Hampshire Partnership NHS
NHS Trust

Speech and Language Therapy Provision for Older People with Mental Health Problems in Hampshire Partnership NHS Trust

by

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November 2006

ACKNOWLEDGEMENTS

I would like to thank the following people for their help in putting together this report:

Martin Robinson
Members of the OPMH DST
Speech and Language Therapists across Hampshire, in particular: Margaret Meikle, Ann Rice, Colin Barnes, Bernadette Ramm, Anne Blamey, Alison Sparkhall, Diane Payne and Shona Tantam
Staff on The Willows, Allington East and Allan Gardiner, in particular: Martin Bream, Sandra Yeo, Lesley Scott and Denise Morris
Members of the East Southampton, Havant and Petersfield community teams
Nursing staff across the directorate, in particular: Kevin Page, Anne Martin, Kay Docherty and Sheila Gascoigne
Speech and Language Therapy colleagues across the UK, in particular: Viki Baker, Jennie Powell, Val Farn and Elizabeth Barnett

EXECUTIVE SUMMARY

Introduction

Speech and Language Therapists (SLTs) have an increasingly proven and well documented role in providing services in older age mental health. Surveys have indicated that 60 – 63% of people with dementia have a communication disorder requiring Speech and Language Therapy (SALT), and 68% have dysphagia (swallowing difficulties). Bronchopneumonia has also been found to be the leading cause of death in Alzheimer's Disease and 28.6% were found to be aspirating.

Currently there are no SLTs employed by HPT and provision of a SALT service varies across the different localities.

Current risks in the provision of a speech and language therapy service in HPT

In order to assess the current risks within HPT 30 in patients were screened for evidence of dysphagia; 150 questionnaires were sent to staff to assess awareness and knowledge of dysphagia; and 19 staff were interviewed. Using evidence from literature and key findings from the above, the following risks are highlighted:

Risk 1: Death due to malnutrition, choking and aspiration pneumonia.
Dysphagia, *if not managed*, results in malnutrition and dehydration, and is causal in repeated chest infections and choking risk. In Hampshire, there is concerning evidence of dysphagia, choking, recurrent chest infections and malnutrition. 40% of in patients screened for dysphagia were assessed as high risk and only 6% of the staff showed a good awareness of all the symptoms of dysphagia and aspiration.

Risk 2: Perpetuation of inappropriate / harmful practice
Currently people with dysphagia are not being managed across all localities in HPT and many staff do not have the skills to keep people safe. There is evidence of malnutrition and dehydration and despite the fact that 60% of patients are receiving a modified diet, only 17% have a swallowing care plan and 81% of staff have never received any training in dysphagia.

Risk 3: Unnecessary admission and readmission to hospital and residential / nursing care.
People with dysphagia are often admitted to hospital when they reach the stage of anorexia or aspiration and direct SALT intervention can prevent this. In Hampshire, there is evidence that some families have expressed distress at the lack of support around communication and dysphagia and this has resulted in admission to hospital.

Risk 4: Decrease in level of independence.
It is essential that staff and relatives caring for the person with dementia are trained to assist and encourage self-feeding as the onset of feeding dependence also correlates with the onset of dysphagia in dementia. Communication and memory therapy for people with early dementia can also

maximise and maintain independence for longer. In Hampshire, there is evidence that nearly half of patients screened were dependent on others for eating. In most localities, people are unable to access a communication assessment and yet staff identified 73% of their patients would benefit from a communication assessment and 43% would benefit from advice around maximising their ability to consent and make choices.

Risk 5: Decrease in quality of life for both the person and their carers.
Dysphagia has well documented effects on physical health but also has adverse effects on self-esteem, socialisation and enjoyment of life. In Hampshire there is evidence that the lack of support around dysphagia and communication is having an impact on the quality of life of patients, families and care staff.

Risk 5: A loss of relationships and an increase in social exclusion
The loss of meaningful interaction and conversation places increased pressure on the caring relationship and carers rate communication problems as more stressful than daily living and self-care impairments. It is therefore important to provide carers with strategies to manage such difficulties and yet in Hampshire there is evidence that this is not occurring.

Risk 6: Perpetuation of the current postcode lottery re access to SALT
Many services across the UK are not fully multidisciplinary and are not yet compliant with the standards in the NSF for Older People, England. Currently SALT services are patchy across Hampshire. E Hants has a good level of service but in the other localities there is a reduced SALT service. In some locations, staff are reporting that they are unable to get a SALT service.

Risk 7: Reduced benefit from interventions from other professionals and a delay in diagnosis and/or incorrect diagnosis.
People with dementia have complex needs and as communication is so fundamental, SLTs should have a role in assisting other professionals to achieve effective communication. They also have an important role to play in diagnosis when language symptoms are prominent. In Hampshire, the only locality that has SLTs on the community teams is East Hants.

Risk 8: Hampshire Partnership Trust will not be able to meet the NICE clinical guideline
The NICE clinical guideline 42 provides guidance around person-centred care; capacity to consent; assessment of communication; accessible information; relationships; maintaining independence; managing challenging behaviour; training staff; and the assessment and treatment of dysphagia. All of the above have specific relevance to the provision of a SALT service and currently Hampshire Partnership Trust is unable to meet the above guidelines across all localities.

<u>The benefits of providing a speech and language therapy service</u>
The benefits of providing a SALT service include:

- ***Specialist assessment and treatment of dysphagia*** to minimise the risks of aspiration and choking; reduce the impact of the dysphagia;

improve nutritional intake; advise on the safety and efficiency of oral intake; and provide advice to carers and staff training.

- ***Specialist assessment and treatment of communication skills*** to assist in the differential diagnosis of dementia; to contribute to the assessment of capacity to consent; to maximise a person's ability to communicate and make choices; to work with carers and staff to improve and maintain relationships; and provide staff training on communication, challenging behaviour and memory.

Options for addressing risks

It is recommended that the shortfall in SALT provision to OPMH needs to be addressed due to the risks identified above. In the short term we also need to assess those patients who were screened as high risk and provide basic dysphagia awareness training to their care staff. In the long term, we need to consider recruiting SLT(s). 4 options are detailed in the report:

Option 1: Continue with current situation

Option2: A centralised minimum dysphagia SALT service across Hampshire

Option 3: A centralised minimum dysphagia and communication SALT service across Hampshire

Option 4: A comprehensive dysphagia and communication SALT service across Hampshire

CONTENTS

1. A CASE STUDY

Code A was a fit and healthy Royal Marine. He was six foot tall and weighed around 13 stone. While still in the Royal Marines, he started having difficulties with his communication and in particular with word-finding and at the age of Code A he was diagnosed with Pick's disease (an early onset frontotemporal dementia).

Code A spent about 3 years at home being cared for by his family; however, they received no support around his communication difficulties and little support generally. When Code A was Code A the family felt they could no longer care for him. He went to Kitnock's Nursing Home where he only spent a few hours and had to be sectioned because of his aggressive behaviour. He was then admitted to Woodhaven where he spent a few weeks. Finally, he was admitted to the Allan Gardiner Unit.

When Code A first arrived at the Allan Gardiner Unit, he had difficulties with eating and drinking due to his head position and this resulted in a lot of problems – his food fell off his spoon or out of his mouth and he developed problems with his gums and teeth. Staff tried to find ways to help Code A by encouraging him to use a straw to drink and by bringing different plates, bowls and spoons in from their own homes. Code A also had a lot of problems with his communication. He mostly mumbled and said 'yes' and 'no' and became very frustrated by his inability to communicate. Staff tried to encourage his communication but were sometimes frustrated by their lack of expertise in this area.

Code A condition deteriorated over the next 15 months. He gradually lost the ability to eat and his weight dropped to around 6 stone and he also lost the ability to speak.

