Dysphagia/Swallowing Management Policy and Guide

Whiddon

Document Control

Title	**Dysphagia (swallowing) Management Policy**
Version	**1.2**
Effective Date	**25/11/2024**
Review Date	**October 2026**
Initiating service area	**Clinical Governance**
Release Authority	**Clinical Governance Committee**

Document Review

Date	Description of review	Initiated by	Version
12 July 2019	New policy	GMCG	**1.0**
12 September 2022	Addition of: Whiddon recognises that choking incidents have a negative impact on consumers and poses significant risk. This high impact high prevalence risk requires effective management which is best practice and tailored for the individual consumer. Where swallowing difficulty is either witnessed or suspected the staff member should observe the consumer for the following: Difficulty swallowing or coughing, choking, gagging while eating Pocketing food in the mouth-usually in the cheeks Decrease in sough/gag reflex Drooling and constant open mouth Taking longer to eat, needing to chew more Gurgling sounding voice or slurred speech Recurrent chest infections and/or delayed swallowing Refer any of these findings to the Registered Nurse immediately, episodes of choking are to be recorded as an incident. Where swallowing difficulty is either witnessed or suspected the staff member should observe the consumer for the following: Difficulty swallowing or coughing, choking, gagging while	GMCG	**1.1**

	eating Pocketing food in the mouth-usually in the cheeks Decrease in sough/gag reflex Drooling and constant open mouth Taking longer to eat , needing to chew more Gurgling sounding voice or slurred speech Recurrent chest infections and/or Delayed swallowing Refer any of these findings to the Registered Nurse immediately, episodes of choking are to be recorded as an incident. Follow the flow chart below to ensure the resident's needs and safety are met in the event of a choking or suspected choking incident: *Table Updated* Tips to make feeding as safe as possible Right diet *Check that you are serving the correct consistency* Right fluids *Check that you are serving the correct consistency* Right Position- *Make sure the consumer is positioned upright with their chin slightly down* Right equipment *If a consumer has been prescribed specific utensil, make sure these are available for each meal* Right pace *provide time for chewing and swallowing- don't rush the consumer* Right Volume of food with each mouthful -*ensure suitable amounts of food are placed on the utensil and that food is swallowed before providing more food* Right moisture-*provide consumer with sips of fluids between mouthfuls* NB A low grade fever may be present and should also be given consideration when reviewing a consumer who has had a known or suspected choking incident		
Nov 2024	Scheduled review Update of International Dysphagia Diet Standardisation Initiative posters as appendix . Objectives and Measures moved to procedures section, further causes of dysphagia added	GMCR&C	**1.2**

Contents

Dysphagia (Swallowing) Management Policy

Introduction

Dysphagia is a swallowing disorder, which may occur as a result of various medical conditions. Dysphagia may originate from problems involving the structures required to swallow a bolus of food or fluid. These structures may include the oral cavity, the pharynx, the oesophagus, or the gastroesophageal junction (www.asha.org). At times food or fluid may 'go down the wrong way' (aspiration) and enter the wind pipe or lungs. This can lead to infection or death if not properly treated by a medical practitioner and/or a Speech Pathologist.

Whiddon recognises that choking incidents have a negative impact on consumers and poses significant risk. This high impact high prevalence risk requires effective management which is best practice and tailored for the individual consumer.

Policy

This policy applies to consumers in Residential Care and Community Care funded by the Department of Health and Aged Care and the National Disability Insurance Scheme (NDIS) .

To maintain clarity and consistency throughout the policy, the terms "consumers," "residents," "clients," "elders," and "NDIS participants" will collectively be referred to as "consumers," all such references encompass these groups equally.

Whiddon is committed to providing a high-quality standard of care to all residents.

This policy is relevant to all team members that provide care to residents. As part of that care, team members must be able to recognise the signs of dysphagia and understand the referral processes involved in gaining a specialist assessment performed by a Speech Pathologist. Team members must then be able to follow the recommendations made by the Speech Pathologist in order to provide safe swallowing care for residents who have dysphagia. Team members must also be aware of the serious risk's dysphagia can have on a person's life and understand the necessary actions to take if a resident presents with swallowing difficulties.

