NursingDirect

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DYSPHASIA

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DYSPHASIA (SWALLOWING DIFFICULTY) AND RISK OF CHOKING POLICY AND PROCEDURE

1. PURPOSE

1.1 To provide a framework for the identification and assessment of Service Users with dysphasia or those at risk of choking and deliver appropriate management that will help to meet Service User nutritional and hydration needs and maintain safety.

1.2 To ensure that Nursing Direct consistently meets the Care Quality Commission's (CQC) Key Lines of Enquiry (Safe, Effective, Caring, Responsive and Well-led) and the associated Quality Statements, in line with regulatory requirements.

1.3 **Relevant Legislation The Care Act 2014**

- Equality Act 2010
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Human Rights Act 1998
- Mental Capacity Act 2005

2. SCOPE

2.1 Roles Affected:

- All Staff including Agency Workers

2.2 People Affected:

- Service Users

2.3 Stakeholders Affected:

- Family / Next of Kin
- Advocates
- Commissioners
- External health professionals
- Local Authority
- NHS / ICB

3. OBJECTIVES

3.1 To ensure that Service Users who have dysphasia receive the highest possible level of care and support to achieve maximum independence and a safe and dignified eating/drinking experience, while keeping the risk of choking to a minimum.

3.2 All Service Users who have swallowing difficulties, or who are at risk of choking, are assessed and have a clear management plan in place so as to accurately determine the level of dysphasia that they have, the associated risks and the strategies in place to reduce the risk. At all opportunities, Service Users are involved in all areas of assessment and care planning.

3.3 Staff including Agency Worker have full access to the latest best practice guidelines in relation to dysphasia (swallowing difficulty) and the risks of choking.

4. POLICY

4.1 Dysphasia describes eating, drinking and swallowing difficulties experienced by the Service User.

Service Users may have difficulties with a range of actions required for eating and drinking safely, including:

- Having food or drink in their mouth
- Moving it backwards for swallowing
- Trying to swallow
- Clearing food or fluid in their mouth after swallowing

Dysphasia can affect the Service User's quality of life, since eating and drinking is an important social aspect.

If not treated, dysphasia can lead to complications, including choking, and can result in the Service User's death.

4.2 Choking occurs when the airway is blocked by food or another object. This can be fully or partially, and the person cannot breathe or breathe properly. Signs of choking include:

- Panic and clutching the throat
- Gasping for breath
- Gagging
- Wheezing
- Passing out
- Bluish lips or skin

4.3 Nursing Direct recognises that reducing the risk of choking and improving the safety of Service Users who have swallowing, eating, and drinking difficulties is an essential part of the safe and appropriate Care that meets Service User needs and supports their rights.

4.4 Nursing Direct will ensure that all Service Users who are at risk of choking or who have dysphasia are assessed so as to accurately determine the level of risk. Nursing Direct will also ensure that all Service Users with dysphasia have a Care Plan which includes any relevant input from specialist professionals', as necessary. This will be regularly monitored and updated with the risks reassessed as the needs of the Service User change.

4.5 Nursing Direct will ensure that staff including Agency Workers have access to this policy and the Resuscitation Council UK guidance on choking and for managing a choking episode.

When a risk of choking is identified, staff including Agency Workers will receive patient-specific training will be provided to address choking risks, have knowledge of dealing with choking incidents and be able to make a first aid response if the person chokes.

4.6 Nursing Direct acknowledges the importance of continuous improvement and reflection on practice. This is incorporated into the risk management and governance systems and processes in place at Nursing Direct (such as accident and incident reporting investigation and analysis).

