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Hampshire Partnership   
NHS Trust

CP 45

## Dysphagia (Swallowing Disorder) Policy

[Version 3]

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## Hampshire Partnership NHS Trust

### POLICIES AND PROCEDURES PROFORMA

**Subject and Version of Document:** Dysphagia (Swallowing Disorder) Policy  
Version 3

**Author:** Trust Lead Speech and Language Therapist

**Persons/Committees etc consulted whilst document in draft:** HPT Speech and Language Therapists

**Date agreed:** Version 1: November 2005  
Version 2: April 2007  
Version 3: June 2007

**By whom agreed:** P&PC, TMT

**Date of next review/update and by whom:** June 2010

**Copy obtainable from:** Website

**Date document issued:** Version 1 - November 2005 – Update 14  
Version 2 – April 2007 – Update 23  
Version 3 – June 2007 – Update 25

**Responsibility for dissemination to new staff:** Head of Speech and Language Therapy

**Principal Target Audience:** All speech and language therapists, DoOps, locality managers

**Training Implications:** Staff Awareness

#### Amendments Summary:

Amend. No.	Issued	Page	Subject
V2	April 2007	4	New point 3.7.3 re The Mental Capacity Act 2005 added. Following point renumbered.
V3	June 2007	3	Changes to paras 1.3 to 2.4 inclusive: clarification of nursing staff responsibilities and training requirements

## **DYSPHAGIA (SWALLOWING DISORDER) POLICY**

### **1 INTRODUCTION**

- 1.1** The term dysphagia is used in this document to describe swallowing disorders characterised by difficulty in oral preparation for the swallow or in the moving the bolus from the mouth to the stomach. Subsumed in this definition are problems in positioning food in the mouth and in the oral movements, including suckling, sucking and mastication.
- 1.2** The Royal College of Speech and Language Therapists (RCSLT) support the principle that speech and language therapists (SLTs) are able to take a central role within the multidisciplinary team in the assessment and management of swallowing disorders.
- 1.3** Early identification of the symptoms of dysphagia is essential and is the responsibility of all qualified nursing staff.

### **2 RESPONSIBILITIES OF ALL NURSING STAFF**

- 2.1** All qualified nursing staff should recognise the symptoms of dysphagia.

Acute symptoms of dysphagia include:

- coughing during or immediately after drinking and/or eating
- choking
- wet vocalisations after drinking
- change of skin colour
- watering eyes
- refusal of food before or during meal
- increased anxiety at drink/meal times
- behavioural difficulties at drink/meal times

Chronic symptoms of dysphagia include:

- chest infections
- signs of malnutrition – weight loss, skin breakdown, hair loss
- signs of dehydration – constipation, strong urine, Urinary tract infections, dry skin

- 2.2** The above symptoms will be made available to all nursing staff within their units (see appendix i) and it is the responsibility of all unit managers to ensure qualified staff and relevant unqualified staff have seen the information.
- 2.3** If a client presents with 1 or more of these symptoms, the staff member should immediately discuss this with the person in charge. It is then their responsibility to ensure appropriate advice is sought from a speech and language therapist.
- 2.4** Within each directorate, key members of staff may be identified by the associate director of nursing and locality managers to undertake the 1 day Trust dysphagia awareness training. These members of staff will work in areas where there is a higher incidence of dysphagia and the training will give them a greater understanding of dysphagia and how to keep clients safe until an assessment has been undertaken.

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### **3 SCOPE OF PRACTICE AND PROFESSIONAL RESPONSIBILITY FOR SPEECH AND LANGUAGE THERAPISTS**

**3.1** SLTs who are employed by HPT and who are required to treat clients with dysphagia will be conversant with the dysphagia policy.

**3.2** SLTs will be aware of the extent and limits of their own skills. They will refer clients whose dysphagia is beyond their knowledge and experience to senior staff. Failure to act appropriately is a breach of the duty of care.

**3.3** SLTs will work as part of a multi-disciplinary team with clients with dysphagia. Every attempt will be made to include the client, their relatives/carers in the decision making process. The professional team may vary but will always include the medical practitioner or consultant responsible for the medical care of the client.