Dysphagia can have serious effects on a person's health and can lead to death. Dysphagia can lead to complications such as malnutrition, dehydration, pulmonary aspiration (fluid, food or medication going into the lungs instead of the stomach) or choking (obstruction of the airways). In addition, team members need to recognise and acknowledge a resident's emotional or psychological responses that could be associated with dysphagia, in particular those resident's which require modified fluids and diets.

A holistic approach to dysphagia care is required where we consider the residents physical and mental health needs while upholding the resident's right to informed choice and decision making.

Team members support the resident to eat and drink as safely as possible whilst maintaining nutrition, hydration, and quality of life.

Purpose

The purpose of this policy is to guarantee that residents who have dysphagia receive an optimal level of assessment, care, and support. The policy reflects best practice and aims to allow the resident with dysphagia to achieve maximum independence with eating and drinking, and experience as close to normal participation and enjoyment at meal times. This is performed by following resident specific recommendations, while keeping the risks associated with Dysphagia to a minimum.

Scope

This policy provides a framework of care for all residents with dysphagia who require a referral to the Speech Pathologist or are currently on modified fluids and diets. It includes a guide for

team members on the referral process, the responsibilities of team members, and how to identify and manage risk.

Application of policy

This policy applies to all workers of Whiddon who are involved in the care and treatment of residents with dysphagia.

Roles and Responsibilities

It is the responsibility of any team members who witness (or are informed by a visitor) a resident experiencing difficulty with swallowing to report the concern to the registered nurse in that section.

Where swallowing difficulty is either witnessed or suspected the staff member should observe the consumer for the following:

- Difficulty swallowing or coughing, choking, gagging while eating
- Pocketing food in the mouth-usually in the cheeks
- Decrease in sough/gag reflex
- Drooling and constant open mouth
- Taking longer to eat needing to chew more
- Gurgling sounding voice or slurred speech
- Recurrent chest infections and/or
- Delayed swallowing

Refer any of these findings to the Registered Nurse immediately, episodes of choking are to be recorded as an incident.

It is the responsibility of the registered nurse to follow up with swallowing concerns by completing a Safe Swallowing Pathway in Autumn Care and arrange for the Speech Pathologist to assess the resident. Whilst waiting for the assessment, if the registered nurse thinks the resident may be in immediate danger of aspiration or choking then they are to contact the resident's medical practitioner, the resident's representative and the speech pathologist and seek advice. Pending medical and speech pathology direction, the resident must be supervised with meals and a thickened diet ordered. When severe risk of choking or aspiration is identified , the resident should be nil by mouth for a short period of time.

The Speech Pathologist may then direct that emergency temporary modifications to food, fluids and medication be put in place until the Speech Pathologist attends the assessment in person. This may involve placing the resident on a higher level of thickener or changing the grading level of the resident's diet texture.

It is the Whiddon Registered Nurses duty in consultation with the resident or their representative and the Speech Pathologist to organise a date and time for the assessment to take place. The Speech Pathologist

will report on the findings and provide recommendations in the resident's file and discuss the findings with the resident and or their representative when feasible and the Registered Nurse. The registered nurse must notify the catering team of any changes to food and fluid consistency, the registered nurse must ensure that care teams are notified of any directives in assisting a resident with food and fluids.

The Speech Pathologist will update the resident's care plan to reflect changes made. If the Speech Pathologist deems a review necessary post initial assessment, details of the review will be in the resident's notes. It is the role of the Director of Care Services, Deputy Director of Care Services or the Care Services Manager or delegate to contact the Speech Pathologist when a resident who has a history of dysphagia requires a yearly review.