4.7 Nursing Direct will risk assess that:

- The Service User has appropriate chairs and beds to ensure safe swallow posture, as well as there being a range of suitable cups and glasses available to support safe swallowing If this equipment is deemed unsuitable during the risk assessment, this will be escalated to the commissioning body.
- Staff including Agency Workers supporting any client with Dysphasia will have received appropriate training, during the initial assessment, Nursing Direct will confirm that the resources and equipment required to prepare high quality specialist dysphasia diets are in place prior to support commencing, in the event that any equipment is missing, this will be escalated to the commissioners.
- There are enough experienced staff including Agency Workers to provide the right level and quality of support
- Staff, including Agency Workers, are trained and regularly supervised so that they can provide really good, consistent care for Service Users with dysphasia, following any guidance provided by the allocated Speech and Language Therapy teams (SaLT).
- There are policies, procedures and systems in place that will support staff, including Agency Workers, to provide good care for Service Users with dysphasia

5. PROCEDURE

5.1 **Pre-Assessment Documentation**

- Before service commencement, the onboarding pre-assessment documentation should identify the Service User:
  - Has any swallowing difficulties
  - Is at risk of choking
  - Has a Speech and Language Therapy assessment
  - Is prescribed a modified textured diet and/or fluids
- The pre-assessment will be recorded and the relevant staff, including Agency Workers, informed - preparations will be put in place before the service starts, such as informing staff including Agency Workers of the need for a modified texture diet and/or fluids
- A risk assessment must be carried out and included in a Care Plan with the appropriate course of action
- Staff including Agency Workers must have local systems in place to know which Service Users are at high risk of choking

5.2 **Signs and Symptoms of Dysphasia**
Staff, including Agency Workers, should be observant for any changes in the Service User's behaviour or presentation, this will help identify a problem early, and could prevent any complications occurring. Symptoms may include:

During Eating and Drinking:

- Multiple swallows for each mouthful
- Pocketing food or food residue in the mouth after swallowing
- Oral or nasal regurgitation of food/drinks
- Food or drink dribbling/spilling from the mouth
- Difficulty chewing or moving food around the mouth
- Holding food in the mouth with difficulty initiating the swallow
- Swallowing looks 'difficult'
- Choking, coughing, or sneezing during/following eating/drinking
- The voice sounding 'wet', 'croaky', or 'bubbly' during/after eating or drinking
- Change of face colour or breathing pattern after swallowing
- Eyes blinking and/or watering

- Discomfort or pain
- Increased distressed behaviours at mealtimes
- Looking scared or uncomfortable when eating/drinking
- Leaving certain foods or pushing the plate away
- Extended time eating/drinking

After Eating and Drinking
- Gurgly or hoarse voice
- Fatigue
- Changes in respiratory pattern
- Delayed regurgitation
- Coughing after eating or drinking
- Increased behaviours following mealtimes

5.3 **Coughing and Swallowing**
Coughing can be a strong indicator that the Service User is having difficulty swallowing.

The cough reflex protects the airway from food and drink from entering it when someone is eating and drinking.

Some Service Users with dysphasia may have a reduced or absent cough reflex and so they are not able to protect their airway in the same way.

Service Users who are frail, have respiratory disease or neurological problems often have a reduced cough, and are at more risk of aspiration.

Silent aspiration is when food or drink enters the airway, and there is no cough triggered. This can sometimes cause repeat chest infections which have no obvious cause.

5.4 **Service Users at Risk of Dysphasia**
Dysphasia can arise from a wide range of neurological, structural, psychological, and behavioural causes. These would include the following (not an exhaustive list):

- Learning disability
- Acquired brain injury
- Stroke
- Parkinson's Disease
- Dementia
- Other progressive diseases, e.g., multiple sclerosis, muscular dystrophy, motor neurone disease
- Epilepsy
- Medication related side effects, e.g., antipsychotic medication
- Cerebral Palsy
- Head and neck cancer
- Autism
- Psychiatric illness
- Gastro-intestinal difficulties
- Rapid eating and cramming of food
- Loss of muscle mass and strength in the elderly

5.5 **Medication**
Certain medications can contribute to or even be the main cause of dysphasia, these include antipsychotic medications. Therefore, a medication review is an important aspect of dysphasia management.

