



Management of FEDS Difficulties in the Residential Care Setting

A consensus document developed by the
Irish Nutrition and Dietetics Institute and the
Irish Association of Speech and Language Therapists

2014

Foreword

Dear IASLT and INDI members,

We are acutely aware that the recommendations in this document may not be what the members of our professions are anticipating. Indeed the final document is produced after months of research, discussion and debate within the working group and also with both professional bodies.

Starting out on this project we envisaged the end product would be an appropriate template to use for over the bed signage that would meet with HIQA's approval, a large poster that could be used at the entrance to nursing homes asking visitors not to give food and fluid to residents without consulting with a member of staff. Through the course of this work many hours were spent liaising with members of the professions who felt their posters etc. had met with HIQA's approval. Many hours were spent designing our own.

A meeting with HIQA representatives in January 2014 resulted in the group reviewing the direction of this framework and our recommendations. Following this meeting we decided that given HIQA's regulatory function it would be inappropriate for the IASLT and INDI to make recommendations that signage should be used in a nursing home for the management of dysphagia. HIQA's standards clearly do not support their use. The consultation with HIQA clarified to us that the legal responsibility lies with the nursing home to meet the standards and implement SLT/Dietitian recommendations for individual residents. Given HIQA's regulatory responsibility we need to encourage our members to ensure that they are working within those standards. The use of generic signage/signage over a patient's bed does not meet these standards.

HIQA does not provide any recommendations on the implementation of SLT/Dietitian guidelines e.g. the systems/procedures can vary from place to place. Procedures and pathways for communication regarding identified risks should be clearly defined and developed locally. Implementation should be in line with HIQA standards. Incident reporting procedures should be followed by SLT's and Dietitians where they identify risk.

IASLT/INDI WORKING GROUP.

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Part 1: Background

The Irish Nutrition and Dietetics Institute (INDI) and the Irish Association of Speech and Language Therapists (IASLT) are aware of the need to define, describe and develop a best practice framework for the management of feeding, eating, drinking, swallowing (FEDS) in the residential care setting for Older Persons within the context of changing social, legislative and policy frameworks. This document was developed by an expert working group of members of the INDI and IASLT.

The document will serve as a reference for SLTs (speech and language therapists), dietitians, the Health Services Executive (HSE), Nursing Homes Ireland, older persons with FEDS difficulties/Dysphagia, their families and other key stakeholders.

Speech and language therapists, dietitians and all members of the multidisciplinary team are committed to providing the highest standards of care in the management of residents with FEDS difficulties in the residential care setting commensurate with best practice. The Health Act 2007 and introduction of HIQA National Quality Standards for Residential Care Settings for Older People in Ireland (2009) have created a welcome focus on improving quality and safety of care for older people in residential care.

As a result of this focus, the traditional method applied to the management of FEDS difficulties/dysphagia: the use of signage regarding eating, drinking and swallowing or dietary recommendations for individual residents in public display has come under scrutiny by HIQA inspectors in the residential care setting due to concerns regarding protecting confidentiality and dignity of residents. Dietitians, SLTs and nursing homes have voiced concerns regarding the risk of managing dysphagia particularly in situations where there is no mitigating factor to prevent visitors from

offering food or drinks to residents and in situations where the residents medical status can fluctuate frequently. In May 2012, INDI and IASLT published a Position Statement on the use of over the bed signage to highlight dysphagia risk in residential care units. The feedback from HIQA at that point was that the approach in relation to dysphagia signage needed further consideration by INDI and IASLT. In recent months INDI and IASLT have been approached by staff in residential care units seeking guidance in relation to supervision of residents at mealtimes following HIQA inspections after incidences of deaths as a consequence of choking. As a consequence of these events, INDI and IASLT have been looking more holistically in relation to the area of dysphagia management in the residential care setting. Following a period of research and consultation with a wider group of stakeholders, this INDI/IASLT Framework Document for the management of FEDS in Residential Care was produced. This document provides a guidance framework for the management of FEDS in the residential care setting.

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Part 2: The development process

Following an initial meeting a number of approaches were adopted to gather information to inform the future direction of the group. The first included a literature review to summarize evidence-based strategies for management of FEDS/ dysphagia including the use of signage. Secondly the group consulted with a number of stakeholders including HIQA, international professional bodies for dietitians and SLTs and organisations representing patients, nurses, nursing homes, and patient safety. Thirdly a survey of dietitians and SLTs working in Ireland was carried out to identify current practices and evidence for best practice in an Irish setting.

Review of the literature

Dysphagia

Eating involves a range of functions including motor, sensory, and cognitive skills. It has significance in terms of cultural and social factors, as well as varying according to individual habits (Kindell, 2002).

Feeding, eating, drinking and swallowing disorders (FEDS) can occur due to a breakdown of any of the aforementioned functions. FEDS disorders include dysphagia, which is a swallowing disorder characterized by difficulty in oral preparation for the swallow, or in moving material from the mouth to the stomach. The physical and nutritional consequences of dysphagia can be profound and include aspiration, choking, malnutrition and death. Swallowing difficulties negatively impact quality of life functioning (Lovell *et al.*, 2005).

Prevalence and mortality rates from dysphagia

The most common diagnostic conditions associated with FEDS disorders in an adult population (this is by no means exhaustive) are listed below:

- Stroke: approximately 10,000 people are admitted to hospital in the Republic of Ireland each year with stroke disease (Irish Heart Foundation, 2008). Prevalence estimates of FEDS disorders following stroke vary from 15 to 41% (Smithard *et al.*, 1996; Falsetti *et al.*, 2009).
- Brain tumour: 63% of patients admitted to a rehabilitation ward or hospital presented with FEDS disorders (IASLT, 2012).
- Parkinson's disease: the incidence of FEDS disorders ranges from 75% (Nilsson *et al.*, 1996; Bushmann *et al.*, 1989) to 95-100% (El Sharkawi *et al.*, 2002; Logemann *et al.*, 1975; Robbins *et al.*, 1986).
- Multiple sclerosis: 33% of individuals were found to have impairment of chewing and swallowing abilities (Hartelius and Svensson, 1994).
- Dementia: An incidence of 68% of FEDS disorders was found in individuals in a nursing home setting with dementia (Steele *et al.*, 1997), while Horner *et al.* (1994) reported 28.6% of patients with Alzheimer's were found to be aspirating. Garon *et al.* (2009), in their study found 67.9% of adults with dementia or Alzheimer's disease who were referred for Videofluoroscopy study (VFS), presented with aspiration during VFS assessment (Garon *et al.* 2009). Feinberg *et al.* (1992), in a retrospective VFS study of 131 individuals with advanced dementia, found that only seven percent presented with a normal swallow.
- Intellectual disability: Adults with intellectual disability were found to be more at risk at having FEDS difficulties that go unrecognised (RCLST, 2006). Similarly, Hickman and Jenner (1997) reported 5.3% of community-based individuals and 36% of hospital-based individuals showed symptoms of dysphagia.

- Motor neuron disease: The general incidence of motor neuron disease is 2 per 100,000 and prevalence is 7 per 100,000 (International Alliance of ALS/MND Associations, 2014). The majority of these patients develop dysphagia.
- Huntington's disease: the general prevalence of 6.4 to 13.5 per 100,000 is reported for Huntington's disease (Morrison, Johnson and Nevin, 1995), while the incidence of FEDS disorders is reported as 100% (Kagel and Leopold 1992).
- Acquired brain injury: Dysphagia occurs in approx 25%- 42% of patient's in hospital with brain acquired injuries (Mackey *et al.*, 1999).

