patients receive all medications prescribed	As per manufacturer's instructions As per manufacturer's instructions. This may vary from product to product Tayside Area Prescribing Formulary at http://www.taysideformulary.scot.nhs.uk/
6	Discard all product if opened for more than 2 months	Product left open for a greater length of time absorbs moisture from the environment, is less effective and does not thicken according to manufacturer's instructions	As per manufacturer's instructions
7	Patient care and the nutrition plan of care must be reviewed on a shift by shift basis or if there is a deterioration/ change in the patient condition Follow Algorithm (Appendix 1) of Management of adults with dysphagia policy	Assessment and treatment of the deteriorating patient Patient safety, person centredness	Management of Adults with dysphagia policy, Section 6 of Food , Fluid and Nutritional Care policy (2014)
8	Oral hygiene must be given at least 4 hourly for all patient with dysphagia	To maintain good oral hygiene and prevent oral infection/ aspiration of contaminated saliva. Reduces discomfort for patients unable to take thin fluids	Protocol for the Management of Oral Hygiene for Adults, Section 5 of Food , Fluid and Nutritional Care policy (2014)
9	If thickening powder/ agent is accidentally ingested alert medical staff immediately Record in patient notes Report through Datix Undertake risk assessment as per step 4 and action immediately	Patient safety	Patient Safety Alert 05/02/2015 (Appendix 3)

10	If patient takes a drink that is not of the correct consistency, please inform medical staff immediately and monitor patient's condition Record in patient notes Report through Datix Undertake risk assessment as appropriate	Patient safety Risk of aspiration	


Appendix 1 - Dysphagia Decision Tree ©
Patient has problems with swallowing
Is patient End of Life?
Yes
No
Follow End of Life Pathway
Has patient had a stroke?
No
Yes
Follow NHST Stroke Pathway
Swallowing problem suspected (may be Cognitive/Structural, Neurological/Functional)
Acute?
Chronic?
Medical Decision Making – within12 - 24 hours (see overleaf)
Deteriorated
Stable
Nursing Assessment
1. Undertake 'MUST'
2. Undertake Generic Nutritional Assessment (including therapeutic diets/ ONS)
3. Follow Step 5 Management Guidelines
4. Oral care assessment
5. Observe eating & drinking, if necessary trial of careful hand feeding
6. 3 day food record chart, fluid chart as required
Step 1 Collect
Trial as per usual diet e.g. Texture modified
Continue patients' usual diet +/- Oral/ Artificial Nutritional Support
Medications Review
Step 2 Consider
Discuss with Patient / Carers
Step 3 Consult
Refer to Speech & Language Therapy, Nutrition & Dietetics, Specialist Nurses e.g. Parkinson's, Pharmacy, Physio, Other Specialties e.g. Neurology
Step 4 Collate
Step 5 Plan and Evaluate – may include one or a combination of treatments below, although this list is not exhaustive. Nil by Mouth is only to be considered as a last resort.
MANAGING ORAL +/ - TEXTURE MODIFIED DIET / THICKENED FLUIDS
NBM + IV/SUB CUT FLUIDS
EAT/DRINK WITH KNOWLEDGE OF ASPIRATION RISK
PATIENT DECLINES FOOD / FLUID
ARTIFICIAL NUTRITION SUPPORT

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?
- Speech & Language Therapy
- Nutrition & Dietetics
- Specialist Nurses
- Pharmacy
- Physiotherapy
- Occupational Therapy
- Other specialities

Step 2 Consider
- What are the aims/ benefits of oral/non 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 Plan

Document in medical notes and share
- Nutrition and Hydration Plan
- Medication Plan (consider alternative routes of administration -see Tayside Area Formulary)
- Oral Care Plan
- Monitoring / review arrangements
- Review dates and individuals responsibilities

Step 6 Evaluation of Care

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

Appendix 2 - Tayside Screening Form for Swallowing Difficulties in Stroke

(To be used in conjunction with the Dysphagia Management in Adult Stroke protocol)

Patient's Name	CHI	Ward
Screening Completed by		Date

BEFORE SCREENING CAN BE CARRIED OUT

Is the mouth clean? If NO, carry out oral hygiene

Is the patient alert and able to maintain an upright position?

If NO, to any of the above please try again in 24 hours.

SWALLOW SCREENING TEST

Step 1
Give 1 teaspoon of water 3 times
Is the swallow absent or delayed?
Does the patient cough?
Ask patient to say "Ah". Does the voice sound wet/gurgly?

If **YES** to any → Nil By Mouth Refer to Speech and Language Therapy

NO

Step 2
Give 1 sip of water from a glass 4 times
Is the swallow absent or delayed?
Does the patient cough?
Ask the patient to say "Ah". Does the voice sound wet/gurgly?