Service Users with dysphasia may struggle to swallow tablets and need some adjustments to ensure they are taking their prescribed medication. Staff including Agency Workers should refer to the Medication Policies and Procedures at Nursing Direct.

When there is an identified choking risk, a review of oral medication will be undertaken. Alternative dose forms may be required. Advice from the GP/pharmacist will be sought on changes in medication that may be necessary.

5.6 **Consequences of Unidentified Dysphasia**
Failure to identify dysphasia problems may have a devastating and life-threatening effect on the Service User. These may include:

- Malnutrition
- Dehydration
- Recurrent chest infections
- Aspiration pneumonia
- Choking
- Weight loss

5.7 **Risk Assessment Procedure**
If staff including Agency Workers observe that a service user may have dysphasia, this will be escalated to the service users GP with a suggestion to make a referral to a Speech and Language Therapist (SaLT) for a swallowing assessment

It is the responsibility of all staff, including Agency Workers, who observe what appears to be a swallowing or choking problem to immediately report it to Nursing Direct.

Service Users with pre-existing conditions will potentially have a high risk of dysphasia. Swallowing difficulties may not be evidenced straight away and, if so, it should remain a risk factor that is considered and reviewed as part of the risk management process.

Staff, including Agency Workers, must gain consent, wherever possible, before any assessment is undertaken. When the Service User is unable to give informed consent, best interest decisions are made using the guidelines in the Mental Capacity Act and best interest requirements.

If a service user is identified as being at risk of choking, a choking risk assessment and reassessment will be undertaken:

- Annually or every time there is concern about the Service User's swallowing ability or their eating and drinking
- If their swallowing ability changes or deteriorates
- If there has been a significant change in the Service User's level of need which might increase their risk of choking
- If the Service User's choking risk increases as a result of their behaviour
- If any service user develops early signs of dysphasia, this will be escalated to the GP and a referral to Speech and Language Therapists (SaLT) would be recommended.

Service Users exhibiting behaviour that may challenge, such as putting non-food items into their mouth or who swallow non-food items which increases their risk of choking, should have a multidisciplinary team assessment. Clear guidelines from the multidisciplinary team must be in place to support the strategies that staff including Agency Workers are required to use to manage the risk.

For all staff including Agency Workers supporting service users who exhibit behaviours such as putting non-food items into their mouth or swallowing non-food items, consideration must be given to items such as PPE, which maybe strategically placed during visits for ease of use and infection prevention, however they could pose a risk to some Service Users who may have a cognitive impairment or may swallow non-food items. A team approach to risk assessment and agreed protocol should be sought.

5.8 **Speech and Language Therapy (SaLT) Referral**
Before suggesting to the GP that a referral to a Speech and Language Therapist (SaLT) be made:

Staff including Agency Workers should closely observe the Service User over several meals to see if the problem is a one-off, or if there is a consistent pattern. Staff including Agency Workers should look at:

- Time of day Fatigue
- Where the Service User is having their meal
- Who they are eating with
- If they are having difficulty with cutlery
- If certain foods are more difficult

Staff including Agency Workers could also look for reasons that might be causing the difficulty and consider:

- Low mood
- Sore mouth
- Dental problems
- Cognitive difficulties
- General physical decline
- Acute illness

If there has been previous SaLT involvement, ensure recommendations are being followed, and monitor the Service User.

Make sure the appropriate assistance techniques are being used.

Think about positioning, environment, equipment, and assistance:

- Would a different area provide less distraction?
- Would reducing/changing cutlery help?
- Would a different weight or shape of cup be helpful?
- Does the Service User need an increased level of assistance?
- Does a different chair help with posture?
- Would different food textures, flavours, finger foods help?
- Try out strategies that you think might help and see if they make a difference.
- Ensure that any medical reasons that may have contributed to a deterioration in swallowing ability are being managed.
- If unsure as to whether a referral would be appropriate, discuss the situation with colleagues, and consider asking the GP's opinion

Referral for Assessment
If the Service User has a swallowing plan and advice given is no longer effective at reducing difficulties, a referral for reassessment should be requested from the GP.