The impact of feeding, eating, drinking and swallowing difficulties in adults can be wide-reaching. Impaired swallowing can cause significant morbidity and mortality:

- Choking and death (Marik and Kaplan, 2003).
- Aspiration (Garon *et al.*, 2009; Smithard *et al.*, 1996).
- Respiratory infection (Doggett *et al.*, 2001; Elmståhl *et al.*, 1999; Stringer, 1999). Bronchopneumonia is the leading cause of death in Alzheimer's disease (Horner *et al.*, 1994), and a leading cause of early death for people with intellectual disability (NPSA, 2004; Hollins *et al.*, 1998).
- Poor nutrition and weight loss (Falsetti *et al.*, 2009; Wright *et al.*, 2005).
- Poor health (Hudson *et al.*, 2000).
- Anxiety, distress and/or depression within the family (Choi-Kwon *et al.*, 2005; Ekberg *et al.*, 2002; McHorney *et al.*, 2002).
- Hospital admissions and extended hospital stays (Low *et al.*, 2001).
- Activity limitations and participation restrictions on individuals' daily life and socialisation (Miller *et al.*, 2006).
- Reduced quality of life (Leow *et al.*, 2010).
- Swallowing problems and malnutrition are interdependent – swallowing problems lead to nutritional decline and at the same time malnutrition can

reduce muscle strength and lead to impaired immune function which in turn increases the risk of aspiration (Hudson *et al.*, 2000).

There is no national Irish register of data which records mortality rates from dysphagia. Incidents relating to dysphagia should be highlighted using risk registers but this information is recorded locally and is likely an inaccurate source. In addition, in the case of deaths where dysphagia is a significant contributing factor, the cause of death may be recorded as something else e.g. pneumonia. Anecdotal evidence and concerns highlighted by healthcare professionals working in the residential care setting in Ireland (dietitians/SLTs/nursing homes) suggest that dysphagia risk is under recognised and incidents and deaths related to dysphagia are under-recognised and under-reported.

Management of patient with FEDS

The primary management of the patient with FEDS is the minimisation of the risk of aspiration or choking and the optimisation of their nutritional wellbeing (Singh and Hamdy 2006; Finestone and Greene-Finestone, 2003; Odderson *et al.*, 1995; Finestone *et al.*, 1995; Cook and Kahrilas, 1999; SIGN, 2010.)

If, after assessment by a speech and language therapist a texture modified diet and/or modified fluid consistency is recommended, a resident must receive the correct consistency of food/fluid at all times. The consequences of non-compliance with safe swallow guidelines in a person with FEDS difficulties include aspiration pneumonia, lower respiratory tract infections, malnutrition, fluid depletion, reduced quality of life, choking and death (Finestone and Greene-Finestone, 2003; Finestone *et al.*, 1995; Gordon *et al.*, 1987; Teasell *et al.*, 1996; Serra-Prat *et al.*, 2012; Martino *et al.*, 2005; Smithard *et al.*, 1996; Kidd D *et al.*, 1995; Barer, 1989; Sala *et al.*, 1998).

Therefore, it is crucial that the resident, all staff/family members/visitors are aware of and comply with the recommended food/fluid guidelines for the resident (SIGN, 2010; Ramritu *et al.*, 2000; DePippo *et al.*, 1994). In persons with cognitive impairment or communication difficulties, awareness and knowledge among care staff and family is even more paramount to support best care in the management of FEDS/dysphagia.

Challenges in the residential care setting

Dysphagia can be a covert condition and as such risks may not be obvious. Also, dysphagia can develop or progress at any point in time. Residents presenting with cognitive impairments may not have an insight into the severity of their dysphagia or the risk posed by not adhering to specific dietary recommendations. Therefore it is necessary that processes are in place to identify and manage dysphagia. These include an assessment of all risks involved and strategies to minimise these risks.

A systematic method for identifying and managing risks related to dysphagia is essential to support traditional management approaches. HIQA standards underpin the care of all residents and a social care model should be considered at all times in the residential care setting.

Signage as risk reduction measure

There is no published evidence to support the use of signage as an efficacious method to manage FEDS/dysphagia in the residential care setting. However, a number of fields where signage is used to reduce risk were identified. These include:

- Falls in healthcare
- Road safety
- Occupational health
- Food labelling
- Traffic light-symbol systems

A review of signage systems used in these areas was carried out by this working group. Best practice Occupational Safety and Health and road safety could be applied to the management of dysphagia using a hierarchy of control risk management system:

- First level: Sustainable prevention of injury and death considering all key areas
- Second level: Real time risk reduction, which involves providing users at severe risk with a specific warning to enable them to take mitigating action (i.e. signage)
- Third level: Risk reduction management including strategies to create awareness, identify risk, monitor risk, support staff, carers, residents and their families using support mechanisms such as information provision and education.

The expert group agreed that these principles mirror the principles of maintaining the safety of individuals with regards dysphagia. As such a warning system using symbols or signage could be used for individual residents if supported by risk management strategies or if the resident consents. Careful consideration of risk versus dignity and confidentiality is imperative; therefore the implementation of such a system should be done in a manner to ensure that HIQA standards relating to privacy and dignity are not breached.

Consultation with stakeholders

HIQA

HIQA is an independent authority responsible for driving quality, safety and accountability in residential services for older people in Ireland. HIQA is responsible

for driving improvements in the quality and safety of healthcare on behalf of patients by developing standards, monitoring compliance with standards and carrying out investigations where there are reasonable grounds to do so. HIQA does not regulate individual healthcare professions.

As part of the developmental process, members of this working group consulted with HIQA to discuss the management of FEDS/dysphagia in the residential care setting. The main discussion centered on access to dietetic and SLT services and the use of signage to manage FEDS in the residential care setting for older persons.

HIQA does not support the use of over the bed signage for the management of dysphagia as there is a lack of evidence in relation to efficacy of this method. In addition the use of signage in this manner is not considered dignified, respectful or person-centered and breaches a person's right to confidentiality and privacy. As such the use of signage is not in line with the following standards:

- National Quality Standards for Residential Care Settings for Older People in Ireland Standard 4: Privacy and Dignity.
- National Standards for Safer Better Healthcare Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

HIQA advised that *'Residents need to have access to services, assessment and appropriate documentation in care plans outlining all risks and steps taken to manage the risk in a holistic way covering all aspects of the residents life which is clearly communicated to all staff and persons who come into contact with the resident and is reviewed regularly and accordingly'* (HIQA, 2012).

INDI and IALST have been clear in stating their concern in relation to access to dietetic and SLT services for Older Persons in Residential Care settings. Service gaps

include a lack of access and a lack of timely access to services. As part of the consultation process, this working group emphasised these concerns to HIQA.

Professional bodies and other stakeholders

A number of professional bodies were consulted regarding the management of FEDS/dysphagia in the residential care setting. These included worldwide professional bodies for dietitians, SLTs and nurses. In addition, the group consulted with organisations involved in quality and safety in healthcare, safety in the workplace and road safety. A number of areas where visual aids (e.g. signage/labels) are used to elicit information/ reduce risk were also researched to identify evidence for this type of approach and to investigate alternative or novel approaches to manage dysphagia in the residential care setting in line with a social care model and HIQA standards. Results are outlined in Tables 1 and 2.