If **YES** to any → Nil By Mouth Refer to Speech and Language Therapy

NO

Step 3
Ask the patient to drink 1/3 glass of water
Is the swallow absent or delayed?
Does the patient cough?
Ask the patient to say "Ah". Does the voice sound wet/gurgly?

If **YES** to any → Nil By Mouth Refer to Speech and Language Therapy

NO

Step 4
Give the patient soft diet and normal fluids
Continue to monitor and observe.
If there are any difficulties return to NBM and refer to SLT.

Soft Diet and Fluids started on:

NO

Step 5
If no difficulties noted with soft diet for 48 hours move onto normal diet.
If there are any further difficulties return to NBM and refer to SLT.

Failed at Step:

Referred to SLT on:

SWALLOWING SCREENING FORM ON REVERSE - PAGE 2

Revised September 2007

Swallowing Screening Test - Guidance Notes

This screening tool is for use by **Qualified Nursing Staff**

It should:

- Prevent patients being kept Nil By Mouth unnecessarily.
- Identify patients who can commence oral intake.
- Identify patients with swallowing difficulties who should be Nil By Mouth and referred to SLT.

This screening test ***should not*** be used if the patient is already under Speech and Language Therapy management. Please contact SLT department should you have concerns regarding these patients.

Please Note – patients with communication difficulties should be referred to Speech and Language Therapy in the usual manner **BUT** this should **NOT** prevent swallow screening from being carried out.

Please ensure:

- **All** patient details, including location, are completed.
- The form is kept and the outcome recorded in the Nursing Notes - ***including patients who pass the screen.***
- If swallowing difficulties are noted once the patient commences a diet, **return to Nil By Mouth** and refer to SLT in the usual manner.

Any comments or questions should be referred to the Department of Speech and Language Therapy.

Revised September 2007

NHS England

Patient Safety Alert

Stage One: Warning

Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

05 February 2015

Alert reference number: NHS/PSA/W/2015/002

Alert stage: One - Warning

Dysphagia (swallowing problems) occurs in all care settings[1] and although the true incidence and prevalence are unknown, it is estimated the condition can occur in up to 30% of people aged over 65 years of age[2]. Stroke, neurodegenerative diseases and learning disabilities can be the cause of some cases of dysphagia, and may also result in cognitive or intellectual impairment, as well as visual impairment.

The modification of liquid thickness and food texture is common practice in dysphagia management to avoid aspiration of material into the airway whilst maintaining adequate hydration and nutrition. Thickening agents are available in a range of preparations, the most common being a powdered form, supplied in tubs and commonly kept in a place that is accessible such as at the bedside.

NHS England has received details of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. Whilst this death remains under investigation, it appears the powder formed a solid mass and caused fatal airway obstruction. Analysis of the National Reporting and Learning System has identified one other similar incident that occurred in hospital:

'HCA alerted by another patient that the patient was choking. Found to have taken the lid off a tub of thickening powder and attempted to tip it back to 'drink'. The patient is partially sighted and his condition fluctuates re conscious / alert levels. Thickener was a fresh tub today as trial re his poor swallow……'

Feedback from frontline staff indicates that the potential consequences of trying to swallow dry thickening powder appear under-recognised therefore there may be significant under reporting.

Whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks to patient safety. Appropriate storage and administration of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia. Individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected.

Actions

Who: All providers of NHS funded care where thickening agents are prescribed, dispensed or administered

When: To commence immediately and be completed by no later than 19 March 2015

1. Identify if the accidental ingestion of dry thickening powder has occurred, or could occur, in your organisation
2. Consider if immediate action needs to be taken locally, and ensure that an action plan is underway if required, to reduce the risk of further incidents occurring.
3. Distribute this alert to all relevant staff who care for children or adults in primary care, emergency care, and inpatient care settings, including mental health and learning disability units.
4. Share any learning from local investigations or locally developed good practice resources by emailing patientsafety.enquiries@nhs.net

Patient Safety | Domain 5
www.england.nhs.uk/patientsafety

Contact us: patientsafety.enquiries@nhs.net

Publications Gateway Reference 02979

Alert reference number:	NHS/PSA/W/2015/002
Alert stage:	One - Warning

Technical notes

NRLS search dates and terms
The National Reporting and Learning System (NRLS) was searched on 8 January 2015 for incidents that had occurred since 1 January 2010 using the search terms 'thickening agents' OR 'thickening products' OR 'thickening powders' OR 'thickening granules' AND 'swallow'. 90 incidents with these keywords were reviewed and one relevant incident was identified which was reported as resulting in moderate harm.