Procedures

Follow the flow chart below to ensure the resident's needs and safety are met in the event of a choking or suspected choking incident:

	Process	Documentation
Identify	**Is there a change in the Resident that alerts you to a change in the Residents ability to swallow, drink, chew.** **Is the resident experiencing: increased dribbling of saliva food going down the wrong way** **This is an incident "Capture It"**	**Incident Report**
Assess	**The Registered Nurse is to assess the Resident's swallowing, complete this as soon as practical after an issue has been identified.**	**AC Charts e.g., food and fluid chart, (SSP) Swallowing Screening Pathway / AC Notes**
Monitor	**Monitor temperature for 3 days and observe for respiratory changes post incident** **Downgrade diet and fluids to ensure safety whilst waiting for a formal review to occur.**	**AC Assessments AC Charts /AC Notes**
Actions	**Complete SSP -Swallowing Screening Pathway**	**AC Assessments / AC Agreed Care and Servicers Plan / AC Notes / NIM**
Escalate	**Refer to GP** **Refer to Speech Pathologist** **Consider transfer to hospital for further assessment if clinically indicated**	**AC Assessments / AC Agreed Care and Servicers Plan / AC Notes**
Document	**Document in AC progress notes-tick handover note** **Registered Nurse to update the *AC Dietary Needs and Preferences*** **Registered Nurse to print, send to kitchen and update drink trolley.** **Complete an *AC Incident Form- Resident***	**AC Assessments / AC Agreed Care and Servicers Plan / AC Notes**
Liaise	**Registered Nurse to update the *AC Dietary Needs and Preferences*** **Registered Nurse to print form and give to Kitchen** **Registered Nurse to ensure drinks list (On Tea Trolley) is updated** **Inform Resident and or their representative of incident and actions, offer copy of Agreed Care and Services Plan** **Inform Care Team**	**AC Assessments / AC Agreed Care and Servicers Plan / AC Notes**

- If a resident is showing signs that they are having difficulty swallowing, report the details to the Registered Nurse.
- It is the role of the Care Services Manager or delegate to contact the Speech Pathologist.
- The Speech Pathologist will book in a time and date with the Registered Nurse to visit the facility and conduct a swallowing assessment with the resident. The clinician will report the findings of the assessment and make recommendations in the resident's file. Changes will also be updated by the Speech Pathologist to the resident's care plan under 'Resident menu choices.'
- In the event that a resident is assessed as requiring to be 'Nil by Mouth' (NBM), the Speech pathologist will discuss the recommendation with the Registered Nurse, who will then discuss recommendations with the resident or the resident's person responsible. The option to sign a 'risk form' or provide alternative feeding options (e.g., referral for PEG feeds or intravenous fluids etc.) may also be discussed.

Objectives and Measures

Measure	Aim
Objective	**To ensure residents with dysphagia are provided with clinical assessment by an appropriately trained allied health professional as clinically indicated, with the aim is to prevent and or reduce the risk of aspiration and or choking.**
Performance Measure	**Residents with dysphagia will be assessed and monitored in a timely manner. A resident with dysphagia will not be compromised because clinical teams have failed to recognise a person at risk of choking or aspiration.**
Risk Assessment	**All residents at high risk of choking or aspiration will have a risk assessment completed on admission or as health issues arise.** **Documentation will be comprehensive and dietary needs communicated to hospitality services and** **care staff in a timely manner**

Risk Management

To reduce the risk of serious injury or death to residents, it is important that all team members are aware of the possible causes, signs and prevention of aspiration and choking.

Causes of dysphagia:

There can be many causes of dysphagia and not all are listed below.

Cause	Result
Reduced tongue control	**This can fail to trigger the swallowing reflex. It tends to cause aspiration of liquids.**
Abnormal swallow reflex	**Without a swallow reflex, the food can roll and fall into the airway.**
Neurological disorders	**Some neurological conditions, such as Parkinson's disease, Multiple sclerosis, Dementia, Motor Neurone disease, brain tumours or neurological events such as a stroke, cause reduced tongue control and weak oral musculature.**
Oesophageal disorders	**These conditions affect the throat and swallowing abilities. They include gastroesophageal reflux disease (GORD), dysphagia, and throat cancer.**
Throat surgery	**People who have had surgery or a condition that affects their larynx may have trouble swallowing. If the larynx does not close tightly, food or liquids can enter the windpipe.**
Dental problems	**This can interfere with chewing or swallowing reflexes.**

www.healthline.com/health/aspiration#causes

Other known causes of Dysphagia include:

- Stroke
- Dementia
- Head, neck, or throat cancer
- History of radiation or chemotherapy in the neck or throat for cancer
- Head injury
- Neurological disorders, such as Parkinson's disease
- Muscular dystrophy (What causes difficulty in swallowing Healthline)

And - infection, inflammation, muscular conditions, cancer treatments such as radiotherapy, throat pouches, congenital conditions, Chronic Obstructive Pulmonary disease (COPD), and head and neck surgery.

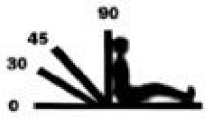
Prevention of choking and aspiration:

Follow the recommendations of the Speech Pathologist.

The Speech Pathologist will give recommendations based upon the International Dysphagia Diet Standardisation Initiative Framework International Dysphagia Diet Standardisation Initiative (IDDSI). Follow the IDDSI requirements for texture modified diet and fluids.

- Ensure their dentures fit correctly in their mouth
- Seat resident no less than 45 degrees for all oral intake (90 degrees is optimal).
- Remain seated no less than 45 degrees for 30 minutes after oral intake to reduce the risk of reflux and aspiration.
- Supervision during meal times. If a resident is at risk, then they are to be fully supervised in their room when eating/drinking or the resident is to be seated in a dining area where supervision is shared by a number of team members.
- Face the resident and feed at a slow pace.
- If the resident wears dentures, ensure these are in place before offering meals.
- Ensure previous bolus is swallowed before giving another.
- Limit bolus size using a teaspoon.

Low Fowler's **position** is when the head of bed is elevated 15-30 **degrees**, Semi-Fowler's **position** is 30-**45 degrees**, Standard Fowler's is **45**-60 **degrees**, and High Fowler's **position** is 60-90 **degrees**.



Oral care:

Some residents may not be able to clear food from the sides of their mouth or may not be able to control saliva. A regular swab may be required to assist with excess saliva. Check the oral cavity after meals to ensure no residue is left between the cheek and the teeth or on the roof of the mouth.

Check how medications are to be administered to the resident.

Recommendations may include cutting or crushing tablets (must be discussed with the Medical practitioner and pharmacist) and mixing this with thickened fluids or in custard or yoghurt, or puree which is a healthy alternative, this is based on a resident's choice. Liquid forms of medication may be recommended for some residents.

Tips to make feeding as safe as possible

- **Right diet** Check that you are serving the correct consistency
- **Right fluids** Check that you are serving the correct consistency
- **Right Position-** *Make sure the consumer is positioned upright with their chin slightly down*

- **Right equipment** *If a consumer has been prescribed specific utensil, make sure these are available for each meal*

- **Right pace** *provide time for chewing and swallowing-do not rush the consumer*

- **Right Volume of food with each mouthful** *-ensure suitable amounts of food are placed on the utensil and that food is swallowed before providing more food*

- **Right moisture***-provide consumer with sips of fluids between mouthfuls*

Signs of Aspiration:

In the event of choking or aspiration follow first aid procedures. Encourage the person to cough as this will help clear the lungs of the substance. Remember aspiration can also be silent, thus monitoring a resident's health is important.

Look out for:

- Coughing during meal times.
- Choking on food or drink.
- Increased temperature (fever) ; NB A low grade fever may be present and should also be given consideration when reviewing a consumer who has had a known or suspected choking incident
- Wet sounding voice.
- Decreased chest status.
- Shortness of breath or fast noisy breathing.
- Wheezing.
- Drooling.
- Phlegm or regurgitation.