Table 1: Feedback from International Professional Dietetic and SLT organisations

Stakeholder	Feedback
Royal College of Speech and Language Therapists (UK)	There are no standardised systems in place regarding the use of signage in the management of dysphagia in the residential care setting. Use of signage appears to be organisation/service specific. The variability in the use of signage has been identified elsewhere as an issue; however, a standardised approach to managing this issue does not exist. There are currently no formal policies in place regarding the use of signage in residential care settings. A diverse range of communication systems to report recommendations are used across organisations including signage, colour codes, symbol systems,
American Speech, Language and Hearing Association (ASHA)	
Speech Pathology Australia	
New Zealand Speech-language Therapists' Association (NZSTA)	
British Dietetic Association (BDA)	

Dietitians Association of Australia (DAA)	documentation in medical charts or care plans. However, there are no standardised international or national practices in any of the countries where these organisations are based. Most organisations contacted await the outcome of this group’s work.
Dietitians New Zealand, Dietitians of Canada	
American Academy of Nutrition and Dietetics	

Table 2: Feedback from other stakeholders

Stakeholder	Feedback
Regulation and Quality Improvement Authority (Northern Ireland)	Similar challenges exist in Northern Ireland and there is no current policy in place. It was reported that there is some use of symbols to address Falls Risks. The placemats system is used to identify patients with FEDS difficulties. Common practice involves removal of the placemats following mealtimes to ensure client confidentiality is maintained.
Nursing Homes Ireland (NHI)	NHI reported that while individual nursing homes may engage in risk-reporting and document risk, there is no standardisation across settings. Again, absence of an official risk assessment tool in relation to FEDS was reported.
An Bord Altranais (ABA)	ABA do not offer specific guidance to nursing homes with regard to use of signage for dysphagia management.
Health and Safety Authority	Health and Safety Authority provides documentation outlining how warning signage should be created (yellow triangle with black edge). This document

	states that all measures should be taken to manage or reduce risk first, with signage only to be used as a final measure.
Food Labelling	Front-of-packet traffic light system labelling has been deemed effective compared with detailed information or numeric systems and traditional labelling that was placed at the back of a packet. The Institute of Medicine in the US has published detailed guidelines indicating four important components in front of packet food labelling: it should be simple, ordinal, interpretive, easily identifiable, and remembered by the general public.
Symbol System Falls Reduction	Although there is some evidence that such a system would be effective, it requires training and therefore is of limited use to the general public or visitors in reducing risk.
Irish Society for Quality and Safety in Healthcare	Attempted to contact on several occasions with no success.

National survey of dietitians and SLTs

In an attempt to decipher practices and gain insight into experiences of clinicians in relation to dysphagia signage INDI and IASLT conducted a survey of members on the topic in August 2013.

In total there were 276 respondents of which 55.5% (151) were speech and language therapists and 44.5% (121) dietitians. Just under half of all respondents (130) reported working in a residential care unit for older persons at some point of their career. Just fewer than 21% of respondents reported currently working in a residential care units for older persons with an additional 15.8% reported working in other residential units (intellectual disabilities commonly reported). Due to the high numbers of respondents reporting working in a residential care unit for older persons at some point we believe the information collected is an accurate representation of practices and experiences with regard to dysphagia signage. Below is a summary of the main findings.

Risk Assessment

Results from this survey show that only 20.3% are using identified risk assessments in the management of FEDS/dysphagia. A further 27% of respondents were unsure whether any type of risk assessment is used. Types of risk assessments currently being used according to members include HSE matrix, incident forms, NHS risk assessment (adapted), NPSA dysphagia risk assessment, and service-specific risk assessments. The main areas of risk identified in the survey referred to the inappropriate provision of modified diets or thickened fluids to residents, issues with SLT service provision and risk in complex cases.

Signage

Of those that responded, the majority (91.04%) reported using some form of signage to highlight dysphagia risk. The types of signage vary widely from care plans at bed end/in the nursing notes/on the client locker, kitchen lists, medication & drinks trolley lists and central copy of care plans in dining room and kitchens. The information included on these signs varies widely however recommended food texture, consistency of fluids, name of resident and therapists were most commonly included (93%, 89%, 81%, 73%). Other frequently included details are guidelines on thickening, safe swallowing strategies, suitable foods and fluids, high risk foods, requirements for adapted utensils, pictures and patient identifiers. Some centres also reported using general public information strategies (posters, information leaflets etc) to educate visitors on dysphagia risk, recommendations and guidelines in residential care units. The use of colour coded trays/mats/menu ordering systems was highlighted as a means of highlighting individual patient's FEDS status to staff.

A number of respondents felt there was reliable anecdotal evidence & feedback in local audits to suggest that:

- Healthcare staff rely on over the bed signage to inform them if the safest consistency of food and fluids for individual patients especially for temporary/transient staff/where English is not their first language.
- Dysphagia signage was effective in communicating guidelines and risk.
- Nurses and healthcare assistants strongly support the use and value of this signage.
- Signage is effective in reiterating food and fluid guidelines to visitors.
- Signage holds high patient approval (one audit reporting 92.5% approval by clients).

Of the 95 respondents who reported working in a residential care unit that had undergone HIQA inspections, there seemed to be an inconsistent approach in

relation to the assessment of dysphagia signage and the opinions of the HIQA inspectors in this area. While some inspectors did not comment on signage on public display, feedback from others was that such signs should not be publicly displayed due to confidentiality issues. Therefore it appears that in some instances, inspectors were satisfied with the use of such signage.

Conclusion

The goals of effective FEDS management and treatment include:

1. Increasing swallowing efficiency (through intervention).
2. Increasing swallowing safety, to minimise aspiration and choking risk.
3. To recommend the most appropriate diet texture and fluid consistency and determine when transition from one form of nutrition to another is appropriate, such as from enteral to oral, or liquidised to regular, non-modified diet (IASLT and INDI, 2009).
4. To determine, in conjunction with a dietitian and/or medical officer, the most appropriate method to maintain or increase nutrition and hydration; this may include oral, or non-oral means, or a combination of these.
5. Maximising the social aspect of eating/drinking where possible.
6. Facilitating a positive mealtime experience for the resident.

Professional role and boundaries

In the residential care setting, the legal responsibility for complying with HIQA standards lies with the service provider. Access to dietitian and SLT services within this care setting is also the legal responsibility of the service provider.

It is the opinion of INDI and IASLT that individual dietitians and SLTs also have a role to ensure that they are aware of standards as set down by HIQA and to ensure compliance with the standards within their scope of practice.

As healthcare practitioners, dietitians and SLTs are responsible for providing the appropriate assessment and recommendations regarding FEDS for individual residents. Implementation of a FEDS management plan as recommended by SLTS/dietitians is ultimately the responsibility of the service provider.

However INDI and IASLT acknowledge that the methods used for the implementation and communication of specific strategies such as the provision of recommended consistency of food/fluid, safe swallowing strategies and the monitoring and optimisation of nutritional well-being are not standardized in specific care settings or internationally. Therefore methods of communication vary widely and can include documentation in the relevant medical notes, use of signs or symbol systems such as colour-coded placemats, computerised ordering techniques etc. There is no evidence to show the effectiveness of any of these strategies over one or the other. There is no gold standard. With such a variation in systems and procedures between service providers, education and support by SLTs and dietitians to residential care service providers is essential. SLT and Dietetic services should be as sought by residential care providers to support implementation of FEDS guidelines where necessary.

Current management strategies

The incidence of dysphagia varies depending on the individual's background and medical presentation, yet a 68% incidence of FEDS disorders in individuals in residential settings for Older Persons is reported in the literature (Steele et al, 1997). Mortality from dysphagia is also not accurately measured and, at present, there is no accurate national Irish system for recording incidents relating to dysphagia. However anecdotal evidence suggests that incidents may be more prevalent than what is

currently recorded and concern has been expressed (as per survey results outlined in this document) about the current management of FEDS by SLTs, dietitians and nurses working in residential care.

Therefore current processes operating in residential care in Ireland may be inadequate to manage risk associated with FEDS. This document aims to provide a framework/support document outlining best management of FEDS/dysphagia in the residential care setting.

Management of FEDS in residential care

The fundamental principles are based on identification and management of FEDS disorders and risks associated with FEDS disorders. Consideration of HIQA Standards must underpin the management of all residents care needs. Therefore any strategies such as the use of signage in public areas with individual patient information must be used with the consent of the resident and be supported by appropriate risk assessments.