At the beginning, Code A family visited regularly but as his condition deteriorated they found the visits increasingly distressing and one of his sons stopped visiting altogether. They found his inability to communicate extremely distressing and needed support from the staff in this and they also didn't know what to do to help him eat.

Code A never received a dysphagia assessment and his family and the staff on the Allan Gardiner Unit never received any advice on how to improve his nutritional intake or reduce his eating difficulties.

Code A never received a communication assessment or any communication intervention and his family and the staff on the unit never received any advice on how to maintain or improve his communication skills and their relationship with Code A

Code A stopped eating altogether in 2006, at the age of Code A He lasted 10 days with no food and drink and eventually died.

2. INTRODUCTION

Speech and Language Therapists (SLTs) have an increasingly proven and well documented role in providing services in older age mental health, in spite of this being a relatively new area for the profession. The Royal College of Speech and Language Therapists (RCSLT) believes that any older person with a communication disorder or dysphagia (eating, drinking and swallowing disorder) including those with a diagnosis of dementia, has a right to access a professional with expertise in these areas; and the incidence of communication disorders and dysphagia is high.

Communication disorder becomes apparent during the course of all types of dementia and surveys have indicated that ***60 – 63% of people with dementia have a communication disorder*** requiring Speech and Language Therapy (SALT) (Lubinski 1995).

Studies that look at the incidence of swallowing difficulty in dementia show that ***68% have dysphagia*** (Steele et al, 1997). Bronchopneumonia has also been found to be the leading cause of death in Alzheimer's Disease and 28.6% were found to be aspirating (Stach 2000). Swallowing problems are also a concern in the later stages of other types of dementia e.g. vascular dementia and those conditions where neurological signs are present alongside cognitive impairment e.g. Huntington's disease, Progressive Supranuclear Palsy, Parkinson's disease and Lewy Body Dementia (Logemann 1998).

3. AIM OF REPORT

The aim of this paper is to report on the current arrangements and need for Speech and Language Therapy (SALT) in OPMH and to make recommendations based on the level of risk identified and recommendations outlined in the Royal College of Speech and Language Therapy (RCSLT) position paper on dementia.

4. NATIONAL CONTEXT

The current policy agenda is clear in that services should be 'designed around the needs and choices of patients, service users and citizens'. It is emphasised that service users should have greater choice in the care they are able to access and that 'diversity of service provision will be required to increase choice for service users' (Better Health in Old Age DH England 2004). The NSF England states that: 'Older People and their carers should receive person centred care and services which respect them as individuals and which are arranged around their needs' (NSF Standard 2) and makes recommendations for the care of people with dementia that reinforce that they should have access to a SALT service (RCSLT, 2005).

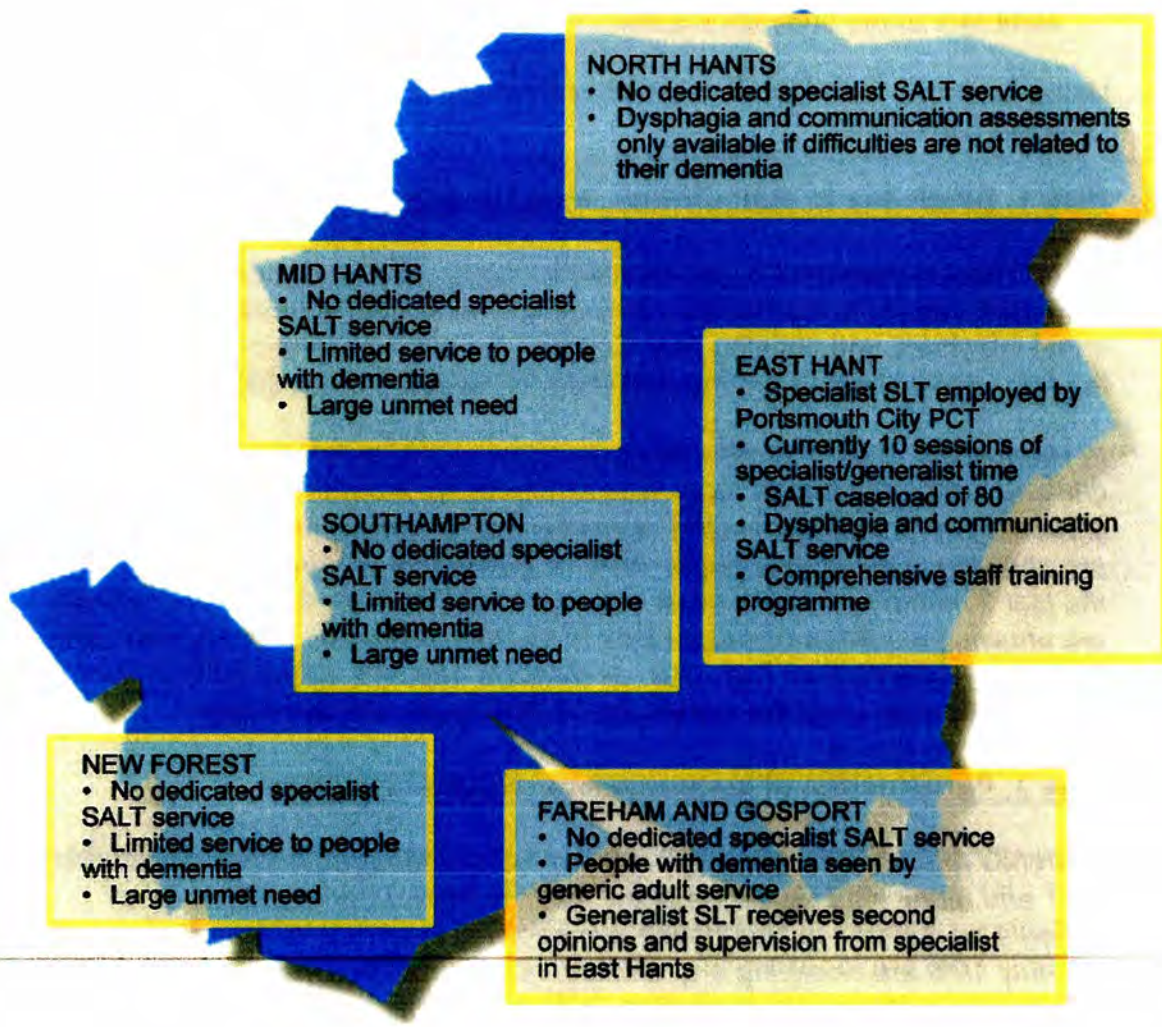
The Forget me not Report (2000) published by the Audit Commission emphasises the need for services such as SLT to be available and the Health Advisory Service report 'Not because we are old' (2000) concluded that SLTs are highly valued and in addition to their own specialist skills, have an important role in training and supporting others.

More recently the publication of the NICE clinical guideline on dementia in November 2006 provides guidance that includes the assessment and treatment of people with communication disorders and dysphagia.

It is therefore essential that all people with dementia and their carers are able to access specialist services such as speech and language therapy if this agenda and philosophy is to be met locally.

5. THE LOCAL CONTEXT

HPT does not employ any SLTs in the OPMH directorate and access to SALT services across Hampshire is varied. A full description of each locality is given in appendix 1 but the following diagram gives a brief description of the availability of SALT in each locality.



6. CURRENT RISKS IN THE PROVISION OF A SPEECH AND LANGUAGE THERAPY SERVICE IN HPT

In order to assess the current risks within HPT, the following actions were completed:

1. **Dysphagia Screening**: 30 patients were screened for evidence of dysphagia (see appendix 2) across 3 wards and this highlighted people with evidence of dysphagia and people who are at high risk of death. A full summary of the findings are given in Appendix 3.