Maintaining Nutritional and Hydration status

If team members recognise a reduction in a resident's fluid or food consumption, it is recommended that the resident's weight and food or fluid intake be monitored. (See Nutrition and Hydration Policy)

Resident Choice

A resident with dysphagia may have limitations on the food types they can manage safely. Whiddon is committed to providing safe alternative food options to encourage choice and decision making. Food presentation can be limiting due to the texture of modified foods. An effort is made to present meals in such a way that looks pleasing and appetising.

The resident or their representative may exercise their right to make an informed choice not to follow the recommendations of the Speech Pathologist. After discussion with the registered nurse, the resident or

their legal representative should complete a 'Dignity of Risk' form which outlines the risks involved with not following the recommendations of the Speech Pathologist, the specific directions or wishes of the resident or representative and the time frame or events which may lead to a review of the form. If a resident wishes to have ordinary fluids or meals despite the risks and has signed a dignity of risk form, clinical monitoring and supervision must be diligent and clinical documentation thorough and regular.

References and Resources

Alison Buchtmann (Speech Pathologist) Director of SpeechWorks Speech Pathology Pty Ltd

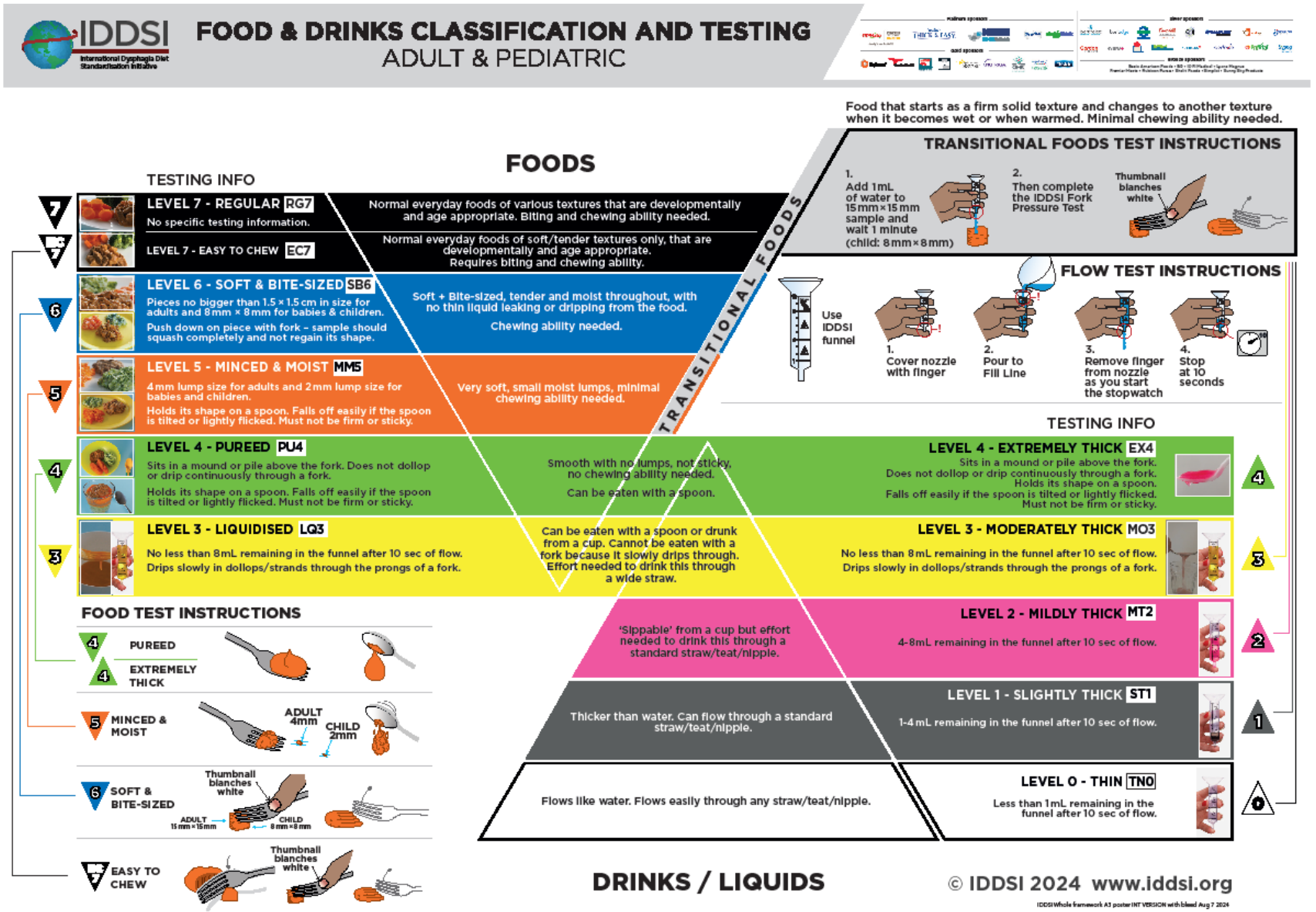
https://www.asha.org/practice-portal/clinical-topics/adult-dysphagia/#collapse_6