Use of signage

Following the process undertaken by this working group, as professional bodies INDI and IASLT cannot recommend the extensive use of signage in the residential care setting due to the lack of efficacy and the price in terms of dignity and person-centred care. The use of a sign does not compensate for a lack of dietetic/SLT services, motility of staff, inadequate communication or for an insufficient knowledge base of care staff regarding the risks and management of dysphagia. It is important to note that the survey results indicate significant levels of concern among dietitians, SLTs and residential care providers regarding the mismanagement of FEDS in this care setting. Therefore access to dietitian and SLT services must be available for resident assessments as needed as well as to provide education and support to all nursing home staff involved in the implementation of FEDS management care

plans. Appropriate systems should be in place to ensure adequate and timely communication of SLT and dietitian recommendations.

For complex or high risk patients it may be necessary to consider the use of a warning sign or system. This should be used only when fully supported by appropriate risk assessment and where consent has been obtained from the resident where possible.

Part 3: Recommendations

Management of FEDS/dysphagia in residential care

Residents need to have access to services, assessment and appropriate documentation in care plans, outlining all risks and steps taken to manage the risk in a holistic way covering all aspects of the residents life, which is clearly communicated to all staff and persons who come into contact with the resident and is reviewed regularly and accordingly (HIQA, 2012).

Guidance document

This document provides a framework outlining important considerations in the management of FEDS/dysphagia in the residential care setting. This framework document aims to support residential care providers identify and manage FEDS in the safest and most effective way possible. This framework also supports the work of SLTs, dietitians and whole multidisciplinary team in the management of FEDS.

The fundamental principles are based on identification and appropriate management of risks associated with FEDS. Residents need to have access to appropriate services, assessment and documentation in care plans outlining all risks and steps taken to manage the risk in a holistic way. Consideration of HIQA Standards must underpin the management of all residents care needs.

A number of specific strategies are identified as essential in this process:

- 1. Identification/Risk Assessment**
- 2. Clear procedures and pathways of communication regarding identified risks**
- 3. Access to professional services for residents**
- 4. Access to professional services for education**



Figure 2: Strategies for management of FEDS/dysphagia in residential care

The resident is at the centre of the care pathway and all four strategies are required for safe and effective management of FEDS.

1. Identification/Risk Assessment

On admission, a resident's food and nutritional needs must be assessed and identified. This includes a full review of a resident's clinical condition including identification of signs or risk factors for dysphagia/FEDS difficulties. This process is supported by standard assessments such as a review of oral health, nutrition screening, observation of feeding, eating, drinking and swallowing ability and collecting information on a resident's food preference which are part of the standard process on admission as per HIQA Regulatory Guidance on Food and Nutrition Requirements for Residential services for older people (2014).

Residents at risk should be referred to a suitably qualified SLT for a clinical swallowing assessment. Residents requiring a texture modified diet should be referred to a dietitian for a full nutritional assessment.

Regular monitoring for signs and symptoms of dysphagia/FEDS difficulties should occur as part of the care planning process. This should occur every three months when the care plan is reviewed or more frequently if clinically indicated. Speech and language therapists and dietitians when assessing a resident may indicate a timeframe for review also.

The most appropriate way to manage FEDS is to ensure comprehensive assessments are carried out by a speech and language therapist and a dietitian in those residents identified as at risk. A care plan developed on the basis of the assessment should then be implemented and must be communicated to the resident, all staff and other relevant parties (family members etc).

Supervision of residents during eating/drinking is based on the level of risk. In residents with an identified FEDS disorder some degree of supervision is necessary. The level of supervision can vary and range from verbal prompting to physical

guidance to full assistance (Kindell 2002). If residents are assessed by an SLT and dietitian, specific guidance regarding supervision will be documented in the care plan and should be followed by all staff involved in the resident's mealtime.

Risk assessment for complex cases

This group has adapted an NPSA risk assessment tool for use in the residential care setting in Ireland. This tool can be used by a multidisciplinary team to identify risks in complex cases (see appendix 1).

2. Procedures and pathways of communication regarding identified risks.

Service providers may vary in the processes of how the identified FEDS issues are managed. It is imperative that systems are adequate to support the management of FEDS. This must include clearly defined procedures and policies particularly with regard to responsibilities for:

- Liaison with SLT and Dietetic services
- Completion, storage and updating of swallow/FEDS care plans
- Informing all staff of changes to care plans
- Informing families and visitors of changes and risks
- Onward referral to other agencies including dental, medical, etc.
- Continuing education and awareness-building regarding risks associated with FEDS.

3. Access to professional services for assessment of residents

Given the high incidence and prevalence of dysphagia, and the potentially severe and even fatal consequences, appropriate diagnosis and management of swallowing and feeding disorders are critical (ASHA, 2002).

The complex nature of FEDS disorders requires the advice and expertise of a variety of professionals working collaboratively to best manage the multiple factors involved (IASLT, 2012).

In the care of patients with FEDS disorders, a collaborative approach between the SLT and dietitian is optimum. Together, the SLT and dietitian determine appropriate food and fluid consistencies that can be safely consumed by the patient to optimize food and fluid intake (Heiss *et al*, 2010).

Given the highly specialised knowledge base and clinical skills which are unique to SLT education and training, SLTs are the primary providers of clinical services to individuals presenting with FEDS disorders. These clinical services include evaluation, treatment and management of FEDS disorders and minimising compromise in respiratory or nutritional status associated with impairments in FEDS (ASHA, 2004)

Dietitians are recognised health care professionals with expertise in food and nutrition and are qualified to prescribe therapeutic diets or individualised nutrition care plans for specific disease states including those with FEDS. The dietitian's essential role includes completing a full nutritional assessment and development of a nutrition care plan to ensure that each patient's nutrition and hydration needs are met (Heiss *et al*, 2010).

Following assessment of an individual with FEDS additional appropriate roles for the SLT include but are not limited to:

- Teaching and supporting individuals and their families about FEDS disorders.
- Educating other professionals (healthcare providers and catering service providers) regarding the needs of individuals with FEDS disorders.
- Educating other professionals regarding the role of the SLT in the evaluation and management of FEDS disorders (IASLT, 2012).

The role of the dietitian in the treatment of an individual with dysphagia is primarily to ensure nutritional needs are met by assessing and monitoring nutritional status, estimating nutritional requirements, providing guidance on food consumption of appropriate texture and consistency and recommending additional support measures when indicated. Additional roles for the dietitian in the management of FEDs include:

- Teaching and supporting individuals and their families about FEDS and the nutritional management of FEDS.
- Education of other healthcare professionals and healthcare providers including catering service providers regarding the nutritional implications and nutritional management of individuals with FEDS disorders.

4. Access to professional services for education

Education and awareness sessions should be made available to all healthcare staff involved in the mealtime experience for Older Persons in Residential Care Settings. Ideally, in order to maximise learning, training should be delivered jointly by a speech and language therapist and dietitian. Training should include but is not limited to the following;

- Dysphagia/ FEDS difficulties definitions
- What is aspiration?

- Who is at risk?
- Signs and symptoms that somebody may have a feeding, eating, drinking and swallowing difficulty / to support staff in identifying a person presenting with FEDS difficulties.
- The role of the SLT in managing a person presenting with FEDS difficulties.
- The role of the dietitian in managing FEDS.
- The Irish Consistency Descriptors for Modified Consistency Food and Fluids (IASLT and INDI, 2009).
- Nutritional implications of dysphagia e.g. dehydration, malnutrition, constipation.
- How dysphagia can be managed in a residential care setting for Older Persons. Management includes reduction of aspiration and choking risk and optimisation of nutritional wellbeing.
- Practical session; thickening fluid consistencies, strategies to assist people with FEDS difficulties at mealtimes.
- Practical session-dietary strategies to prevent and manage nutritional problems.
- Catering support i.e. menu planning, nutritional analysis.
- Risk assessment tool.
- Referral process.
- Communication regarding dysphagia management, identification of care pathways and the use of FEDS care plans.