2. **Staff Awareness of Dysphagia:** 150 questionnaires were sent out to staff in the OPMH directorate (see appendix 4). This highlighted how many staff were supporting people with dysphagia, whether they have received any training and whether they know how to recognise the symptoms of dysphagia. A full summary is included in appendix 5.

3. **Meetings with staff members and Community Teams:** 19 members of staff were interviewed and their opinion sought on what services they currently receive from SALT around communication and what their patients/clients would benefit from receiving (see appendix 6). A full summary of the findings is given in appendix 7.

Using evidence from literature and key findings from the above, the following risks are highlighted:

Risk 1: Death due to malnutrition, choking and aspiration pneumonia.

Weight loss in dementia is not inevitable (Wang 1998). Dysphagia, *if not managed*, results in malnutrition and dehydration, and is causal in repeated chest infections and choking risk. Community-acquired pneumonia is also the leading cause of death among residents of nursing homes (Marik et al 2003).

In Hampshire, several deaths have occurred in the past few years due to choking, and a number of near-miss incidents have been recorded. The screening of 30 patients in HPT revealed that at least a third of the patients are showing signs of dysphagia; 40% of patients have had a chest infection in the last 3 months and 20% have recurrent chest infections; 37% of patients are showing evidence of weight loss or chronic problems with nutrition; and 40% were assessed as high risk. In addition, only 6% of the staff showed a good awareness of all the symptoms of dysphagia and aspiration.

Risk 2: Perpetuation of inappropriate / harmful practice

Currently people with dysphagia are not being managed across all localities in HPT and many staff do not have the skills to keep people safe. 37% of patients on 3 wards in Hampshire are showing evidence of malnutrition and yet only 10% are receiving any artificial nutrition; 57% are showing evidence of chronic problems with hydration; 60% of patients are receiving a modified diet and yet only 17% have a swallowing care plan; and a number of staff are

altering diet and drinks 'as required' with no previous training. 88% of staff support people with dysphagia and yet 90% do not recognise the symptoms of dysphagia and 19% have ever received any dysphagia awareness training.

Risk 3: Unnecessary admission and readmission to hospital and residential / nursing care.

People with dysphagia are often admitted to hospital when they reach the stage of anorexia or aspiration (RCSLT, 2005) and direct SALT intervention with carers providing training, advice and support enables them to continue in the caring role for longer (Barnes 2003).

Code A *family were unable to continue to care for him and expressed distress at the lack of support around his communication and dysphagia.*

Risk 4: Decrease in level of independence.

It is essential that staff and relatives caring for the person with dysphagia are trained to assist and prompt without reducing the person's ability to self-feed (Siebens 1986) as the onset of feeding dependence also correlates with the onset of dysphagia in dementia.

*Being dependent on someone else for **eating and drinking** affects a person's ability to eat and drink safely and 47% of patients screened are dependent on others for eating. Only 19% of staff in HPT have ever received dysphagia training and yet 88% of staff support people with dysphagia.*

Communication and memory therapy for people with early dementia can maximise and maintain independence for longer (Clare and Woods 2001).

*In most localities in Hampshire, people are unable to access SALT for a **communication** assessment and most staff identified this as a huge deficit in their area. A carer in Mid Hants has recently complained due to the lack of SALT provision for his wife (see appendix 8). Staff interviewed on the 3 wards identified 73% of their patients would benefit from a communication assessment and 43% would benefit from advice around presenting information to maximise their ability to consent and make choices. All staff interviewed identified a need for training in communication, except in E Hants, where they already receive a SALT service.*

Risk 5: Decrease in quality of life for both the person and their carers.

Dysphagia has well documented effects on physical health but also has adverse effects on self-esteem, socialisation and enjoyment of life including anxiety and panic during mealtimes (Ekberg 2002).

Staff on the Allan Gardiner Unit described Code A *case to me as they felt distressed that his dysphagia had a huge impact on his quality of life at the end and the carers' distress in his last few days. Staff felt inadequate in their ability to reassure the carers due to the fact that the person needed dysphagia*

support from a SLT. In addition, the lack of SALT for his communication difficulties, also affected Code A *quality of life and his family's quality of life.*

Risk 5: A loss of relationships and an increase in social exclusion

The loss of meaningful interaction and conversation places increased pressure on the caring relationship (Nolan et al 2002). Gilleard et al (1984) found that carers of people with dementia exhibiting communication and behavioural difficulties were twice as likely to report symptoms of their own psychiatric distress. Carers rate behavioural and communication problems as more stressful than daily living and self-care impairments. It is important to provide carers with strategies to manage such difficulties (Barnes 2003).

All staff identified the importance and need for communication intervention for their clients and carers to maintain relationships. Staff on the E Hants community teams stated that one of the most beneficial services that they currently receive from SALT is the support in running groups for both clients and carers to maintain abilities in communication and relationships.

Risk 6: Perpetuation of the current postcode lottery re access to SALT

A survey indicated that many services are not fully multidisciplinary and that service variability continues to exist with many services not yet compliant with the standards in the NSF for Older People, England (Challis et al 2002).

Currently SALT services are patchy across Hampshire. E Hants has a good level of service but in the other localities there is a reduced SALT service. In some locations, staff are reporting that they are unable to get a SALT service.

Risk 7: Reduced benefit from interventions from other professionals and a delay in diagnosis and/or incorrect diagnosis.

People with dementia have complex needs and it is therefore vital that services are coordinated and seamless. As communication is so fundamental, SLTs should be core MDT members as they have a role in assisting other professionals to achieve effective communication with patients who have dementia (Orange and Ryan 2000). SLTs also have an important role to play in diagnosis when language symptoms are prominent. Heritage and Farrow (1994) found that the work of the SLT was most effective when the SLT was a permanent and specialist member of the multiprofessional team. As well as specific benefits for clients, the whole team benefited from heightened awareness of communication disorder and advice and training on how to manage it.

Staff on the Community teams in Havant and Petersfield stated that the SLTs are an essential and valued member of their MDT. They are based on the community teams and attend MDT meetings. All team members said they often needed communication assessment/advice to support their intervention.

Risk 8: Hampshire Partnership Trust will not be able to meet the NICE clinical guideline

The NICE clinical guideline 42 published in November 2006 provides the following guidance:

a) ***Person-centred care***
The principles of person-centred care assert *'the importance of the perspective of the person with dementia'* (p.6). Communication is central to effective person-centred care and a communication assessment of the person's strengths and needs is essential.

b) ***Capacity to consent***
'People with dementia should have the opportunity to make informed decisions about their care and treatment. Health and social care professionals should always seek valid consent from people with dementia. This should entail... checking that he or she understands. If they do not have capacity to make decisions... professionals will need to follow a code of practice accompanying the Mental Capacity Act 2005. Adults must be assumed to have capacity to make decisions for themselves unless proved otherwise' (p. 6/7/9). SLTs are qualified to assess an individual's capacity to communicate and understand information, and to advise on the most effective means of presenting information and choices to the individual.

c) ***Assessment of communication***
'Health and social care staff should identify the specific needs of people with dementia and their carers arising from... communication difficulties' (p.12). *'Care coordinators should ensure that care plans are based on an assessment of the person with dementia's... current level of functioning and abilities'* (p.16). *'Clinical cognitive assessment... should include examination of... language'* (p.23). SLTs have a key role in assessing a person's communication to identify strengths and weaknesses for an individual, to assist in differential diagnosis and to assist others in managing their communication disorder.

d) ***Accessible information***
'Information should be offered in a form that is tailored to meet the needs of the individual' (p.8) and *'if language is a barrier to... understanding services, treatment and care, health and social care professionals should provide the person with dementia... with information in... an accessible format'* (p.13). SLTs have the specialist skills to advise on how to maximise an individual's ability to understand information.