Remember to include the following when requesting a re-referral from the GP:
- Medications
- History of, or current chest infection
- Concerns overweight loss related to dysphasia.
- If the Service User has been seen before - what the current advice is with regards to diet and drink texture modification
- Describe the problem, how long it has been happening, and what is being done to help

- Level of concern of Service User/staff including Agency Workers
- What it is hoped will be gained from SaLT assessment

If the Service User's swallowing seems to have improved, and they may not now need such a modified diet, a request should be made for a review.

Loss of weight, lack of teeth, or the Service User who is not eating very much should not in themselves trigger a referral to SaLT.

Other potential underlying causes of a problem should be explored. Only those Service Users with identified or suspected dysphasia should be referred.

5.9 **Assessment by Speech and Language Therapist (SaLT)**
Once alerted to a swallowing or choking problem, it is the responsibility of the Clinical Lead at Nursing Direct to promptly alert the GP and ensure a referral is made to the Speech and Language Therapist (SaLT), In all instances, Nursing Direct must be informed..

SaLT services have variable waiting times, and although services will prioritise referrals, there may be a wait of several days or weeks before the Service User is seen.

Until an assessment of swallowing difficulties has taken place by the SaLT, staff including Agency Workers should consider:

- Increasing supervision/assistance for the Service User at mealtimes
- Trying different strategies, e.g., changes to seating, environment, cutlery, or shape of drinking vessel
- Implementing food and fluid charts
- Boosting nutritional intake through providing easy to eat nutritious snacks or drinks

In discussion with the GP, staff including Agency Worker should discuss and consider whether a conservatively modified diet should be introduced whilst waiting for an assessment and any high-risk foods that should be avoided. This must be based on the International Dysphasia Diet Standardisation Initiative (IDDSI). High risk food to be avoided during this period should include:

- Stringy, fibrous textures, e.g., pineapple, runner beans, celery, lettuce
- Vegetables, pulses, and fruit skins, e.g., broad beans, baked beans, soya beans, kidney beans, peas, grapes
- Mixed consistency foods, e.g., breakfast cereals which do not absorb all the milk (such as muesli), mince with thin gravy, soup with lumps.
- Crunchy foods, e.g., toast, flaky pastry, dry biscuits, crisps Crumbly items, e.g., bread crusts, pie crusts, crumble, dry biscuits.
- Hard foods, e.g., boiled, and chewy sweets and toffees, nuts, and seeds Husks, e.g., sweetcorn and granary bread
- Any foodstuffs that have resulted in a choking incident

This should be implemented in line with guidance and written confirmation from the GP.

Drinks should not be thickened without assessment from a qualified professional - usually either a SaLT or GP. This is because thickened drinks occasionally can cause more of an aspiration or choking risk than unthickened drinks. Staff, including Agency Workers, can try drinks that are of a naturally thicker consistency without advice from the GP, to see if this does help, e.g., full fat milk drinks, syrupy fruit juices, smoothies.

Once an assessment has taken place, it is the responsibility of the Clinical Lead of Nursing Direct to update the Service User's Care Plan and ensure that all staff including Agency Workers comply with the Care Plan to manage safe eating and drinking.

Where the Service User chooses not to follow recommended advice and this is based on an informed decision, this will be respected, recorded and the SaLT informed.

If the Service User is deemed to lack capacity to make an informed decision, a best interest decision will be made in accordance with the Mental Capacity Act as part of a multidisciplinary decision. This must include the GP and the SaLT.

5.10 **Following Assessment by a Speech and Language Therapist (SaLT)**
Once an assessment has taken place, it is the responsibility of Nursing Direct to update the Service User's Care Plan and ensure that all staff including Agency Workers comply with the Care Plans to provide appropriate dietary choices, modifications and manage safe eating and drinking.