Summary

INDI and IASLT are committed to supporting their members to provide the highest quality of care to their service users. Within the residential care sector for Older Persons, the implementation of HIQA standards has been welcome. At the centre of all of these standards is the resident; whose individual care needs are paramount. It

is not appropriate to recommend the use of 'signage' generically across the residential care sector to implement guidelines for the management of FEDS difficulties. Access to SLT and Dietetic services for timely assessment and follow up of residents at risk or with FEDS difficulties is essential. Clear pathways and procedures must be developed locally to implement management guidelines for FEDSs and to best meet the needs of the resident.

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Appendix 1

Modified NPSA Dysphagia Risk Assessment

Guide to levels of risk of negative health consequences from dysphagia.

Risk assessments carefully examine systems to identify factors that could cause or contribute to harm to an individual. This guide identifies the factors that increase the risk of negative health consequences arising from a person's dysphagia. The negative health consequences are **asphyxiation and/or choking episode, aspiration incidents, dehydration and poor nutritional status.**

These factors are not always related to the severity of the dysphagia itself but to other intrinsic and extrinsic factors which may exacerbate dysphagia risks. These factors affect the predictability of the person's presentation and interact with dysphagia. High risk and low risk are easier to manage than fluctuating risk i.e. the person's risk varies for any intrinsic or extrinsic factor from meal to meal or day to day. Each factor can increase the risk of all the negative health consequences outlined above.

The modified risk assessment tool is recommended to be used by a multidisciplinary team for complex cases. Risks affecting dysphagia can be identified and graded using the tables provided. Overall severity of risk can then be determined using the proforma at the end of the document.

This modified risk assessment document should be used in conjunction with the NPSA Dysphagia Risk Assessment summary document (see appendix 2) which includes space for details of the exact nature of the client's difficulties as well as an action plan.

Intrinsic factors	Indicators associated with low risk	Indicators associated with increasing risk	Indicators associated with high risk
Level of learning disability/cognitive function	<ul style="list-style-type: none"> • Person able to understand risks associated with their dysphagia. • Person able to understand and implement their management strategies. 	<ul style="list-style-type: none"> • Person reliant on others to implement dysphagia management strategies. • Person is cognitively dependent on others to eat and drink. 	<ul style="list-style-type: none"> • Person unable to understand risks associated with his/her dysphagia. • Person unable to recognise the health and safety aspects of eating and drinking (e.g. volume, temperature, rate of intake and presence of inedibles).
Alertness and cooperation	<ul style="list-style-type: none"> • Person maintains alertness during eating and drinking. • Person alert throughout the day. • Person shows anticipation of the food and drink presented. • Person opens and closes mouth appropriately. • Person does not experience things which may affect level of alertness or cooperation. 	<ul style="list-style-type: none"> • Person has reduced ability to focus. • Person less alert at different times of day (e.g. early morning and after bathing). • Person has reduced response to helper or food and drink. • Person does not consistently open and close their mouth in response to food and drink. • Person experiencing things that may affect levels of alertness or cooperation (e.g. medication and ill health). 	<ul style="list-style-type: none"> • Person is sleepy or drowsy and hence less alert. • Person is unable to maintain sustained periods of alertness. • Person has no anticipatory response to helper or food and drink. • Person does not anticipate arrival of bolus. • Person is experiencing many things which affect levels of alertness or cooperation (e.g. medication cocktail and serious ill health).
Distractibility	<ul style="list-style-type: none"> ▪ Person focusing on helper and/or food and drink. 	<ul style="list-style-type: none"> ▪ Person is occasionally distractible during mealtimes. 	<ul style="list-style-type: none"> ▪ Person is highly distracted by environmental sounds or activity.
Fatigue	<ul style="list-style-type: none"> ▪ Person does not get fatigued during meals and drinks. ▪ Person has a regular sleep pattern and is refreshed after sleeping. 	<ul style="list-style-type: none"> ▪ Person may become fatigued during meals and drinks (e.g. because they tire after physical activity, have sleep apnoea or 	<ul style="list-style-type: none"> ▪ Person visibly and/or rapidly fatigues during course of meal or drink showing signs of inco-ordination which affect eating and drinking. ▪ Person falls asleep during oral intake. ▪ Person takes medications which increase

	<ul style="list-style-type: none"> Person sleeps unaided by medication and/or is not on medications that affects sleep. Person's safe posture is not compromised as they become fatigued. 	<p>require postural adjustments during the night which disturbs sleep).</p> <ul style="list-style-type: none"> Person sleeping during the day. Person requires medication to attain regular sleep pattern. Person's safe posture is compromised as they fatigue. 	<p>fatigability and reduce energy levels.</p> <ul style="list-style-type: none"> Person's safe posture cannot be maintained when they fatigue.
<p>Rapid decline in function (decompensation) due to ill health</p>	<ul style="list-style-type: none"> Person has good general health. Person appears physically unaffected by everyday infections. Person appears cognitively unaffected by everyday infections. 	<ul style="list-style-type: none"> Person has a suppressed immune system. Person has underlying medical problems that may interact with new infections. Person decompensates when experiencing any kind of infection e.g. UTI. Person has reduced ability to make decisions because of decompensation (e.g. volume or rate intake). 	<ul style="list-style-type: none"> Person has seriously compromised immune system. Person decompensates rapidly when experiencing any kind of infection e.g. UTI. Person has extremely reduced or no ability to make decisions (e.g. volume, temperature, rate of intake or presence of inedibles).
<p>Seizure activity</p>	<ul style="list-style-type: none"> Person does not have seizures. Person's seizures are well controlled by medication or very infrequent and easy to recognise. 	<ul style="list-style-type: none"> Person's seizure activity is less controlled or predictable. Person experiences some changes in skills pre or post seizure. Person's seizure activity is affected by other things (e.g. increased temperature or fatigue). 	<ul style="list-style-type: none"> Person's seizure activity leads to increased arousal pre or post seizure. Person's seizure activity leads to loss of alertness and inco-ordination. Person's seizure activity is difficult to recognise or is atypical.
<p>Oral health problems</p>	<ul style="list-style-type: none"> Person has no oral health problems. Person has minor oral health problems which do 	<ul style="list-style-type: none"> Person has occasional and/or low level oral health problems which impact on 	<ul style="list-style-type: none"> Person has severe oral health problems which impact on eating and drinking (e.g. many mouth ulcers or severe case of oral

	<p>not impact on eating and drinking.</p> <ul style="list-style-type: none"> Person has minor oral health problems which are managed well. Person can independently manage their own oral hygiene. 	<p>eating and drinking (e.g. occasional mouth ulcers or mild case of oral thrush).</p> <ul style="list-style-type: none"> Person has mild or occasional tooth decay, gum disease or toothache which may impact on eating and drinking. Person has limited or no dentition/dentures which may impact on eating and drinking. Person needs assistance with their own oral hygiene. 	<p>thrush or dry mouth).</p> <ul style="list-style-type: none"> Person has serious and/or frequent tooth decay, gum disease or toothache which does impact on eating and drinking. Person has limited or no dentition/dentures which significantly impacts on their eating and drinking ability. Person is reliant on others to perform oral hygiene. Person is on a number of mouthcare products.
<p>Underlying respiratory problem</p>	<ul style="list-style-type: none"> Person has no underlying respiratory problems. Person's respiratory function is effectively monitored and managed and does not affect eating, drinking or swallowing. Person's underlying respiratory problems is well controlled by medication. Person's respiratory function is being improved via, for example, exercises and postural management. Person has active and effective cough reflex. 	<ul style="list-style-type: none"> Person prone to infections that affects respiratory function. Person finds it difficult to adapt eating and drinking style to compensate for respiratory problems. Person finds it difficult to implement medication regime e.g. inhaler. Person is unable to participate in activities to improve respiratory function. Person has delayed cough reflex and/or less effective cough. Persons dietary intake is limited by respiratory issues i.e. SOB 	<ul style="list-style-type: none"> Person has severely impaired respiratory function (e.g. COPD, rapid respiratory rate, reduced functional reserve or reflux with ascending aspiration). Person unable to adapt eating and drinking style to compensate for respiratory problems (e.g. inspires post swallow due to rapid respiratory rate, swallows during inhalation or incoordination between respiration and deglutition). Person's respiratory problems are not improved by medication. Person has respiratory problems which will not or are unlikely to respond to intervention. Person has severely delayed, weak or absent cough reflex. Person requires assisted breathing devices i.e. oxygen mask, CPAP, BIPAP. Persons dietary intake is significantly limited by respiratory issues.