e) ***Relationships***
Communication is central to our relationships and one of the principles of person-centred care is *'the importance of relationships and interactions with others to the person with dementia'* (p.6) and *'the impact of dementia on relationships... should be assessed in a sensitive manner'* (p.15). Profile based assessments by SLTs can allow the communicative

relationship between the person with dementia and their carers to be analysed and advice given to improve / maintain these.

f) ***Maintaining independence***
'Health and social care staff should aim to promote and maintain the independence... of people with dementia... to include... environmental modifications to aid independent functioning, including assistive technology' and *'People with mild-to-moderate dementia should be given the opportunity to participate in a structured group cognitive stimulation programme. This should be commissioned and provided by a range of health and social care staff with appropriate training and supervision'* (p.28/29). SALT intervention for dysphagia focuses on care practice, environmental modification, adaptation of equipment and texture modification of food and drinks. They can provide detailed assessment of the eating environment and make appropriate recommendations to ensure maximum independence. Communication in semantic dementia can also be maintained and enhanced by specific interventions.

g) ***Managing challenging behaviour***
'Staff should... identify, monitor and address... factors that may increase the likelihood of behaviour that challenges... and these factors include... poor communication between the person with dementia and staff' (p.37). Inability to communicate effectively may be the cause of many challenging behaviours and the SLT has skills to enhance the performance of others to optimise communication.

h) ***Training staff***
'Health and social care managers should ensure that all staff... have access to dementia-care training that is consistent with their roles and responsibilities... Trainers should consider... understanding behaviour that challenges as a communication of unmet need... and the importance of and use of communication skills for working with people with dementia and their carers; particular attention should be paid to pacing of communication, non-verbal communication and the use of language that is... tailored to an individual's ability' (p.17/18). SLTs have specific skills in training others in communication and dysphagia.

i) ***Assessment and treatment of dysphagia***
'Staff should identify the specific needs of people with dementia and their carers arising from... problems with nutrition and poor oral health' (p.12) and *'Staff should encourage people with dementia to eat and drink by mouth for as long as possible. Specialist assessment and advice concerning swallowing and feeding in dementia should be available... Nutrition support... should be considered if dysphagia is thought to be a transient phenomenon'* (p.42). SLTs are uniquely qualified to assess and treat dysphagia and to provide advice on minimising the impact of dysphagia on the person and carers.

Currently Hampshire Partnership Trust is unable to meet the above guidelines across all localities.

7. THE BENEFITS OF PROVIDING A SPEECH AND LANGUAGE THERAPY SERVICE

Speech and Language Therapists have clinical expertise in the areas of **communication disorder** and **dysphagia**. The role of the SLT encompasses working with clients and their carers from the early to late stages of the disease providing services that enable people to retain a sense of independence/ self worth and remain at home for as long as possible. Within this the SLT aims to reduce the impact of the communication disorder and/or dysphagia on the person and their carers by providing advice, education and support to them and the multidisciplinary team.

The benefits of providing a SALT service include:

1. **Specialist assessment and treatment of dysphagia**

   SLTs are qualified to assess and treat dysphagia and will advise on how to ***minimise the risks of aspiration and choking***, reduce the impact of the dysphagia and ***improve nutritional intake*** (Biernacki et al 2001).

   The SLT will also provide specialist advice on the safety and efficiency of oral intake and the need to consider **non-oral feeding**. Current unpublished research suggests early intervention improves outcomes (Regnard 2006).

   The SLT will also provide ***advice to carers*** and ***staff training*** on specific strategies for the ***safe provision of nutrition*** to an individual.

2. **Specialist assessment and treatment of communication skills**

   SLTs have a key role in the ***early diagnosis*** and recognition of different types of dementia through specific analysis of language disorders (Snowden and Griffiths, 2000).

   The SLT also has specific skills in contributing to the assessment of ***capacity to consent*** and to advise on how to present information to enable a person to make choices.

   The SLT will work to ***maximise a person's ability to communicate*** through specific language programmes.

   The SLT will ***work with carers and staff*** to enhance their understanding of the person's communication and to give advice on how to ***improve and maintain relationships***.

3. **Specialist training for staff in dysphagia and communication**

   The SLT can provide training on dysphagia; communication; challenging behaviour; and memory and to enhance the performance of others and optimise communication and eating and drinking (Maxim et al 2001).

8. OPTIONS FOR ADDRESSING RISKS

It is recommended that the shortfall in SALT provision to OPMH needs to be addressed due to the risks identified above. 4 options are detailed below, 3 of which address some or all of the risks identified.

OPTION 1: Continue with current situation
Total cost: none
Risks addressed: none

OPTION 2: A minimum SALT service to people with dysphagia

Aim of service

1. To minimise the risk of death due to malnutrition, choking and aspiration pneumonia
2. To minimise the risk of unnecessary admission and readmission to hospital and residential / nursing care
3. To increase level of independence in eating and drinking at an earlier stage of dementia
4. To increase quality of life at mealtimes

Description of service

A centralised dysphagia SALT service across Hampshire (apart from East Hants) that includes:

- Assessment and treatment of dysphagia in both inpatient units and in the community
- Comprehensive staff training programme to include:
  - Recognition of dysphagia and aspiration
  - Management of dysphagia and aspiration including dietary modification and feeding techniques
- Individual staff training around complex cases

Risks Addressed

- Risk 1: death due to malnutrition, choking and aspiration pneumonia
- Risk 2: perpetuation of inappropriate/harmful practice
- Risk 3 (partial): unnecessary admission and readmission to hospital and residential care
- Risk 4 (partial): decrease in level of independence
- Risk 5 (partial): decrease in quality of life for both the person and their carers
- Risk 6 (partial): perpetuation of the current postcode lottery re access to SALT
- Risk 8 (partial – point (i) only): HPT will not be able to meet the NICE clinical guideline

Resources required		Cost
Capital	1 pulse oximeter	£240
	1 stethoscope	£50
	academic resources	£100
Total		**£390**
Staffing	1 full time SLT at Band 7*	£36,416
	1 session of Band 8b	£5,073
Total Staffing Cost		**£41,489 per annum**

**Amount of SLT time is estimated using information gained from East Hants.*

OPTION 3: A minimum SALT service to people with dysphagia and communication difficulties

Aim of service

1. To minimise the risk of death due to malnutrition, choking and aspiration pneumonia
2. To minimise the risk of unnecessary admission and readmission to hospital and residential / nursing care for both dysphagia *and communication* difficulties
3. To increase level of independence in eating and drinking *and communication* at an earlier stage of dementia
4. To increase quality of life at mealtimes for both the person and their carers
5. *To minimise the risk of a delay in diagnosis and/or incorrect diagnosis.*

Description of service

A centralised dysphagia and minimum communication SALT service across Hampshire (apart from East Hants) that includes:

- Assessment and treatment of dysphagia
- Assessment and treatment of communication at early stage dementia for prevention and maintenance of communication and memory skills
- Assessment of communication to aid differential diagnosis
- Assessment and treatment of individuals where language problems are prominent e.g. progressive aphasia, vascular dementia
- Comprehensive dysphagia staff training programme

Risks Addressed

- Risk 1: death due to malnutrition, choking and aspiration pneumonia
- Risk 2: perpetuation of inappropriate/harmful practice

- Risk 3: unnecessary admission and readmission to hospital and residential care
- Risk 4 (partial): decrease in level of independence
- Risk 5 (partial): decrease in quality of life for both the person and their carers
- Risk 6 (partial): perpetuation of the current postcode lottery re access to SALT
- Risk 7 (partial): reduced benefit from interventions from other professionals and a delay in diagnosis and/or incorrect diagnosis
- Risk 8 (partial): HPT will not be able to meet the NICE clinical guideline