Where the Service User chooses not to follow recommended advice and this is based on an informed decision, this will be respected, recorded and Nursing Direct will be informed, escalating to the SaLT where necessary.

If the Service User is deemed to lack capacity to make an informed decision, a best interest decision will be made in accordance with the Mental Capacity Act 2005 as part of a multidisciplinary decision. This must include the GP and the SaLT.

5.11 **Treatment for Dysphasia**
Treatment plans from SaLT may include:

- Exercises to help improve the efficiency of the swallow
- Strategies to follow when eating and drinking to improve safety and/or comfort

- Advice about:
  - Posture and positioning
  - The rate of presentation of food or liquid
  - The time between bites and swallows
  - How the environment might help at meal and drink times (e.g., less distractions)
  - How others might be able to help at meal and drink times
  - Texture modification
- Other professional who may also provide help for Service Users with dysphasia may include:
  - Physiotherapists for advice about posture, positioning, and chest care
  - Occupational therapists for advice about aids, adaptations, and utensils at mealtimes
  - Dietitians for advice about nutritional intake
  - Psychologists for advice about distress at mealtimes

5.12 **Modified Texture Meals and Drinks**
Modifying the texture of the diet reduces the need to chew it as much before it is safe to swallow.

Thickening drinks provides more time for the swallow to trigger effectively, allowing the liquid to be swallowed safely, without it 'going down the wrong way' (aspiration).

How much modification of either diet or fluids is needed to enable the Service User to swallow more safely and effectively will depend on the individual's particular pattern of dysphasia.

The International Dysphasia Diet Standardisation Initiative (IDDSI) has been developed to provide a framework to describe food textures and drink thickness in care and catering. It must be used in all verbal and written communications.

Nursing Direct must ensure that meals remain as pleasurable as possible for the Service User, and foods of whichever texture, as far as possible, can still be identified by the Service User as 'normal' food.

5.13 **International Dysphasia Diet Standardisation Initiative (IDDSI)**
The IDDSI framework consists of a continuum of 8 levels (0 - 7) where drinks are measured from levels 0 – 4, while foods are measured from levels 3 – 7. The IDDSI Framework provides a common terminology to describe food textures and drink thickness.

Each level has a name, number and colour with detailed descriptions and ways to test that the texture is correct.

The Speech and Language Therapist has the responsibility to make recommendations for foods or drinks for a particular Service User based on their comprehensive clinical assessment. Staff including Agency Workers must ensure this is followed.

IDDSI Testing Methods are intended to confirm the flow or textural characteristics of a particular product at the time of testing. Testing should be done on foods and drinks under the intended serving conditions (especially temperature).

Where fluids are required to be modified, staff including Agency Workers must follow the manufacturer's guidance on the thickener, to obtain the correct consistency.

5.14 **Assisting the Service User with Dysphasia**
When Service Users with dysphasia are eating or drinking, staff including Agency Workers should ensure they follow the SaLT recommendations and make sure that:

- They are fully awake and alert
- They are sat in an upright position
  - In a chair - Table in front of the Service User, body supported, feet flat on the floor or hard surface
  - In bed - Should be in a good sitting position, far enough up the bed, head supported
- NEVER assist the Service User to eat or drink in a lying or semi-reclined position

- They have checked the Care Plan for any specific information:
  - Swallow recommendations
  - Food and fluid textures
  - Specific equipment
  - Assistance
  - Environment, seating
- The meal and drinks are the correct consistency
- The Service User is using correct cutlery and crockery
- Distractions are reduced
- The elements of the meal are explained if required
- If assisting, they are sat at eye level with the Service User
- They allow plenty of time
- They offer small amounts of food at a time
- If the Service User coughs or their voice becomes wet or gurgly, they stop giving food immediately:
  - Encourage them to cough
  - Encourage them to relax, get their breath back
  - Encourage them to take extra swallows to clear their throat
  - Ask a senior Care Worker or the Registered Manager for advice regarding continuing
- After the meal:
  - Check there nothing left in the mouth
  - The Service User must remain upright for 20-30 minutes after the meal
  - Check if the Service User requires mouth care