www.healthline.com/health/aspiration#causes

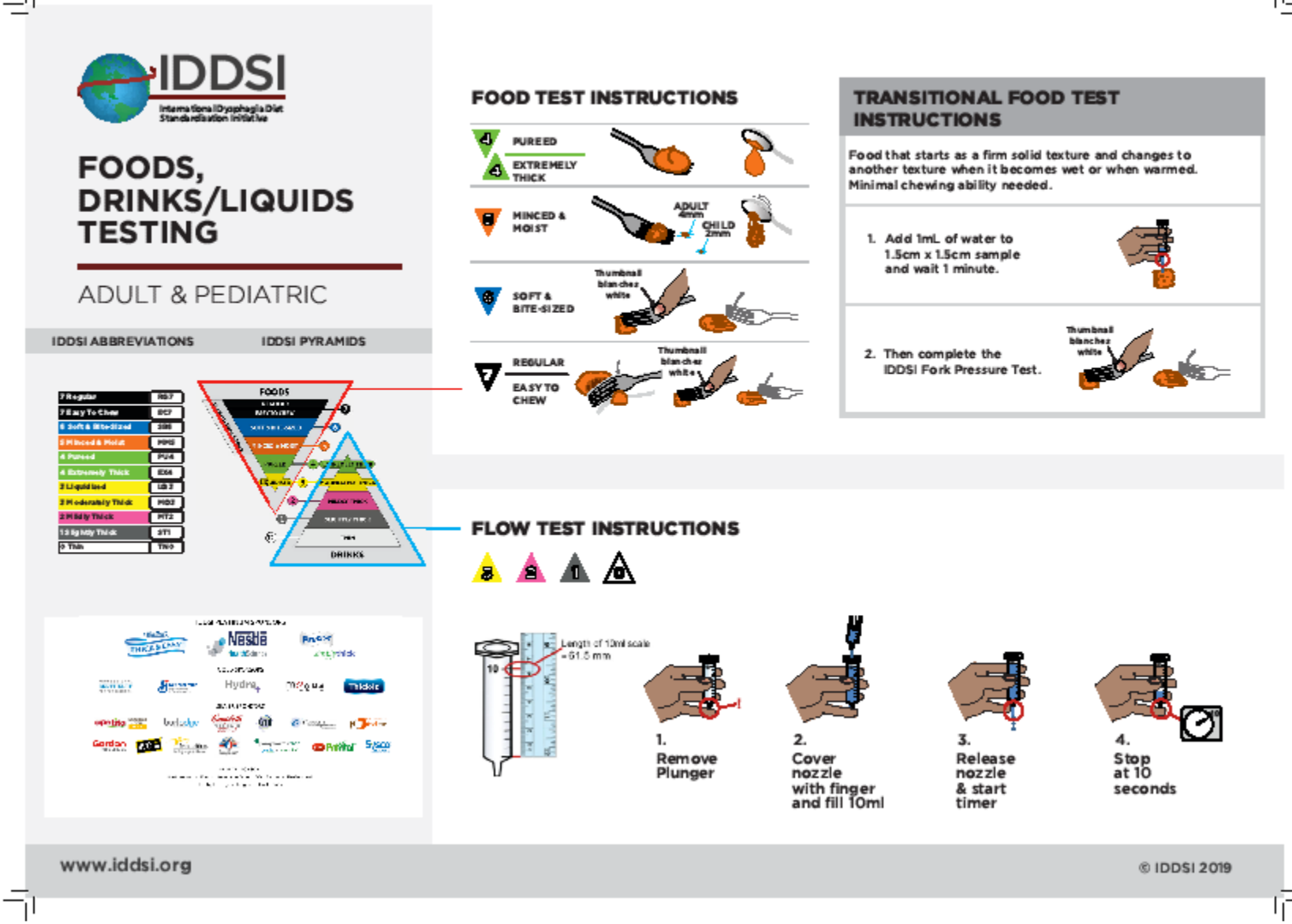
www.iddsi.org

www.speechpathologyaustralia.org.au