Resources required		**Cost**
Capital	1 pulse oximeter	£240
	1 stethoscope	£50
	academic resources	£100
Total		**£390**
Staffing	2 full time SLTs at Band 7	£72,832
	1 full time SLT at Band 6	£31,004
	1 session of Band 8b	£5,073
Total Staffing Cost		**£108,909 per annum**

OPTION 4: A gold standard SALT service to people with dysphagia and communication difficulties

Aim of service

As option 2 but in addition:

4. To increase quality of life and sense of well-being *around communication* for both the person and their carers
5. *To improve access to and benefit from necessary interventions from other professionals.*
6. *To increase individuals' involvement in decision making.*
7. *To minimise the risk of social exclusion.*

Description of service

A comprehensive dysphagia and communication SALT service across Hampshire (apart from East Hants) that is based within the local Community Teams and includes:

- Assessment and treatment of dysphagia
- Assessment and treatment of all communication difficulties
- Assessment of communication to aid differential diagnosis

- Assessment and intervention of communication to aid capacity to consent and maximise choice
- Assessment and provision of communication aids
- Assessment and treatment of communication and challenging behaviour
- Group work on communication, memory, validation therapy and reminiscence
- Comprehensive dysphagia staff training programme
- Comprehensive staff / carer training on communication, challenging behaviour and memory

Risks Addressed

- Risk 1: death due to malnutrition, choking and aspiration pneumonia
- Risk 2: perpetuation of inappropriate/harmful practice
- Risk 3: unnecessary admission and readmission to hospital and residential care
- Risk 4: decrease in level of independence
- Risk 5: decrease in quality of life for both the person and their carers
- Risk 6: perpetuation of the current postcode lottery re access to SALT
- Risk 7: reduced benefit from interventions from other professionals and a delay in diagnosis and/or incorrect diagnosis
- Risk 8: HPT will not be able to meet the NICE clinical guideline

Resources required		**Cost**
Capital	5 pulse oximeters	£1200
	5 stethoscope	£250
	academic resources	£500
Total		**£1950**
Staffing	1 full time SLT at Band 8a	£42,278
	2 full time SLTs at Band 7	£72,832
	2 full time SLTs at Band 6	£62,008
Total Staffing Cost		**£177,118 per annum**

9. APPENDICES

Appendix 1 Current Provision of Speech and Language Therapy across Hampshire

Mid Hants

Currently there is no specialist SALT service to older people with mental health problems in Mid Hants. People with dementia living in Winchester, Andover and Eastleigh North will be seen as hospital inpatients, in their own homes and in OPMH nursing homes for a dysphagia assessment with advice for management. They will also assess people with communication problems relating to early stage dementia and give generalist advice on communication strategies. They provide some dysphagia awareness training locally which staff at the OPMH homes could access if they wanted to.

There is no specialist advice, assessment or treatment of communication; specialist dementia dysphagia work; or blocks of therapy or ongoing work for either communication or dysphagia.

The manager of the local adult SALT service feels that there is a 'large' unmet need and has recently had a letter of complaint (see appendix 4).

Southampton

Currently there is no dedicated specialist SALT service to people with dementia in Southampton. In the acute setting, patients with dementia who are admitted to an elderly care/general medical ward with an acute episode of communication or swallowing difficulty are referred and seen by the acute hospital SALT service for assessment and advice as part of the acute service. However in the community there is limited input to the OPMH wards/units as this work accounts for less than 1 session of unfunded SALT time. Referrals accepted are therefore not seen within the RCSLT standards as other patients will be prioritised above the OPMH patients. Patients with dementia referred for dysphagia by a GP as an outpatient are not seen, but the referrer and the carers are sent a swallowing advice sheet.

There is no assessment or treatment of communication; assessment and treatment of long standing dysphagia or dysphagia that is not directly caused by oral or pharyngeal stage difficulties; blocks of therapy or ongoing work for either communication or dysphagia; or a community/ domiciliary service.

The manager of the local adult SALT service feels that this is an area where patients are not receiving an adequate service and there is a huge unmet need.

New Forest

In the acute setting, patients who are admitted to a general medical/elderly care ward at Lymington hospital with communication and /or swallowing problems will be seen as part of the SLT acute hospital service. In the community Southampton does not have the Mental Health contract for the New Forest. This service is provided by Salisbury.

There is no out patient service to patients referred with dementia who are experiencing communication or swallowing difficulties. Communication and swallowing advice sheets are sent to the referrer and the carers.

North Hants

Currently there is no dedicated specialist SALT service to people with dementia in North Hants. The adult SALT service currently provides dysphagia assessment to all patients and communication assessment if their difficulties are **not** related to their dementia, for example, due to CVA.

There is no specialist advice, assessment or treatment of communication difficulties related to dementia; specialist dementia dysphagia work; staff awareness training in dysphagia; or blocks of therapy or ongoing work for communication.

The manager of the local adult SALT service feels that their current work with patients with dementia is only a very small percentage of the potential need in the area and there is a large unmet need.

East Hants

Currently, Portsmouth City PCT employs a specialist SLT for 4 sessions a week (2 days) to work in OPMH and to act as a consultant to other generalist SALT colleagues who also accept referrals for patients with dementia (6 sessions). The SALT department have an approximate caseload of 80 people with dementia (40 in Petersfield and 40 in Havant). On average, 25% of the caseload is dysphagia. The SALT department also run regular communication and dysphagia training for staff. They provide a 1 hour basic dysphagia awareness training pack for care staff in residential and nursing homes and a 1 hour training session to all OPMH team staff. They also a more detailed 'swallow and mealtime awareness training' pack which incorporates 3 sessions of 1 hour for nurses and carers. The SLTs have a base within the local CMHTs and work closley alongside their colleagues in Psychology, nursing and OT.

Fareham and Gosport

Currently there is no dedicated specialist SALT service to people with dementia in Fareham and Gosport. Clients can be referred into the generic adult service for both dysphagia and communication difficulties and generalist SLTs in Fareham and Gosport can seek specialist support, second opinions and supervision from the specialist SLT in Portsmouth or East Hants as needed. Referral rates for SALT in OPMH are not as high in Fareham and Gosport as in Portsmouth City or East Hants due to the OPMH team being aware of the fact that there is no specialist SALT service. Previous service development bids for a specialist SALT post in dementia have been unsuccessful.

Appendix 2 Dysphagia Screening Tool

Ward	**Patient** .....
Completed by	**Date** .....