#### **3.4 DELEGATION**

**3.4.1** SLTs may delegate certain therapy tasks to other team members, relatives or carers, this may include assisting and supervision of oral intake. The decision to delegate must be clinically led and documented.

**3.4.2** SLTs remain responsible for the intervention even when it is carried out by another person, providing that:

- a. the written instructions are correctly followed by the named person
- b. there has been no deterioration in the client or client's physical condition
- c. the patient is on the therapist's caseload for dysphagia intervention

#### **3.5 DUTY OF CARE**

**3.5.1** There is no duty of care until assessment has begun. Once the duty of care has started it must be discharged in full.

#### **3.6 DUTY TO ACT**

**3.6.1** If there is a clinical risk to a client's life, a positive duty to act arises. SLTs are required to do whatever is reasonably expected in these circumstances.

#### **3.7 DISAGREEMENT BETWEEN PROFESSIONALS, THE CLIENT OR CARERS**

**3.7.1** Where disagreement exists between the client or their relatives and the team, every effort should be made to resolve it through discussion.

**3.7.2** If the client refuses to consent to intervention, this should be documented and communicated to the doctor responsible for that client's care.

**3.7.3** The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who are not able to make their own decisions. A key principle of the law is that every adult has the right to make their own decisions and is assumed to have capacity to do so unless it is proved otherwise. Further guidance is available in the Trust's Mental Capacity Act 2005 Policy.

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**3.7.4** Where there is disagreement amongst the MDT, particularly between the doctor responsible for the client's care and team members, every effort should be made to resolve it through discussion. Where the doctor chooses a course of action contrary to the opinion of the SLTs, and the therapist believes that such an action may cause harm to the client, the therapist is advised to record their opinion in writing to the doctor and inform their line manager. In some cases it will be necessary to withdraw from involvement.

#### **4 LOCAL PROFESSIONAL STANDARDS FOR WORKING WITH PATIENTS AND CLIENTS WITH DYSPHAGIA**

**4.1** SLTs working with this clinical group must have this specified in their job description and will have a completed post-registration certificate of practice in dysphagia management which is approved by the RCSLT.

**4.2** Prior to receiving such education and training, SLTs will only work under direct supervision and will not be held responsible for any treatment and management decisions. Any resulting case notes and programmes will be countersigned by the supervising therapist.

**4.3** The training programme will enable SLTs to move from observation of skilled SLTs through a period of supervised work with clients, to independent working.

**4.4** During observation, therapists will keep a log for discussion with the named clinical supervisor (appendix ii).

**4.5** Prior to independent working, a minimum of 40 hours supervised work will be completed over a 3-6 month period, of which a minimum of 30 hours will be direct patient contact.

**4.6** The therapist will complete the required checklist of competencies in consultation with the clinical supervisor. If either party feels that there are still competencies to be achieved, further supervised work will be arranged (appendix iii).

**4.7** Therapists will present a case study report to an appropriate professional group.

**4.8** Therapists will attend relevant journal/research updates.

**4.9** There will be at least one SLT in HPT who is trained in dysphagia to an advanced level.

**4.10** All dysphagia trained SLTs will receive supervision from an advanced practitioner in dysphagia.

**4.11** Advanced practitioners will attend at least one national dysphagia conference/course annually.

**4.12** The identified advanced practitioner in dysphagia will maintain membership of a national SIG – to include attendance at meetings and feedback to other staff.

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**4.13** The identified advanced practitioner will undertake annual peer review, across trusts as appropriate. Formal paperwork should be completed and returned to the Speech and Language Therapy Manager.

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## **5 HEALTH AND SAFETY PROCEDURES AND POLICIES**

### **5.1 Therapists' working practice should reflect local policy and procedures relating to the following:**

- Moving and Handling
- Resuscitation
- HIV/Aids
- Control of Infection
- Adverse Events
- Pulse Oximetry
- Cervical Auscultation

Pulse oximetry and cervical auscultation procedures are held locally within the S&LT department.