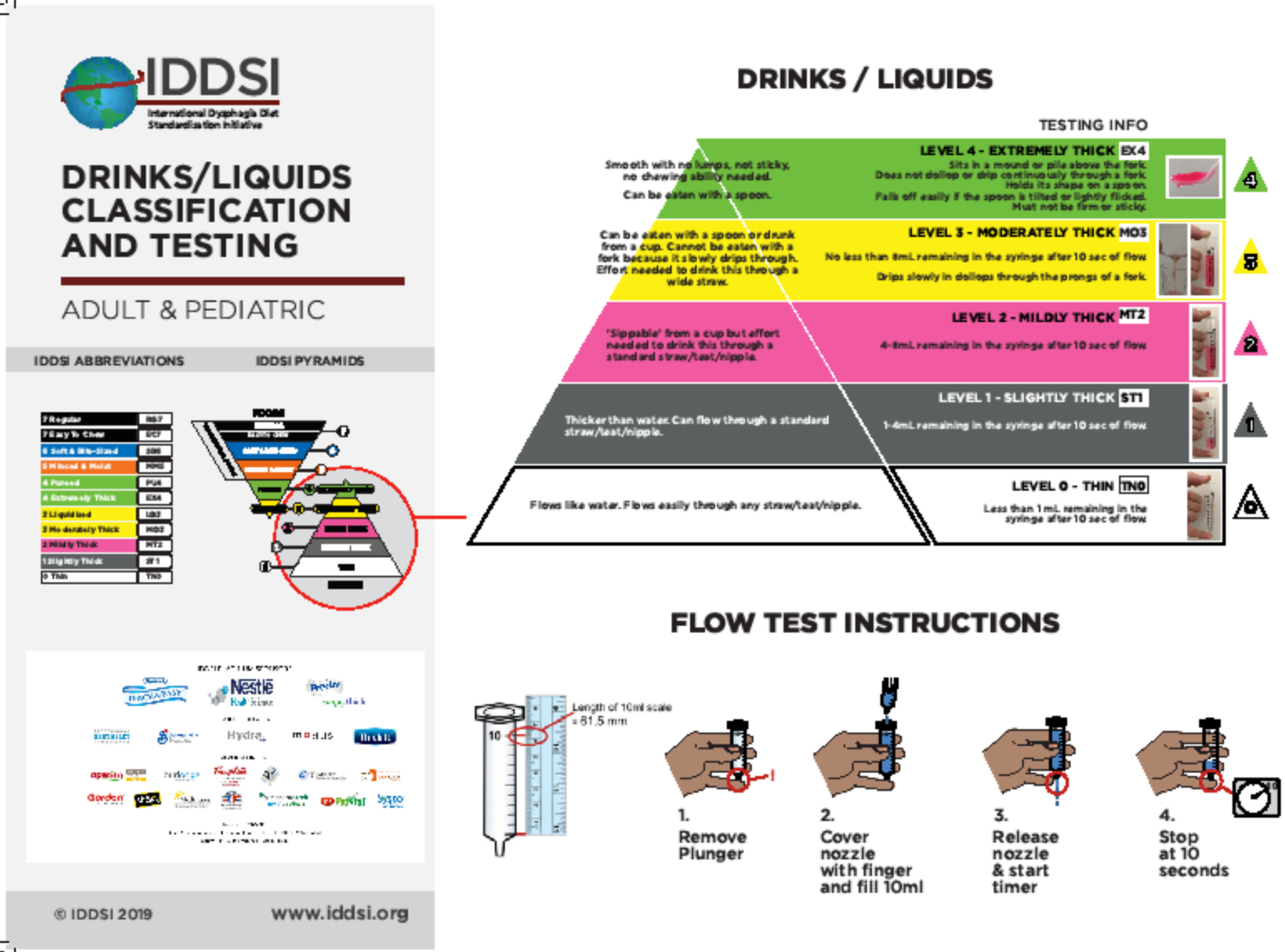
Appendix A IDDSI Food & Drinks Classification and Testing