Dietary Modification				**No**	**Yes**
Do they have a modified diet?					
If yes, is it...	Mashed/soft		Pureed		
Do they have modified fluids?					
If yes, is it...	Syrup	Custard	Pudding		
Any comments					

Respiratory Status	**No**	**Yes**
Have they had a chest infection in the last 3 months		
Do they have recurrent chest infections (2 or more in last 3/12)		
Do they have a past history of chronic chest disease (e.g. chronic bronchitis, pulmonary emphysema, asthma) with worsening of symptoms in last 3 months?		
Any comments		

Independence with eating and drinking	**No**	**Yes**
Eating Totally dependent – needs to be fed all of the meal		
Moderately dependent – needs to be fed half or more of meal and/or needs lots of verbal prompting and encouragement		
Mildly dependent – needs a little physical assistance and/or a little verbal prompting		
Independent – eats independently with no physical help or prompting (except perhaps has help with cutting up food)		
Drinking Totally dependent – needs to be physically assisted with all of a drink		
Moderately dependent – needs to be assisted with half or more and/or needs lots of prompting and encouragement		
Mildly dependent – needs a little assistance and/or a little prompting		
Independent – drinks independently (except perhaps being told once that the drink is there)		
Any comments		

Oral stage of eating and drinking	**No**	**Yes**
When *eating*, do they have definite trouble getting the swallow started e.g. holding the food in the mouth, spitting out food, chewing difficulties, losing food from mouth		
When *drinking*, do they have definite trouble getting the swallow started e.g. holding the drink in the mouth, drinks come back out of mouth		
Any comments		

Pharyngeal stage of eating and drinking	No	Yes
Once the swallow starts, do they have problems swallowing food e.g. coughing, choking, swallowing seems uncomfortable		
Once the swallow starts, do they have problems swallowing a drink e.g. coughing, swallowing seems uncomfortable		
Is there evidence that aspiration is occurring e.g. coughing, wet vocalisations, choking episodes, change of skin colour, watery eyes		
Any comments		

Nutrition and Hydration	No	Yes
Have they had unintentional weight loss over past 3 months		
Any evidence of chronic problems with nutrition e.g. skin, bowel, tiredness		
Are they receiving artificial nutrition		
Do they drink less than 6 cups of fluid a day		
Any evidence of chronic problems with hydration e.g. constipation, UTIs		
Are they receiving artificial hydration		
Any comments		

Formal assessment of swallowing	No	Yes
Have they had a formal dysphagia assessment by a speech and language therapist?		
If yes, when?		
Where?		
Do they have a swallowing care plan?		
Do they need a SALT dysphagia assessment?		
Are they high risk?		

Summary

Appendix 3 Dysphagia Screening Results

30 patients were screened for evidence of dysphagia (see appendix 1) across 3 wards: The Willows, Petersfield Hospital; Allington East, Moorgreen; and Allan Gardiner Unit, Andover War Memorial Hospital.

The following risk indicators were considered:

1. Dietary modification
2. Respiratory status
3. Dependence for eating and drinking
4. Oral stage difficulties
5. Pharyngeal stage difficulties
6. Nutrition concerns
7. Hydration concerns
8. Previous SALT input
9. Need for SALT assessment

1. Dietary modification

Food texture

Normal	40%
Mashed/soft	43%
Puree	17%

Drink thickness

Normal	73%
Syrup	3%
Custard	21%
Pudding	3%

Diet modification is common and yet this is being done without prior training or a SALT assessment. Staff also report that some patients are given a modified diet 'as required'. Inappropriate modification of diet can cause additional problems, for example pureed diets can worsen a person's nutritional status. Staff are less likely to modify drinks and yet unthickened drinks can increase the risk of aspiration and chest infection in people with dysphagia. Only 17% had a swallowing care plan and these were all where a SALT assessment had taken place in E Hants.

Summary

- *Staff feel that 60% of patients require a modified food texture*
- *And 27% require thickened liquids*
- *Only 17% had a swallowing care plan and had received any training in dietary modification*

2. Respiratory status

	Chest infection in last 3/12	Recurrent CI (2 or more in last 3/12) and/or past history of chronic chest disease with worsening symptoms
YES	40%	20%
NO	60%	80%

In some cases, chest infection is likely to be due to aspiration or silent aspiration. Breathing difficulty in itself can also cause swallowing to be unsafe especially in this vulnerable patient group.

Summary

- *Chest infections are very common and nearly a quarter of patients' respiratory status has deteriorated in the last 3 months*

3. Dependence for eating and drinking

	Eating	Drinking
Independent	43%	50%
Mildly independent	10%	13%
Moderately dependent	20%	10%
Totally dependent	27%	27%

Being dependent for eating and drinking significantly affects the ability to eat and drink safely. The screening revealed that a significant number of patients are moderately or totally dependent for eating and drinking.

Summary

- *47% of patients are moderately or totally dependent for eating*
- *37% of patients are moderately or totally dependent for drinking*
- *On one ward, this figure rose to 71% of patients being moderately or totally dependent for eating and drinking*

4. Oral stage difficulties

	Eating	Drinking
No obvious problems	57%	70%
Definite problems	43%	30%

Oral stage difficulties can often go unnoticed by untrained staff. However, a significant number of patients were felt to be experiencing oral stage problems.

Summary

- *Staff feel that a significant proportion (30-43%) have definite oral stage difficulties*

5. Pharyngeal stage difficulties

	Eating	Drinking
No obvious problems	70%	67%
Definite problems	30%	33%

~~Pharyngeal stage difficulties, that is, problems with the swallow reflex, can~~ often go unnoticed by untrained staff. However, 30% of patients are showing

evidence that aspiration is occurring when eating or drinking through coughing, choking etc.

Summary

- *Staff feel that around a third of the patients have definite pharyngeal stage difficulties*

6. Nutrition concerns

	Unintentional weight loss	Evidence of chronic problems	Receiving artificial nutrition
YES	37%	37%	10%
NO	63%	63%	90%

Patients with dysphagia that is not being managed well can often show evidence of weight loss or malnourishment. This can be linked to poor recovery and repeated infections.

Summary

- *Over a third of patients are showing evidence of weight loss or chronic problems with nutrition*
- *Only 10% are receiving artificial nutrition*

7. Hydration concerns

	Drink less than 6 cups of fluid a day	Evidence of chronic problems	Receiving artificial hydration
YES	33%	57%	0%
NO	67%	43%	100%

Patients with dysphagia that is not being managed well can often show evidence of dehydration. This can be linked to poor recovery and repeated infections.

Summary

- *A third of patients are not drinking enough and 57% are showing evidence chronic problems with hydration, for example repeated UTIs*
- *No one is receiving artificial hydration*

8. Previous SALT input

	Previous SALT assessment (The Willows)	Previous SALT assessment (Allington and Allan Gardiner)
YES	17%	0%
NO	83%	100%

Summary

- *17% of the patients have received a SALT assessment on the Willows in E Hants.*

- *No one had received a SALT assessment on the other 2 wards*

9. Need for SALT assessment

	Need a SALT assessment	Identified as high risk
YES	37%	40%
NO	63%	60%

Summary

- *37% of the patients need an up to date SALT assessment*
- *40% have been identified as high risk*

Individual ward comparison

The Willows, Petersfield Hospital

The Willows has 10 beds and a slow turn over (approximately 6 new referrals per year). Staff were highly complimentary about the SALT service they currently receive and feel that there have been some very successful outcomes for their patients. They mainly have support around dysphagia and the staff have also had dysphagia awareness training.

There were 5 patients (71%) who were considered to be high risk following screening but these are being managed currently by a well trained staff team and a specialist SLT.

Allington East, Moorgreen

Allington East has 12 beds plus 1 respite and is a challenging behaviour ward. They have had 9 new referrals in the last 12 months. They do not have any direct SALT any more and say that if they refer to SALT, they tend to just get a telephone contact. They state that nurses are managing the patients' dysphagia. Staff informed me that they have had one near miss choking incident in the last 2 years and 1 death from choking about 3 years ago. A consultant psychiatrist at Moorgreen also informed me that recently they had to get one of their patients admitted to the SGH just to get a SALT service.

Following screening, there were 2 patients (17%) who were considered to be high risk and both of these have had choking or near-choking episodes recently.

Allan Gardiner Unit, Andover War Memorial Hospital

The Allan Gardiner Unit has 16 beds and is a short term assessment unit. They have at least 40 new referrals a year and therefore a high turnover. They do not get a SALT service and staff expressed real concerns about their inability to access this service for their patients. They reported that they know of 2 deaths in the last 3 years in Winchester due to choking and 1 death this year on the unit where dysphagia was a factor and where SALT input would have made a real difference to the patient's last few days and the carers' distress. They also stated that due to the high turnover, patient need can vary greatly and if I had visited the previous month, they felt that 75% of their

patients would have been assessed as high risk and requiring a SALT assessment.