### **5.2 Where therapists are supporting clients within a General Hospital setting they may also need to be aware of their local policies and procedures and these may include:**

- Radiation Protection
- Videofluoroscopic Swallowing Examination (VF)
- Fibrescopic Endoscopic Examination of Swallowing (FEES)
- Tracheostomy tubes/ventilated patients

## **6 CLINICAL STANDARDS FOR WORKING WITH PATIENTS OR CLIENTS WITH DYSPHAGIA**

### **6.1 REFERRALS**

#### **6.1.1 All patients or clients with dysphagia requiring access to the SLT Service must have a written referral from the doctor responsible for the management of the case.**

#### **6.1.2 Where blanket referrals are in operation, a letter of agreement will have been signed by the specialist clinical director, copies of these letters will be held centrally by the advanced practitioner and copies to the Speech and Language Therapy Lead.**

### **6.2 CONSENT**

#### **6.2.1 It is necessary to follow the guidelines relating to consent to treat (see Trust Policy CP16 and Communicating Quality 2 (S&LT professional standards) P206).**

### **6.3 LIAISON AND COMMUNICATION**

#### **6.3.1 The medical practitioner is responsible for the client and must be kept informed in writing of the aims and methods of intervention and the expected outcome.**

### **6.4 DELEGATION**

#### **6.4.1 Any recommendation or advice should be recorded in the client's medical records and the SLT case notes. Where a specific individual has been trained, they will be named in the instructions.**

#### **6.4.2 People acting under therapist's instructions must be given written information regarding the expected outcome of their actions, how to identify deterioration of function and what to do if difficulties arise.**

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## **6.5 ADVERSE EVENTS OR SUDDEN DEATH**

- 6.5.1** Therapists must ensure that they understand how to document adverse events in the different clinical locations and buildings across the service.
- 6.5.2** Respiratory arrest, choking and other adverse events must be recorded in detail **immediately following** the event in the SLT notes and where appropriate, the medical notes. An adverse incident form should also be completed.
- 6.5.3** The therapist will report the event to the manager of the location, the locality manager and to the Lead SLT to discuss any further administrative actions which may need to be taken.

## **7 STANDARDS OF CARE**

### **7.1 RESPONSIVENESS**

- 7.1.1** A dysphagia telephone risk assessment will be completed at point of referral (appendix iv). High risk referrals will be seen within 10 working days to receipt of referral. Non-urgent referrals will be seen within 4 weeks of referral.
- 7.1.2** A contemporaneous record of the initial assessment and an outline of the proposed management will be documented in the appropriate client notes.
- 7.1.3** This record will be periodically audited using the audit checklist for Dysphagia (appendix v).
- 7.1.4** The case history will include:
- reason and date of referral
  - medical diagnosis
  - referral agent
  - SLTs clinical or risk assessment
  - treatment or management objectives
  - signed, dated and time of patient contact
  - contact with relatives
  - reason for discharge and discharge procedure

### **7.2 DISCHARGES**

- 7.2.1** Team members, client and carer, should be involved in the decision to discharge a client.
- 7.2.2** In some instances it will be useful for the SLT to make recommendations regarding the criterion for re-referral. This may include:
- persistent weight loss
  - recurrent chest infection
  - move to a new health care facility
  - progressive dysphagia
  - change in staff trained to support recommendations