5.15 **Care Plans**
On completion of a dysphasia assessment by the SaLT, Nursing Direct must update the Service User's Care Plan. This should include:

- All recommendations given by the SaLT, including any high-risk foods which should be avoided
- IDDSI terminology must be used
- Safe storage of thickening powders if used, and where the use of thickening powder is recorded
- Recommendations for changes or modifications to the environment where eating will take place
- Presentation of food and communication around mealtimes
- The most suitable eating cutlery / implements to be used
- Positioning of the Service User during eating
- Guidance should be explicit regarding the pacing and staging of eating at mealtimes
- The level of support required at mealtimes, for example, if a 1:1 staff including Agency Worker is required and who this should be
- Potential signs and symptoms of distress / choking and how the Service User may communicate this
- Action to be taken should the Service User choke
- Include information on the Service Users food and drink preference where applicable. However, it is important to remember that foods need to be given in accordance with food modification and texture advice

The development of individual Care Plans will, wherever possible, include the Service User and those who provide care. Individual needs and requirements will be accurately documented in the Care Plan.

Follow the principles of the Mental Capacity Act, and where decisions are made on behalf of the Service User, they need to be in their best interests.

Care Plans will be reviewed in accordance with the Person-Centred Care and Support Planning Policy and Procedure at Nursing Direct.

In addition to regular reviews, staff including Agency Workers must remain vigilant and responsive to individual needs on a daily basis. Daily records will indicate that the appropriate foods have been given according to advice from a SaLT.

Staff including Agency Workers should also ensure that the Service User's Medication Care Plan has guidance on how to administer oral medications safely and effectively.

5.16 **Eating and Drinking with Acknowledged Risks**
Service Users may choose to continue to eat and drink specific diet and fluids even though they are aware of the risks.

Staff, including Agency Workers, should refer to the Royal College of Speech and Language Therapists' guidance 'Eating and Drinking with Acknowledged Risks', which can be found online.

5.17 **The Dining Experience**
Mealtimes will be recognised as an opportunity for reassessing risk in the Service User identified as being at an increased risk of choking, where this forms part of the Care Plan.

There should be minimal distractions when someone who has difficulties in swallowing is eating. Modifying the environment will involve consideration of how the Service User is positioned in the room in relation to noise, heat, and light.

Staff including Agency Workers must have the skills to support individuals at risk of choking with their eating and drinking including:

- Having adequate skills in making mealtimes as safe and pleasurable as possible, including communication at mealtimes
- Ensuring Service Users are positioned correctly and safely when eating or drinking

- Being able to prepare and present food and drink to the Service User in a way that follows their documented recommendations
- Ensuring that any foods brought in match the appropriate consistency Being aware of foods with high choking risk

The presence of staff, including Agency Workers at mealtimes, is critical for observation and to reduce the risk of any unobserved incident of choking. Mealtimes are also a good time to build relations with Service Users and to fully understand their behaviour, motivations, and specific dietary requirements.

Staff including Agency Workers should refer to the Nutrition and Hydration Policy and Procedure at Nursing Direct.

5.18 **Alternative Feeding Methods**
For some Service Users, their swallowing difficulties are so severe that it may be decided that oral feeding is unsafe or not providing sufficient nutrition. In these cases, a percutaneous endoscopic gastrostomy (PEG) may be necessary.

Some Service Users with a PEG may continue to have small amounts of food or fluid orally, some will have none.

Staff including Agency Workers should refer to the PEG Policy and Procedure at Nursing Direct.

5.19 **Choking First Aid**
Choking can happen at any time to anyone and therefore, staff including Agency Workers, regardless of their role, must understand how to recognise a choking event and know how to respond.

If choking occurs, all staff including Agency Workers will follow the advice accessible from the Resuscitation Council, which can be found online.