Appendix B IDDSI Food, Drinks / Liquids Testing



Appendix C IDDSI Drinks / Liquids Classification and Testing



Appendix D IDDSI Food Classification and Testing

IDDSI
International Dysphagia Diet Standardisation Initiative

FOOD CLASSIFICATION AND TESTING

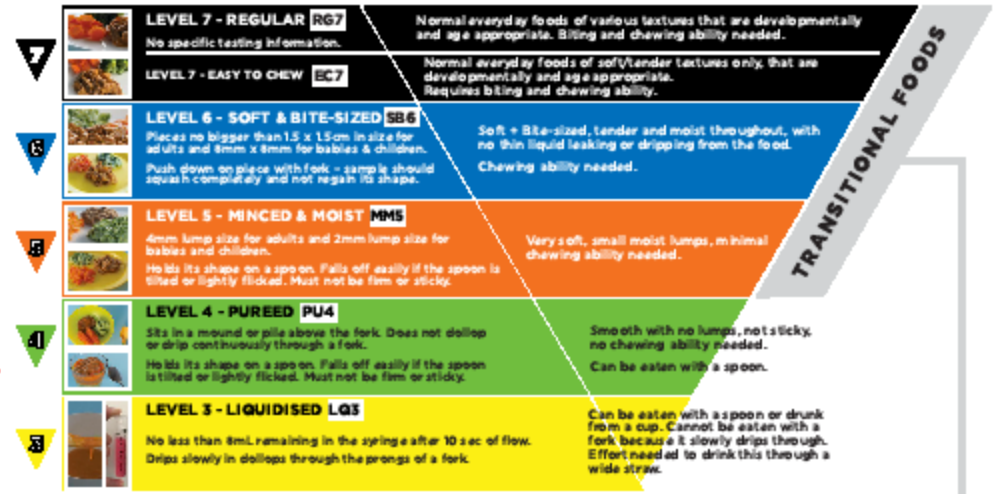
ADULT & PEDIATRIC

IDDSI ABBREVIATIONS | IDDSI PYRAMIDS

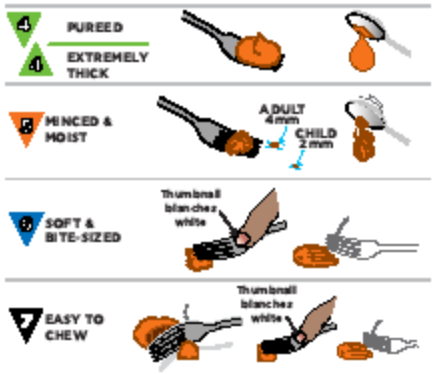
www.iddsi.org

FOODS

TESTING INFO



FOOD TEST INSTRUCTIONS



TRANSITIONAL FOOD TEST INSTRUCTIONS

Food that starts as a firm solid texture and changes to another texture when it becomes wet or when warmed. Minimal chewing ability needed.

1. Add 1mL of water to 1.5cm x 1.5cm sample and wait 1 minute.

2. Then complete the IDDSI Fork Pressure Test.

1