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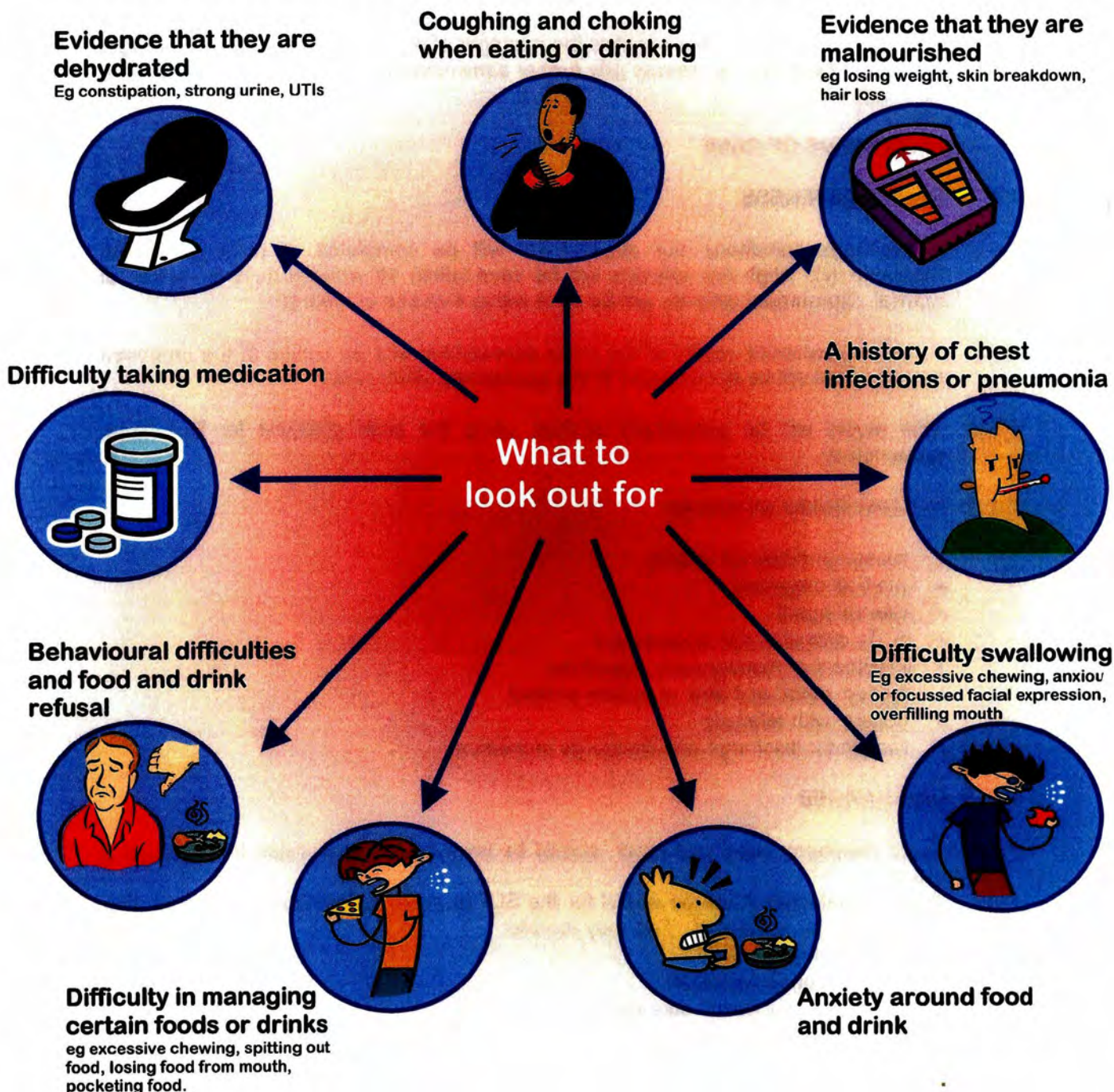
Procedure to re-refer to SLT Department should be made clear to client and carer, and MDT.



# What do you know about swallowing problems?

## Did You Know...

People with Dementia and adults with a learning disability often have a problem swallowing? This is called dysphagia and is a major cause of early death.



If you are worried about someone's swallowing, please discuss your concerns with the Person in Charge. For more information on Dysphagia please contact your local Speech and Language Therapist or telephone the Trust Lead Speech and Language Therapist, Alex Kelly, on 023 8087 4222.



## Appendix ii

<b>DYSPHAGIA POST-REGISTRATION TRAINING PERSONAL LOG</b>
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Name ..... Week beginning: .....

Supervisor's name: .....

TYPE OF ACTIVITY	DESCRIPTION / OUTCOMES	TOTAL HOURS
<b>Assessment</b>		
<b>Treatment</b>		
<b>Management</b>		
<b>Team Working</b>		
<b>Reporting</b>		
<b>Supervisor's comments</b>		

Signed: ..... (Supervisor) Date: .....