<p>Postural control</p>	<ul style="list-style-type: none"> ▪ Person has no postural difficulties. ▪ Person can be assisted to achieve and maintain a stable position during and after oral intake. ▪ Person can achieve and maintain a stable position during and after oral intake. 	<ul style="list-style-type: none"> ▪ Person's postural stability deteriorates during and after eating and drinking (e.g. head tilting forward or backwards or changes to hand to mouth co-ordination as a result of loss of postural stability). ▪ Person needs to reposition self and this is judged to be safe or the person is repositioned and this is judged to be safe. ▪ Person requires equipment to achieve and maintain postural stability. 	<ul style="list-style-type: none"> ▪ Person unable to achieve and maintain a stable posture aided or unaided during and after eating and drinking. ▪ Person requires frequent repositioning, aided or unaided and this affects functioning (e.g. disrupts concentration, increases fatigue or makes respiratory demands).
<p>Behavioural difficulties</p>	<ul style="list-style-type: none"> ▪ Person has no behavioural problems. ▪ Person is able to eat and drink safely with appropriate support. 	<ul style="list-style-type: none"> ▪ Person's behaviour affects the efficiency and safety of their eating and drinking (e.g. increasing level of agitation or wanting to move when eating and drinking). ▪ Person's management strategies impact on the safety of eating and drinking. ▪ Person's behaviour difficulties result in limitations in the food and fluids variety, portions and consistencies that they will take. 	<ul style="list-style-type: none"> ▪ Person's behaviour is incompatible with safe eating and drinking. ▪ Person's management strategies are incompatible with safe eating and drinking. ▪ Person's behaviour difficulties result in significant limitations in the food and fluids variety, portions and consistencies that they will take.
<p>Unmanaged pain</p>	<ul style="list-style-type: none"> ▪ Person does not have any unmanaged pain. ▪ Person's unmanaged pain 	<ul style="list-style-type: none"> ▪ Person is likely to or does experience unmanaged pain which may distract 	<ul style="list-style-type: none"> ▪ Person is likely to or does experience unmanaged pain which distracts them during eating and drinking.

	<p>does not impact on eating and drinking.</p> <ul style="list-style-type: none"> Person is able to communicate about any pain and this can be managed (e.g. using medication). 	<p>them during eating and drinking.</p> <ul style="list-style-type: none"> Person has limited ability to communicate about pain experienced. Person is likely to or does experience unmanaged pain which may restrict their intake of food and fluids. 	<ul style="list-style-type: none"> Person cannot communicate pain experienced. Person experiences unmanaged pain which restricts their intake of food and fluids.
Mental health problems	<ul style="list-style-type: none"> Person has no mental health problems that impact upon safe eating, drinking and swallowing. Person's mental health problems are well controlled by medication and/or therapy. 	<ul style="list-style-type: none"> Person has mental health problems that are less controlled or predictable which may impact upon safe eating, drinking and swallowing. Person has mental health problems that are exacerbated by other things (e.g. changes to daily routine increasing anxiety, exposure to stressful situations or noise). 	<ul style="list-style-type: none"> Person has severe and enduring mental health problems which impact upon safe eating, drinking and swallowing. Person has fluctuating mental health problems which can impact upon safe eating, drinking and swallowing (e.g. response to offered support, behaviour around eating and drinking and capacity to make decisions are all likely to be more variable).
Medication	<ul style="list-style-type: none"> Person is not on medication. Person is on medications that have no or minimal impact upon their physical, sensory or cognitive functions. Person is on medications with no or minimal side effects that impact on their physical, sensory or cognitive functions. Person's dysphagia medication sensitivities are considered when selecting the form and administering 	<ul style="list-style-type: none"> Person is on medications that may impact on physical, sensory and cognitive functioning (e.g. some anticonvulsants and neuroleptics can cause dyskinesia and some antipsychotics can cause loss of concentration). Person is on medications with side effects which may effect physical, sensory and cognitive 	<ul style="list-style-type: none"> Person is on medication the primary action and/or side effects of which cause dysphagia (e.g. dantrolene sodium (muscle relaxant effect)). Person is on medication the primary action and/or side effects of which can suppress the cough or gag (e.g. haloperidol). Person has a history of sensitivity to medications. Person is prescribed medication in an unsafe form (e.g. gelatine capsule or not in line with dysphagia recommendations i.e large uncrushable capsulated tablet for individual

	medications.	<p>functioning (e.g. some antipsychotics, antispasmodics and diuretics can cause xerostomia (dry mouth)).</p> <ul style="list-style-type: none"> ▪ Person is taking a number of medication some of which may be the same type (e.g. polypharmacy). 	on smooth puree diet.
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Additional Intrinsic Factors	Low risk	Medium risk	High risk
*Instrumental Assessment findings.	<ul style="list-style-type: none"> • Person has minimal or no dysphagia identified on instrumental swallow assessments (e.g.VFU, FEES) 	<ul style="list-style-type: none"> • Person has an identified level of dysphagia on instrumental swallow assessments. • The level of dysphagia falls in the mild to moderate range (DOSS levels 5 to 3) 	<ul style="list-style-type: none"> • Person has a level of dysphagia which is rated as severe on instrumental swallow assessments. • Level 2 to 1 on the DOSS scale. • Person may be identified as being aphagic or as having severe frequent aspiration.
*Health history & Medical State	<ul style="list-style-type: none"> • Person presents with a medical history which does not predispose towards dysphagia. • Neurological status and sensory integration is normal. • Developmental history is within normal range. 	<ul style="list-style-type: none"> • Person presents with a neurological condition (acute or progressive) which is known to predispose towards dysphagia. • Person presents with a developmental condition known to predispose towards dysphagia. • Person presents with a structural abnormality or has had surgery in the oro-pharyngeal area. 	<ul style="list-style-type: none"> • Person presents with a history of stroke and has been identified as dysphagic. • Person is in the final stages of a progressive neurological condition. • Person presents with a developmental condition and has been identified as being dysphagic. • Surgery/radiotherapy or a structural abnormality in the oro-pharyngeal area are known to be having a significant effect on the person's swallow.