Stakeholder engagement
Medical Specialties Patient Safety Expert Group
Mental Health Patient Safety Expert Group
Learning Disability Patient Safety Expert Group
Primary Care Patient Safety Expert Group
Surgical Services Patient Safety Expert Group
NHS England Nutrition and Hydration Commissioning Strategy Group
Royal College of Speech and Language Therapists
British Dietetic Association
International Dysphagia Diet Standardisation Initiative

References
1) Julie A. Y. Cichero et al (2013) The Need for International Terminology and Definitions for Texture-Modified Foods and Thickened Liquids Used in Dysphagia Management: Foundations of a Global Initiative Current Physical Medicine and Rehabilitation Reports http://link.springer.com/article/10.1007%2Fs40141-013-0024-z/fulltext.html
2) Martino R, Foley N, Bhogal S, Diamant N, Speechley M, Teasell R. Dysphagia after stroke: incidence, diagnosis, and pulmonary complications. Stroke. 2005;36:2756–63. Stroke. 2005 Dec;36(12):2756-63. Epub 2005 Nov 3 http://www.ncbi.nlm.nih.gov/pubmed/16269630?dopt=Abstract

Other
The National Patient Safety Agency issued a Signal on Harm from ingestion of Vernagel in September 2011. Whilst Vernagel is used to thicken urine in urinals to prevent spillage, rather than to thicken oral fluids, the mechanism of harm from airway obstruction after accidental ingestion is the same; see http://www.nrls.npsa.nhs.uk/resources/?entryid45=132835

Patient Safety | Domain 5
www.england.nhs.uk/patientsafety
Contact us: patientsafety.enquiries@nhs.net
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APPENDIX 4: NHS Tayside Thickened Fluids

Thickened Fluid	Description of Fluid Texture	Scoops of Nutilis required per 200ml			
		Ensure/milk supplement	Orange Juice/ squash, tea, fizzy drinks	Enlive/juice supplement	Milk
Stage 1 Syrup Consistency	▪ Can be drunk through a straw ▪ Can be drunk from a cup if advised or preferred ▪ Leave a thin coat on the back of a spoon	2	2 heaped	3	3 heaped
Stage 2 Custard Consistency	▪ Cannot be drunk through a straw ▪ Can be drunk from a cup ▪ Leaves a thick coat on the back of a spoon	3	3 heaped	4	4 heaped
Stage 3 Paste Consistency	▪ Cannot be drunk through a straw ▪ Cannot be drunk from a cup ▪ Needs to be taken with a spoon	4	4	5	5

DEPARTMENT OF SPEECH AND LANGUAGE THERAPY
PERTH ROYAL INFIRMARY

SWALLOWING ADVICE SHEET

NAME : ..... **C H I No :** .....

WARD : ..... **DATE :** .....

POSITIONING

HEAD :- Midline ☐ Turned to (R) ☐ Turned to (L) ☐

CHIN TUCKED DOWN :- For Fluids ☐ For all swallows ☐

Patient to remain sitting upright for 15 > 20 minutes after oral intake

FLUIDS

NO oral fluids ☐ **NORMAL** ☐ **STAGE 1** ☐ **STAGE 2** ☐ **STAGE 3** ☐

Temperature of fluids :- Cold only ☐ No Restriction ☐

Teaspoon fluids only ☐ TEASPOON HELD BY STAFF ☐

Cup Drink ☐ CUP HELD BY STAFF ☐

Straw Drink ☐

Fluids Closely Supervised ☐ Fluids Distantly Supervised ☐

DIET CONSISTENCY

Breakfast	Soup	Main Course	Pudding

Please use a teaspoon ☐

Fed by staff ☐ Closely supervised ☐ Distantly supervised ☐

SPECIAL INSTRUCTIONS

SPEECH AND LANGUAGE THERAPIST ..... **BLEEP No.** .....

SPEECH AND LANGUAGE THERAPY MANAGEMENT

PATIENT: **CHI NO.:**

Phone referral received:_____ (*insert date*) Written referral received:_____(*insert date*)

DATE	**SUMMARY OF INITIAL SWALLOW ASSESSMENT**					
RECOMMENDATIONS						
	DATE	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**
DIET						
No oral food						
Texture C1: Practice diet						
Texture C : Thick pureed diet						
Texture D : Mashed moist diet						
Texture E : Soft moist diet						
Normal diet						
FLUIDS (*including soups*) *please insert S = spoon; C = cup*						
No oral fluids						
Stage 3: Paste consistency						
Stage 2: Custard consistency						
Stage 1: Syrup consistency						
Normal fluids						
STRATEGIES ***please insert VP = verbal prompts***						
Carry out oral hygiene before and after oral intake						
Only feed when fully alert and actively moving food to back of mouth						
Sit upright (90°)						
Position head in midline						
Tuck chin onto chest						
1:1 nursing supervision required						
Assist with feeding						
Feed from right/left side						
Two purposeful swallows required per mouthful						
Encourage purposeful cough followed by swallow to clear						
Check mouth for pocketing						
Leave sitting upright for 15 mins after oral intake						
Please monitor chest status						
Liaise with pharmacy re: an alternative form of medication						
Other						
Signature						

JN:SWLLFRM