Following screening, there were 5 patients (45%) who were considered to be high risk.

Conclusion of screening of patients for dysphagia

The screening of 30 patients for dysphagia has revealed the following:

- 60% of patients are receiving a modified diet and 27% are receiving thickened liquids. However, only 17% had a swallowing care plan and had received any training in dietary modification and a number of staff were altering diet and drinks 'as required' with no previous training.
- 40% of patients have had a chest infection in the last 3 months and 20% have recurrent chest infections
- 47% of patients are moderately or totally dependent for eating and 37% of patients are moderately or totally dependent for drinking and this significantly affects someone' ability to eat and drink safely.
- 30-43% have definite oral stage difficulties and 33% have definite pharyngeal stage difficulties
- 37% of patients are showing evidence of weight loss or chronic problems with nutrition and yet only 10% are receiving artificial nutrition
- 33% of patients are not drinking enough and 57% are showing evidence chronic problems with hydration, for example repeated UTIs and no one is receiving artificial hydration
- 17% of the patients have received a SALT assessment on one ward in East Hants but no one had received a SALT assessment on the other 2 wards.
- 37% of the patients need an up to date SALT assessment
- 40% have been identified as high risk (n 12)
- Currently 7 of these 12 will not receive a SALT assessment

Appendix 4 Staff Awareness Questionnaire on Dysphagia

Please can you complete this short questionnaire about dysphagia? It should take you around 5 minutes (or the time it will take to eat your sweet!) and will help me assess the future need for Speech and Language Therapy in your place of work.

THANK YOU and ENJOY!

A. Supporting People with Dysphagia

		Yes	No	Not sure
1	Do you support anyone with dysphagia?			
2	Have you ever received any dysphagia training? *If no, please go to question 5*			
3	What did it consist of?			
4	Was it helpful?			
5	Have you ever referred anyone for a dysphagia assessment? *If no, please go to question 10*			
6	Did they get one?			
7	Was it helpful?			
8	Were the SALT recommendations followed? *If yes, please go to question 10*			
9	If recommendations were not followed, what were the reasons for this?			
10	Do you support anyone with a modified diet? E.g. pureed/soft			
11	Do you support anyone with modified drinks? E.g. thickened			
12	Are you aware of the Trust Dysphagia Policy?			
13	Do you know the signs to look out for to indicate dysphagia?			
14	Do you know how to alter food and drink to make things safer or easier for someone with dysphagia?			
15	Do you know how to recognise the signs of aspiration?			

B. Referring for a SALT dysphagia assessment

If a patient was exhibiting the following, would you request a referral for a dysphagia assessment?		1 definitely not	2 not very likely	3 possibly	4 likely	5 definitely	Comments
1	Coughing while eating						
2	Coughing while drinking						
3	A wet sound to their voice after eating/drinking						
4	Problems swallowing their medication						
5	Behavioural difficulties at mealtimes						
6	Difficulty supporting the person to eat / drink						
7	Refusal to eat						
8	Refusal to drink						
9	Drinking lots						
10	Dislikes mealtimes						
11	A change in preferences (drink or food)						
12	Choking episodes						
13	Chewing difficulties						
14	Pocketing food in mouth						
15	Apparent discomfort when swallowing						
16	Takes long time to eat						
17	Doesn't finish meal						
18	Doesn't finish drink						
19	Frequent chest infections						
20	Weight loss/ evidence of malnourishment						
21	Chronic dehydration						
22	Change of skin colour when eating/drinking e.g. red/blue						
23	Loss of food/fluid from mouth						
24	Food/fluid coming out of their nose						
25	Eyes watering when eating/drinking						

C. A little bit about you

1	How long have you worked with older people with mental health problems?
2	What is your job title?
3	Is there anything else you think may be useful for me to know?

THANK YOU VERY MUCH!
This questionnaire is anonymous but it would be helpful to know your place of work.

Place of work .....

Please return in the internal mail to:

Alex Kelly,
Trust Lead for Speech and Language Therapy,
Rufus Lodge,
Tatchbury Mount

In case of any questions, my telephone number is: 023 80874222

THANK YOU!!

Appendix 5 Results from Staff Awareness Questionnaire on Dysphagia

150 questionnaires were sent out to staff in the OPMH directorate. These were distributed proportionally across the localities and divided equally between qualified nursing staff and unqualified staff. 86 questionnaires were returned (57%); 46 qualified and 40 unqualified.

The purpose of this questionnaire was to assess the following:

1. Do staff support people with dysphagia
2. Have staff received dysphagia training and did they find it useful
3. Do staff refer and receive SALT assessments
4. Are staff aware of the Trust Dysphagia Policy
5. Do staff know the signs to look out for to indicate dysphagia
6. Do staff recognise the signs of aspiration
7. Do staff have a good awareness of when to refer for a SALT assessment

1. Do staff support people with dysphagia?

18 respondents said they did not support people with dysphagia (21%) however 8 of the 18 do support people with a modified diet and drinks and can therefore be assumed to have some form of eating and drinking difficulty. Therefore these 8 staff had either not understood the question or the term dysphagia.

Summary

- *88% of staff (76) support people with dysphagia*

2. Have staff received dysphagia training?

16 respondents have received dysphagia training in the past (19%) and out of these 15 found it helpful. Out of these 16, only 6 showed a good awareness of dysphagia and when to refer to SALT. This is probably due to the fact that the training was a long time ago and most could not remember what they had learnt. Interestingly, out of the 6 that showed good awareness, 3 were from E Hants where they have a dedicated SALT service.

Summary

- *19% of staff have received training*
- *Training is most effective when it is recent and where there is regular contact from a SALT.*

3. Do staff refer and receive SALT assessments?

38 respondents have referred people in the past for a dysphagia assessment (44%) and 33 got one. 5 clients were not seen. This referral rate is disproportionately low in relation to the number of people being supported

with dysphagia. Staff reported that they do not refer mostly because they know they will not receive a service.

Summary

- *Only 44% of staff have ever referred someone for a dysphagia assessment*
- *13% of these referrals were not seen*
- *Staff are not referring due to a lack of service*

4. Are staff aware of the Trust Dysphagia Policy?

18 respondents were aware of the Dysphagia Policy (21%). Of these 18 people, 12 were qualified staff and out of these 12, 10 showed a good awareness of dysphagia.

Summary

- *Only 21% of staff were aware of the Trust Dysphagia Policy*
- *Most of these were qualified staff who had a good awareness of dysphagia*

5. Do staff know the signs to look out for to indicate dysphagia?

60 respondents stated that they were aware of the signs to look out for to indicate dysphagia (70%) however only 9 respondents (10%) showed a good awareness of all the 12 key signs of dysphagia. This was assessed by staff responding that they were 'likely to' or would 'definitely' request a SALT referral if a patient exhibited one of the key symptoms of dysphagia. 31% of staff showed awareness of 10 or more of the key signs of dysphagia. Worryingly, 9 respondents (10%) said that they would only 'possibly' refer for a choking episode (2 of these were qualified staff).

Summary

- *70% of staff stated that they were aware of the signs to look out for to indicate dysphagia*
- *However, only 10% of staff showed an awareness of all the 12 key signs of dysphagia*
- *90% of staff do not recognise all the symptoms of dysphagia*

6. Do staff recognise the signs of aspiration?

64 respondents stated that they did know how to recognise the signs of aspiration (74%) however only 14 respondents (16%) showed a good awareness of all the 6 key signs of aspiration by saying they were 'likely to' or would 'definitely' request a SALT referral.