<p>*Nutritional Status</p>	<ul style="list-style-type: none"> • Person is healthy weight (i.e. BMI between 20 and 25kg/m² and has no history of weight loss. • Person eats a wide variety of foods from a balanced diet. • Person does not have any special dietary requirements. • Person has been identified as low risk of malnutrition on a malnutrition screening tool (e.g. MUST or MNA) 	<ul style="list-style-type: none"> • Person has a history of unintentional weight loss. • Person has a low BMI (body mass index). • Person has been identified as at risk of malnutrition on a malnutrition screening tool (eg MUST or MNA) • Person may be on a modified diet consistency. • Limitations to allowance of diet portions due to dysphagia impact adequacy of diet and fluid intake. • Person is following a high protein high calorie nutrition plan. • Person requires oral nutritional supplements to maintain adequate dietary intake. 	<ul style="list-style-type: none"> • Person has oral nutrition supplemented non-orally (either via PEG, RIG, PEJ, or NG). • Person has long-standing history of unintentional weight loss, low BMI or difficulties maintaining weight. • Person has been identified as at risk of malnutrition on a malnutrition screening tool (eg MUST or MNA) • Person may have issues with feed tolerance and maintaining oral and no-oral feeding regimes. • Person is likely to be taking only small limited amounts orally. • Person is reliant on oral nutritional supplements to maintain adequate dietary intake.
<p>*Oesophageal Status</p>	<ul style="list-style-type: none"> • Person has no known difficulty at the oesophageal level. 	<ul style="list-style-type: none"> • Person may have occasional episodes of vomiting. • Person has a known history of reflux or motility disorder which is under control with medication and behavioural management. 	<ul style="list-style-type: none"> • Person presents with frequent vomiting. • Person regurgitates meals regularly. • Person has a known history of severe reflux or motility disorder. • Person has objectively identified issues with aspiration of reflux. • Difficulties with positioning of the person are inducing reflux.

<p>*Oral secretions</p>	<ul style="list-style-type: none"> • Person has no issues with oral secretions. 	<ul style="list-style-type: none"> • Person has intermittent issues with saliva or secretion control. • Person may drool intermittently. • Person may have excessive or dry oral secretions at various times throughout the day which are managed by either oral care or medications. • Artificial saliva may be required to aid safe food swallowing and chewing. 	<ul style="list-style-type: none"> • Person has severe issues with saliva or secretion control. • Suctioning of secretions may be necessary. • Person may be unable to swallow or clear (cough) their own secretions. • Secretions may be so thick and tenacious constant oral care and medications are required for comfort. • Secretion issues interfere with the safe swallowing of food despite attempts at managing same.
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Extrinsic factors	Indicators associated with low risk	Indicators associated with increasing risk	Indicators associated with high risk
<p>Physical environment</p>	<ul style="list-style-type: none"> ▪ Person needs no environmental adaptations for safe eating and drinking. ▪ Person's environment is appropriate and adapted to their management needs. 	<ul style="list-style-type: none"> ▪ Person's environment is temporary (e.g. respite or hospital) and hence not adapted to their specific management needs. 	<ul style="list-style-type: none"> ▪ Person's environment is not temporary and is inappropriately or insufficiently adapted to their specific management needs.
<p>Social environment</p>	<ul style="list-style-type: none"> ▪ Person needs no environmental adaptations for safe eating and drinking. ▪ Person's safe eating and drinking is not adversely affected by others in the environment. ▪ Person's support needs do not conflict with others in the environment. 	<ul style="list-style-type: none"> ▪ Person's safe eating and drinking may be adversely affected by others in the environment. ▪ Person's support needs and those of others in the environment compete for caregiver time. 	<ul style="list-style-type: none"> ▪ Person's safety during eating and drinking is seriously compromised by others in the environment. ▪ Person has incompatible support needs with others in the environment during meals and drinks.

Extrinsic factors	Indicators associated with low risk	Indicators associated with increasing risk	Indicators associated with high risk
Access to eating and drinking equipment	<ul style="list-style-type: none"> ▪ Person needs no specialised equipment. ▪ Person has a ready supply of appropriate working equipment for safe eating and drinking. ▪ Person can access and recognise his/her own equipment needs. ▪ Person can adapt eating and drinking to non-personal adapted equipment (e.g. different sized spoon). 	<ul style="list-style-type: none"> ▪ Person's access to equipment is dependent upon carers. ▪ Person's equipment function is dependent upon caregivers checking before use (e.g. correct lid on cup for the person). ▪ Person has limited ability to adapt beyond own specialised equipment. 	<ul style="list-style-type: none"> ▪ Person can only be safe eating and drinking with specified specialised equipment (e.g. slow-flow equipment where valve needs to be in place). ▪ Person's access to functional specialised equipment is likely to be compromised. ▪ Person has no ability to adapt beyond own specialised equipment.
Staffing level	<ul style="list-style-type: none"> ▪ Person does not require staff support to eat and drink safely. ▪ Adequate staff are available to support the person to eat and drink safely at all times. ▪ Person has a staff team of less than seven members which is stable and consistent. ▪ Additional staff responsibilities do not interfere with safe management. 	<ul style="list-style-type: none"> ▪ Person is partially physically dependent on staff to eat and drink safely. ▪ Staffing level is insufficient to meet the support needs of all people in a specific setting. ▪ Person has a staff team of more than seven members that is stable or a small but unstable team of less than seven. ▪ Staff vacancies leading to cover from a variety of carers. ▪ Additional staff responsibilities may interfere with safe management. 	<ul style="list-style-type: none"> ▪ Person is totally physically dependent on staff to eat and drink safely. ▪ Staffing levels are not sufficient to provide adequate support and monitoring during mealtimes. ▪ Person has large and unstable staff team of more than seven members. ▪ Use of unmonitored, untrained, unfamiliar agency staff. ▪ Additional staff responsibilities interfere with safe management i.e. competing tasks at meal times: medication round, note writing, staff breaks.

Extrinsic factors	Indicators associated with low risk	Indicators associated with increasing risk	Indicators associated with high risk
<p style="text-align: center;">Staff adherence to plan</p>	<ul style="list-style-type: none"> ▪ Staff understand and believe the dysphagia management guidelines are appropriate for the person. ▪ Staff are fully trained in dysphagia management by experienced staff. ▪ Staff have read and understood the management guidelines and have a thorough knowledge and understanding of implementing the guidelines. ▪ Staff follow the dysphagia management guidelines. ▪ Staff have a thorough knowledge of the risks associated with dysphagia and non-adherence to management. ▪ Staff are able to empathise with and have a positive attitude to people with dysphagia and their health needs. ▪ Staff inform relevant people when the person experiences changes which may impact on the safety of their eating and drinking. 	<ul style="list-style-type: none"> ▪ Staff partially believe in and understand dysphagia management and associated guidelines. ▪ Staff are trained by more experienced staff only and do not read the management guidelines. ▪ Staff do not update their knowledge about dysphagia management. ▪ Staff forget important aspects of management whilst maintaining other interventions. ▪ Staff do not update their knowledge about dysphagia risks. ▪ Staff spend little time empathising with the people with dysphagia that they support. ▪ Staff intermittently inform relevant people about changes which may impact on safe eating and drinking. ▪ While staff may be informed on institution level policy on dysphagia they are not familiar with individual patients dysphagia status and recommendations. 	<ul style="list-style-type: none"> ▪ Staff do not acknowledge or believe the person has dysphagia and do not agree with the guidelines. ▪ Staff are untrained and have no knowledge of dysphagia management. ▪ Staff fail to implement guidelines or implement them inconsistently. ▪ Staff are unaware of the health risks associated with non-adherence. ▪ Staff have a negative attitude and do not empathise with people with dysphagia. ▪ Staff fail to inform relevant people about changes which may impact upon safe eating and drinking. ▪ Staff do not comply with individual patients dysphagia recommendations.