Adults:
Suspect choking if someone is suddenly unable to speak or talk, particularly if eating. In adults, staff including Agency Workers should follow the Resuscitation Council UK guidelines on adult choking:

- Encourage the person to cough
- If the cough becomes ineffective, give up to five back blows:
  - Lean the person forward
  - Apply blows between the shoulder blades using the heel of one hand
- If back blows are ineffective, give up to five abdominal thrusts:
  - Stand behind the person and put both your arms around the upper part of their abdomen
  - Lean the person forward
  - Clench your fist and place it between the umbilicus (navel) and the ribcage Grasp your fist with the other hand and pull sharply inwards and upwards
- If choking has not been relieved after five abdominal thrusts, continue alternating five back blows with five abdominal thrusts until it is relieved, or the person becomes unresponsive
- If the person becomes unresponsive, start CPR (Resuscitation Council - Adult Basic Life Support Guidelines.)

If the person's airway is still blocked after trying back blows and abdominal thrusts, staff including Agency Workers should get help immediately:

- Call 999 and ask for an ambulance. Tell the operator the person is choking
- Continue with the cycles of five back blows and five abdominal thrusts until help arrives Staff including Agency Workers should refer to the Resuscitation Policy and Procedure at Nursing Direct.

Service Users who have received abdominal thrusts should be seen by their GP or paramedics.

When safe to do so, the choking episode/incident will be reported on an accident/incident form. For Service Users, it will also be documented in their Care Plan in accordance with the Record Keeping Policy and Procedure. The frequency and severity of events will be monitored and strategies in the Care Plan will be reviewed.

All choking incidents (whether there are serious consequences or not) must be reported.

Children:
For choking in children, staff including Agency Workers should refer to the Resuscitation Council UK's guidelines on paediatric basic life support, which can be found online.

5.20 **Choking Incidents**
There have been a number of cases highlighted where registered providers have failed to assess or manage the Service User's risk of choking.

These have included:

- Staff including Agency Workers not following the swallowing assessment advice from SaLT for the Service User regarding diet, fluids, positioning
- Staff including Agency Workers not passing on the advice from SaLT for the Service User
- Staff including Agency Workers not recording advice from SaLT in the Service User's Care Plan
- Staff including Agency Workers not sharing and sending the Service User's SaLT assessment on transfer to another provider or hospital

Nursing Direct must ensure that robust procedures are in place to ensure that all staff including Agency Workers are aware when Service Users require a modified diet or fluids and this must be communicated to all staff including Agency Workers involved in the care of the Service User.

5.21 **Transfer of Care**
If the Service User is transferred to another health/social care provider for any reason (e.g., hospital admission) eating and drinking needs will be communicated, including any SaLT assessment and recommendations.

5.22 **Training and Education**
The Eating, Drinking and Swallowing Competency Framework (EDSCF) is an assessable competency framework, which informs strategies for developing the skills, knowledge, confidence and ability of staff including Agency Workers to contribute more effectively in the identification of Service Users with, and in the management of, eating, drinking and swallowing difficulties (dysphasia).

Use of the Eating, Drinking and Swallowing Competency Framework (EDSCF) will enable the Registered Manager to determine the levels of competency required at Nursing Direct.

Every member of staff including Agency Workers will have a public level of awareness for recognising a choking event and knowing how to respond. It is recommended that practice scenarios and drills take place to maintain that awareness and the responsiveness of everyone.

When supporting service users with Dysphasia, in order to safely meet the needs in relation to choking, all care staff including Agency Workers must have knowledge and competence in the following:

- Recognition and assessment of risk and delivery of safe care in line with the agreed Care Plan
- Management of dysphasia
- Understanding the individualised support needed to reduce their risk of choking when eating or drinking and provide the required support to promote the Service User's safety
- Familiarity with this policy and procedure
- Staff including Agency Workers will be aware that chronic symptoms of dysphasia include chest infections, malnutrition and dehydration
- Relevant staff including Agency Workers must be able to identify and manage Service Users at choking risk/with dysphasia and ensure appropriate management
- Staff including Agency Workers supporting Service Users identified as at risk of choking must have first aid training to be able to provide emergency aid response to choking. They must also have access to the latest resuscitation guidance
- Being involved in the Care Plan process for Service Users at risk of choking
- Being aware of the consequences of not following an agreed eating and drinking plan
- Completing a Choking Risk Assessment when a new or increased choking risk is identified, or if one is requested.
- Identifying support services

Nursing Direct should also ensure that staff, including Agency Workers, are competent and confident to manage any choking episodes that may occur as a result of difficulties with eating, drinking, and swallowing. Any training requirements will be agreed with the training department and addressed in a suitable timeframe.

Dysphasia training must be offered to all staff, including Agency Workers who support Service Users with dysphasia and who are a choking risk.

The Registered Manager, on behalf of Nursing Direct, will identify an appropriately trained, skilled, and experienced member of staff including Agency Worker to take lead responsibility for dysphasia services.

5.23 **Audit and Review**
- Incident reporting systems must be in place for accurate recording, reporting, and actioning of choking incidents, or potential choking incidents for all Service Users with dysphasia or who are at risk of choking
- All incidents, accidents and near misses will be reviewed by Nursing Direct and investigated as necessary
- Nursing Direct will discuss any choking events with staff including Agency Workers and review associated risk assessments and Care Plans to ensure that they remain robust and aim to reduce the risk of events occurring again
- All staff including Agency Workers supporting service users with a known risk of choking must complete Basic Life Support (BLS) training which includes management of a choking episode, the training includes a competency sign off.
- Care Plans and risk assessment audits will include the risk of choking. Any identified themes and trends will be addressed and changes in practice embedded

6. DEFINITIONS

6.1 **Aspiration**
The inhalation of food/drink particles into the airways and potentially the lungs, causing risk of bacterial infection and pneumonia.

6.2 **Speech and Language Therapist (SaLT)**
- A health professional who provides life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking, or swallowing.
- The Royal College of Speech and Language Therapists (RCSaLT) uses the abbreviation 'SaLT' for a Speech and Language Therapist, and this is the abbreviation used in this policy. There are other abbreviations used in the wider population, including 'SaLT', that staff including Agency Workers should be aware of

6.3 **Nutritional Requirement**
The amount of nutrients needed to maintain health and reduce the risk of diet-related diseases.

6.4 **The Mental Capacity Act 2005**
Primary legislation is designed to support and enhance the lives of people who are assessed as not having capacity to make decisions themselves.

6.5 **Aspiration Pneumonia**
A lung infection that develops after food, liquid or vomit is aspirated (inhaled) into the lung.

OUTSTANDING PRACTICE

To be "outstanding" in this policy area you could provide evidence that:

- There is evidence that the Service User or relevant others are involved in the care planning process.
- The local SaLT team reports that referrals are always appropriately made and there is excellent and detailed evidence to support any referral.
- Staff, including Agency Workers, are clear on the issues surrounding choking, have received training and are confident in their own knowledge to manage situations when they arise.
- People using services report that staff, including Agency Workers, are extremely knowledgeable and act in a clear, decisive, and effective way when dealing with a choking incident.
- Staff, including Agency Workers refer to national descriptors and national best practice as a means of delivering quality safe practice.
- Nursing Direct recognises how stressful being involved in a choking incident can be and provides debriefing sessions and emotional support for staff including Agency Workers, people subject to the incident and, if appropriate, their relatives
- Documentation surrounding choking is very clear and the service is highly transparent in the management of choking incidents.
- Creative, attractive, and person-centred meals are provided for people at risk of choking.
- Staff including Agency Workers have had relevant training and evidence understanding of IDDSI and the national descriptors.

COMPLETED DATE:	27.01.2026
SIGN OFF DATE:	27.01.2026
REVIEW DATE:	27.01.2027
SIGNED:	 Marc Stiff – Group Managing Director