## Appendix iii

## COMPETENCIES CHECKLIST

Name .....

Supervisor's name: .....

KNOWLEDGE REQUIREMENTS	DATE ACHIEVED	SIGNED
1. Current specialist procedures		
2. Prognostic indicators		
3. Associated legal issues and ethical decision making		
4. The needs of clients with complex conditions e.g. pmld		
5. Understanding of own role within the MDT		
6. Physiology of the normal swallow		
7. Factors pertaining to aspiration		
8. Awareness of current terminology in the field of dysphagia		
9. Specialist equipment for the client group		
10. Local dysphagia policy		
11. Procedure for referral for videofluoroscopy		
12. Knowledge of a range of formal and informal procedures		
13. Psychosocial factors related to dysphagia		
SKILL REQUIREMENTS	DATE ACHIEVED	SIGNED
1. Prioritise and manage a dysphagia caseload		
2. Use compensatory techniques within therapy		
3. Optimise the eating environment for a client and carer		
4. Contribute to the decision making process regarding the risk factors and non-oral feeding		
5. Advise on risk management		
6. Apply management strategies including compensatory techniques, positioning and food consistencies		
7. Recommend appropriate management following videofluoroscopy		
8. Select appropriate assessment procedures		
9. Train other professionals and carers		
10. Advise and support clients, carers and professionals in the MDT		
11. Co-ordinate a MD approach		
12. Provide basic training within the MDT		
13. Provide accessible care plans / meal time mats for carers		

Signed: ..... (Supervisor)

Date completed: .....

A copy of this should be placed in your reflective practice folder

## Appendix iv

Dysphagia Risk Assessment

**CHECK REFERRAL IS FROM GP**  
or REFERRAL IS FOR REVIEW OF EXISTING E&D CAREPLAN

Name ..... D.O.B. ....

Date referred: ..... Risk assessment completed .....

Information collected from: .....

Symptoms of aspiration?	✓/✗	If yes - high risk symptoms?	✓/✗	Comments
<b>Chronic</b>				
Chest infections.		More than 2 in previous year.		
Evidence of malnutrition.		Evidence of significant weight loss and / or evidence of skin breakdown or severe fatigue.		
Evidence of dehydration.		Currently more than 1 symptom of dehydration i.e. UTI's, dry skin, constipation, strong urine.		
Refusal to eat.		Has resulted in symptoms of malnutrition (see above).		
Refusal to drink.		Has resulted in symptoms of dehydration (see above).		
Behaviour difficulties at meal times e.g. increased anxiety		Has resulted in symptoms of malnutrition or dehydration (see above).		
<b>Acute</b>				
Coughing when eating.		Regularly at meal times. Results in redness, watery eyes, gasping for breath.		
Coughing when drinking.		Regularly at drink times. Results in redness, watery eyes, gasping for breath.		
Choking.		More than 1 incident of choking in the past 6 months.		
Difficulties chewing food.		Results in choking incidents.		
Losing food / fluid from front of mouth.		Results in symptoms of malnutrition or dehydration (see above).		

**Client is high risk:** 

(1 or more high risk symptoms or a number of non high risk symptoms- therapist's discretion)

Comments.....

**Action:** Assess within 2 weeks (high risk) Assess within 4 weeks of receipt of referral

Signed..... Speech and Language Therapist

## Appendix v

**AUDIT CHECKLIST FOR DYSPHAGIA**

<b>STANDARD</b>	<b>YES</b>	<b>NO</b>
1. Risk assessment completed at point of referral		
2. High risk clients seen within 2 weeks		
3. Non-urgent clients seen within 4 weeks		
4. Case history contains relevant medical information		
5. Initial assessment is objective, completed and detailed in the case notes		
6. Written report includes summary of assessment and recommendations		
7. Care plan in place		
8. Accessible meal time information produced		
9. Staff training evident in case notes		
10. Reason for discharge/review in case notes		

Completed by: ..... Date: .....