Extrinsic factors	Indicators associated with low risk	Indicators associated with increasing risk	Indicators associated with high risk
<p>Family adherence to plan</p>	<ul style="list-style-type: none"> ▪ Family believe in, understand, follow and agree with the dysphagia management guidelines for the person. ▪ Families inform relevant people when the person experiences changes which may impact on the safety of their eating and drinking. ▪ Time pressures and organisational issues in the family do not impact on safe eating and drinking (e.g. management is prioritised). ▪ Person is supported at mealtimes by only a small number of experienced family carers. 	<ul style="list-style-type: none"> ▪ Family past experiences, attitudes and beliefs make it difficult for them to accept and implement the changes necessary for safe eating and drinking. ▪ Families intermittently inform relevant people about changes which may impact on safe eating and drinking. ▪ Time pressure and organisational issues in the family lead to reduced and variable safe support. ▪ Person is supported by many different family carers at mealtimes. 	<ul style="list-style-type: none"> ▪ Family member(s) refuse to engage with dysphagia management and encourage/assist the person in non compliance with their dysphagia recommendations. ▪ Families do not inform relevant people when the person experiences changes which may impact on the safety of their eating and drinking. ▪ Time pressure and organisational issues in the family lead to unsafe practices. ▪ Person is supported by many inexperienced family carers mealtimes.

Additional risks			
Compromised quality of life and loss of personal dignity	<p>These risks increase when too little attention is paid to:</p> <ul style="list-style-type: none"> ▪ communication about food and drink; ▪ hygiene and personal care needs around eating and drinking; ▪ protection of clothing and suitable clothing protection; ▪ cultural needs and age in relation to eating and drinking; ▪ food and drink preferences, and choices around eating and drinking; ▪ personality and history in relation to food and drink; ▪ the way the person is assisted; ▪ eating and drinking in an appropriate place; ▪ experiences and feelings about dysphagia ▪ the social experience of mealtimes 		
	Situations associated with low risk	Situations associated with increasing risk	Situations associated with high risk
	Carers take into account the above factors associated with quality of life and dignity when supporting the person during meals and drinks.	Carers find it difficult to consider these factors when supporting the person during meals and drinks (e.g. due to competing time demands and insufficient personal information available).	Carers do not consider the above factors when supporting the person during meals and drinks.
Injury and discomfort	<p>Risk of injury may increase due to:</p> <ul style="list-style-type: none"> ▪ actions of the person's carer (e.g. wiped excess saliva rather than dabbing – causing sore chin); ▪ utensils they have to use (large metal spoon); ▪ food and drink (hot food, hard food, food with sharp edges, bones). <p>Risk of discomfort may increase due to:</p> <ul style="list-style-type: none"> ▪ the position the person is in; ▪ food, drink or drool around the mouth, chin or neck; ▪ the speed at which food or drink is given; ▪ oral health problems; ▪ debris in the mouth; ▪ food or drink temperature ▪ engaging in physical activity too soon after eating or drinking. 		
	Situations associated with low Risk	Situations associated with increasing risk	Situations associated with high risk
	Carers take into account the above factors when supporting the person during meals and drinks.	Carers find it difficult to consider these factors when supporting the person during meals and drinks.	Carers do not consider the above factors when supporting the person during meals and drinks.

Proforma for indicating degree of negative health risks for individual clients

Negative health consequence: _____							
Intrinsic factors	Low risk (0)	Increasing risk (1)	High risk (2)	Extrinsic factors	Low risk (0)	Increasing risk (1)	High Risk (2)
Level of learning disability/cognitive function				Physical environment			
Alertness/cooperation				Social environment			
Distractibility				Access to specialised equipment			
Fatigue				Staffing level			
Rapid decline in function due to ill health (decompensation)				Staff adherence			
Seizure activity				Family adherence			
Oral health problems				Additional risks			
Underlying respiratory problem				Quality of life/loss of dignity			
Posture control				Injury/discomfort			
Behavioural difficulties							
Unmanaged pain				Other identified risks			
Mental health problems							
Medication							
*Instrumental swallow assessment findings							
*Health history and medical state							
*Nutritional status							
*Oesophageal status							
*Oral secretion control							
Totals							

High risk levels should always be monitored by a specialist dysphagia practitioner.

Notes: These documents are for reference and clinical use. The guide has not been piloted in clinical practice, and the reliability and validity of the guide has not been checked. Scoring of risk factors using the guide is optional. Scoring needs trialling in practice to identify scores which equate to high, medium and low overall health consequence risk. Scoring risk can allow practitioners to prioritise and sequence dysphagia management. Room is provided for additional factors to be incorporated onto the proforma and further intrinsic and extrinsic factor may be developed in the future. Feedback on this document can be provided through the ALD-Dysphagia UK Group (alddysphagiauk@gmail.com)

©Jane Jolliffe (the Manchester Learning Disability Partnership) & Darren Chadwick (Manchester Metropolitan University) 23/11/06

Note from IASLT/INDI:

The above document has been adapted and for ease of use additional relevant intrinsic factors have been added. These are indicated by * in the above table. This list is not exhaustive and users are encouraged to include any additional relevant factors for each individual case.

This document is generally used in conjunction with the NPSA Dysphagia Risk Assessment summary document (0500C) which includes space for details of the exact nature of the client's difficulties as well as an action plan. Refer to Appendix 1 below.

This type of document is unlikely to be necessary for all cases of dysphagia but would be very useful in cases where there is a need for a full MDT opinion regarding level of dysphagia risk or in cases where there is non-compliance or difficulty identifying the level of risk in a particular or complex case. It can be very helpful for use with other team members and families in identifying actions which need to be taken to minimize risk.

Our sincere thanks to Darren Chadwick and Jane Jolliffe for permitting the alteration and circulation of this document.

Dysphagia risk assessment

For use at a formal risk review meeting

Risk assessments carefully examine systems to identify factors that could cause or contribute to harm to an individual. They investigate whether adequate precautions are in place to prevent injury, or if further measures are required. The NPSA dysphagia risk assessment seeks to answer the following questions:

1. What is the current situation?
2. What could go wrong?
3. How serious is the harm to the person?
4. How likely is the harm to occur?
5. What actions are needed to prevent harm?
6. How and when will the situation be reviewed?

Assessment Group Members (Group should include health practitioners, family members, the person with learning disabilities if appropriate, social worker, home manager and carers from day and residential provision. (Tick box for those involved))	
<input type="checkbox"/> Person with learning disabilities	Name: Date of birth: Address:
<input type="checkbox"/> Family member/caregiver	Name:
<input type="checkbox"/> Residential staff	Name:
<input type="checkbox"/> Day centre staff	Name:
<input type="checkbox"/> Speech and language therapist	Name:
<input type="checkbox"/> Dietician	Name:
<input type="checkbox"/> Physiotherapist	Name:
<input type="checkbox"/> Occupational therapist	Name:
<input type="checkbox"/> GP	Name:
<input type="checkbox"/> Other (give details)	Name:
Notes (including any additional members of the group): 	

DYSPHAGIA RISK ASSESSMENT

DATE.....

NAME DOB NHS No

Nature of problem

(for example, risk of choking, risk of chest infection, risk of nutritional compromise and risk of dehydration)

Is this a new problem or an existing problem that has worsened ? (Please tick)

Other existing needs

(include details of current medication)

Current eating and drinking situation

(include where meals are taken and level of support needed)

Previous health and risk issues

(include any previous factors which have the potential to affect the swallow)

Client's Name: :Date:

Dysphagia risk management plan

What could go wrong (risk area)	Impact of problem			Likelihood of harm occurring			Severity <small>(impact x likelihood)</small>	What needs to be done	Agreed actions	Named person responsible for actions	Timescale (date by which action is to be completed)
	low	med	high	low	med	high					

Clinician's Name::..... Date:

Tick this box if review will be conducted by the assessment group

Client's Name: : Date:



National Patient Safety Agency

Dysphagia risk management plan review

What could go wrong (risk area)	Impact of problem			Likelihood of harm			Agreed actions	Named person	Agreed timescale	Progress to date	Revised problem impact			Revised harm likelihood			Revised agreed actions
	low	med	high	Low	med	high					low	med	high	low	med	High	

Date of next review:.....

Clinician's Name:.....
group

Date:Tick this box if review will be conducted by the assessment