Summary

- *74% of staff stated that they did know how to recognise the signs of aspiration*

- *However, only 16% showed an awareness of all the 6 signs of aspiration*
- *84% of staff do not recognise all the signs of aspiration*

In addition only 5 respondents recognised all the symptoms for dysphagia and aspiration.

- *Only 6% of staff recognise all the signs of dysphagia and aspiration*

7. Do staff have a good awareness of when to refer to SALT for a dysphagia assessment?

Using the rating scale, respondents were given a total score based on their responses (1-5) and this was compared with a sample of Speech and Language Therapists' responses. Using this analysis, scores of between 93 and 111 would show a good awareness of when to refer to SALT.

21 respondents showed a good awareness of when to refer (24%) and out of these, 13 were qualified staff and 8 were unqualified. 4 respondents were overcautious and had total scores of over 111 (5%) and 61 did not have a good awareness (71%).

Summary

- *Only 24% of staff show a good awareness of when to refer for a SALT assessment*
- *71% did not have a good awareness*

It was also possible to look at those staff who showed a particularly poor awareness of dysphagia by seeing how many would 'definitely not' or are 'not very likely' to refer for a SALT assessment when clients exhibit one of the 12 key indicators for dysphagia.

Key indicator of dysphagia	*% of staff indicating a poor awareness (actual number)*
Coughing while eating	13% (n11)
Coughing while drinking	8% (n7)
Wet vocalisations after food/drink	16% (n14)
Problems swallowing medication	16% (n14)
Chewing difficulties	12% (n10)
Discomfort when swallowing	3% (n3)
Frequent chest infections	28% (n24)
Weight loss/malnutrition	13% (n11)
Chronic dehydration	16% (n14)
Change of skin colour when eating/drinking	6% (n5)
Food/fluid coming down their nose	9% (n8)
Eyes watering when eating/drinking	15% (n13)

The relatively high percentage of staff who did not recognise chest infections as important could be explained by the fact that chest infections are often

caused by other factors and in isolation are not necessarily an indicator of dysphagia. However, in conjunction with other symptoms, chest infections do become a very important key indicator and risk factor.

Summary

- *Up to 28% of staff are unlikely to refer people when they exhibit one or more of the key indicators of dysphagia.*

Conclusion of staff awareness questionnaire

From the 86 questionnaires returned, we can conclude that the majority of staff (88%) support people with dysphagia and yet their knowledge of dysphagia is poor with only 6% of staff showing a good awareness of the signs of dysphagia *and* aspiration. In addition staff awareness of when to refer for a SALT assessment is also poor with only 24% of staff showing a good awareness of when to refer someone. A few staff have received training in the past but in most of these, the training was too long ago to be useful. A small number of staff who have received training and showed a good awareness of dysphagia were from E Hants where they have some dedicated SALT input.

Appendix 6 Staff Interview on SALT provision

Name.....

Service..... **Date** .....

Previous experience of SALT	**yes**	**no**
1. Have you ever received a SALT service for one of your patients/clients?		
2. What is your experience of the SALT service you received?		
3. How many patients/clients are you responsible for i.e. are on your ward/caseload?		
4. How often does your caseload/ inpatients change? e.g. number of new referrals per month		

The following are some of the services a SALT can provide	**Ever received support on this?**	**Would this benefit any of your patients?**	**If yes, how many?**
1. Detailed assessment of *memory (to assist differential diagnosis)*			
2. Strategies (e.g. memory aids) / individual therapy programmes to maintain memory			
3. Advice to carers on approaches that can be used to help/ maintain memory			
4. Detailed assessment of *communication skills*			
5. Strategies / individual therapy programmes to help specific communication difficulties			
6. Approaches to enable individuals to achieve their communication potential e.g. multi sensory approaches			
7. Advice to carers on approaches that can be used to help them manage communication difficulties and minimise isolation			
8. Assessment, advice and provision of *communication aids*			
9. Assessment of communication to aid process of determining *capacity to consent*			
10. Advice on ways to present information to maximise their ability to consent and make choices			
11. Assessment of communication and *challenging behaviour*			
12. Advice / strategies / programmes on managing behaviour and communication difficulties			

The following are some of the services a SALT can provide	**Ever received support on this?**	**Would this benefit any of your patients?**	**If yes, how many?**
13. Assessment of *eating and swallowing difficulties*			
14. Advice on keeping an individual safe at mealtimes and drink times			
15. Group work on managing mild memory problems			
16. Group work on maintaining communication skills			
17. Group work on validation therapy			
18. Reminiscence groups			
19. Staff training on memory			
20. Staff training on communication			
21. Staff training on communication and challenging behaviour			
22. Staff awareness training on dysphagia			

Any comments

Completed by .....

Appendix 7 Results of Staff Interviews on SALT provision

19 members of staff were interviewed and their opinion sought on what services they currently receive from SALT around communication and what their patients/clients would benefit from receiving.

Inpatient services

The following services were identified as being of high importance by all 3 wards visited:

- Detailed assessment and intervention of communication skills with advice to carers on how to manage communication difficulties
- Assessment of communication to determine capacity to consent and advice on maximising an individual's ability to make choices
- Assessment and advice on communication and challenging behaviour
- Staff training on communication and challenging behaviour

In addition, 2 of the wards also wanted:

- Assessment and advice on memory
- Support in running groups

Community Teams

All of the SALT services identified were considered to be important by the 3 community teams visited.

In Southampton, nurses have received no SALT service for any of their clients and in particular were concerned about the need for communication assessments and training (and also the need for dysphagia assessments when there is an issue). A near-miss choking incident was discussed.

In Havant and Petersfield, they have access to a SLT and receive all aspects of a SALT service. The following aspects of the service were highlighted as being of particular benefit:

- The SLT being part of the MDT
- The education and training part of their role
- Support in running groups for clients and carers
- Support to nurses to provide advice around communication and dysphagia
- Service development

Appendix 8 Copy of complaint received and reply given by SALT department in Winchester

Dear Sirs,

My wife has advanced Alzheimer's and now has little comprehension, reverting to her mother tongue of Code A after being fluent in six languages.

It has become apparent that when friends visit her and converse in Code A she becomes very excited and takes part in the conversation.

I have been trying to get her G.P. and psychiatric consultant to fund speech therapy for her, so far without success.

However, over the past three months one of her carers has taken a special interest in her and they are communicating with each other by speech and signs in English.

This leads me to believe that with the correct therapy, she would regain comprehension in English although ideally the therapist should be able to converse in Code A as well.

Surely, facilities must exist within the NHS for this to be done. I would be very grateful for any information and advice.

Best regards, Name and Address

****

15.9.06

Dear Mr Code A

Re 'Speech Therapy for Mentally Incapacitated Wife'

My colleague Miriam Edwards forwarded to me your recent email regarding your search for additional speech and language therapy input for your wife. I know that both Miriam and Natalie Windebank have been to see your wife in the past, concerning the swallowing problems she has been experiencing and I hope that you have found their advice helpful.

Whilst we can and do offer some general help to people with dementia, mostly in the management of swallowing problems, unfortunately we do not have within our service the specialist skills required to work with the communication difficulties that they experience. This does mean, as you rightly point out, that there is a gap in the health services available to our local population at present. From your email, I suspect that you have already flagged this up with local health providers and I regret that the situation does not seem to be changing.

It is possible that there may be private speech and language therapists locally who are specialists in working with adults with mental health problems. If this is an avenue you wish to pursue, I suggest you contact the Association of Speech and Language Therapists in Independent Practice, on 0870 2413357 who will be able to give you the information you need.

Yours sincerely

Diane Payne
Head of Adult Speech and Language Therapy Service

cc PALS, RHCH
Pippa Cook, Speech and Language Therapy Service Manager, RHCH

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