Government of JERSEY

Health and Community Services

Dysphagia Policy: Adults in Community Settings

Updated January 2023

DOCUMENT PROFILE

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Author	**Laura Flynn, Lead Adult Speech and Language Therapist**
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Description	**The aim of the policy is to ensure the safe and effective management for any person with dysphagia in the community**
Linked policies	**Dysphagia: Adult in patients FEES/Videofluoroscopy Nutrition & Dietetic Service Operational Policy and Referral Procedure Nutritional Screening and First Line Oral Nutritional Care Enteral Feeding Policy Adult Speech and Language Therapy Operational Policy**
Approval forum	**PPRG**
Review date	**2 years from approval**
Contact details	**l.flynn@health.gov.je**

CONTENTS LIST:

1. INTRODUCTION

1.1 Rationale

The aim of the policy is to ensure the safe and effective management for any person with dysphagia in the community. This includes any patient referred into the service from Nursing Homes, Residential Homes, Sandybrook, and those on the Elderly Mental Health wards at St Saviours Hospital.

Dysphagia is a complex condition which can be the consequence of a large number of different aetiologies. It impacts on nutritional and hydration status and can have serious consequences for quality of life including more frequent hospital admissions and increased length of stay in hospital.

1.2 Scope

This policy is written for any person working with a patient with dysphagia, their families, and carers, across community settings and may relate to a number of different client groups, including (but not exhaustive) people with:

- dementia
- a diagnosis of stroke
- progressive neurological conditions
- head and neck cancer

It covers adults only.

1.3 Principles

Multi-disciplinary (MDT) working is crucial for the safe and effective management of patients with dysphagia.

2. POLICY PURPOSE

This policy is intended for use by any member of staff involved in the MDT assessment and management of disorders of swallowing (dysphagia) or in the provision of nutrition (food) and hydration (fluids) for adults with dysphagia across community and care home settings. It outlines the roles and responsibilities of different professional groups to ensure co-ordinated MDT best practice.

This document has been produced by the Speech and Language Therapy as part of Jersey Health and Community Services Department. Consultation with other professional groups was undertaken and current best practice guidelines (1-7) were used in the development of the policy.

As highlighted in the Royal College of Physicians Report 2010 (4) (p. ix), patients with dysphagia require care tailored to their requirements. It should, as far as possible,

preserve their oral intake. When this is impossible consideration for long term tube feeding may be necessary.

The policy sets out to achieve the following aims:

1. promote awareness for all involved in the care of community with dysphagia
2. provide best practice for patients with dysphagia
3. promote patient safety by minimising the complications arising from dysphagia (i.e. aspiration pneumonia, asphyxiation, dehydration and malnutrition)
4. promote quality of life and achieve swallow safety balanced with preserving pleasure with adequate nutrition and hydration

3. CORPORATE PROCEDURE

See Appendix 1 for diagram of summary of multi-disciplinary pathway for managing dysphagia for Adults with dysphagia living in the community.

3.1 Clinical Issues of Relevance to Dysphagia

Dysphagia can manifest in several ways including dehydration, weight loss, frequent coughing and spluttering, prolonged mealtimes and loss of the pleasures and social aspects of eating and drinking. In severe cases it might result in aspiration pneumonia.

3.2 Conditions associated with Dysphagia

Patients with established lung disease may be more susceptible to the development of respiratory complications following aspiration and the diseases themselves may reduce the effectiveness of coughing. Breathlessness itself makes oral feeding difficult.

General medical problems such as loss of appetite; nausea; xerostomia (dry mouth); pain; lower oesophageal inflammation, infection and dysmotility; oral infection and ulceration; and poor dentition are some of the problems that can cause or contribute to dysphagia.

Structural disease of the face, mouth and upper gastrointestinal tract, including the effects of recent or past surgery and radiotherapy, can preclude effective oral preparation of the bolus and swallowing, and compromise or preclude oral feeding.

Neurological problems such as weakness; loss of voluntary control; apraxia of the face, lips, tongue and palate; coma; deleterious change in conscious level, vigilance, attention and concentration; impairments of posture, balance, visual fixation, spatial awareness; and poor coordination are examples of some of the neurological problems which may affect the pre-oral phase, bolus control in the mouth, swallowing and respiratory function.

People with Learning Disabilities will be at greater risk of having dysphagia. The NPSA (2004) states that dysphagia is a significant health risk for people with a learning disability (8). 40% of people with a learning disability experience recurrent chest infections and respiratory tract infections. Aspiration pneumonia is a significant cause of death, and they are more likely to die due to choking/asphyxiation than the general population. Improving

the management of dysphagia therefore increases quality of life and reduces hospital admissions.

Prevalence studies of dysphagia in people with dementia show that 68% of patients with dementia / in care home present with dysphagia (Steele et al 1997) (9). This is associated with an increased risk of choking incidents and aspiration due to problems with chewing, difficulty swallowing, effects of medication, or behavioural issues e.g. eating too fast.

Oropharyngeal dysphagia is an important factor leading to pneumonia in the elderly, with pneumonia being the leading cause of death among residents in nursing homes (Marik & Kaplan 2003) (10). It is also known that those most at risk of aspiration pneumonia are those who are reliant on others for both oral care and assistance with eating & drinking (Langmore et al 1998) (11).

Evidence from the literature suggests that dysphagia is a common problem in adults with mental health problems. Prevalence rates vary from 19% - 32% (Aldridge and Taylor 2011) (12). Choking is also prevalent with this client group. Ruschena et al (2003) reported that the risk of death by choking was 30 times greater in people with schizophrenia than in the general population (13).

3.3 Environmental and Situational Considerations

The following factors all have the potential to impact mealtimes and safe eating and drinking. The availability of carers, the consistency, temperature and appearance of available food, the atmosphere in the ward or home including the number of distractions and interruptions, and a lack of appropriate seating.

These are of particular relevance to the pre-oral stage, and motivation to eat and drink. These are important considerations in those patients with conditions affecting cognition and behaviour.

3.4 The Roles of the Multi-disciplinary Team in the Management of Dysphagia

Dysphagia requires expert and close collaborative MDT working in order to address the multifaceted nature of the difficulty [7]. The team members will vary depending on the particular needs of the person, the carers and the individual setting. The roles of different staff are summarised in table one below:

Table 1: The Roles of the Multi-disciplinary Team

Team member	**Roles**
Patient and carers	Participation in assessment, decision making, goal planning and implementation when appropriate.
GP or Medical Teams managing patient conditions (e.g. Neurology, Respiratory, ENT)	i) Referral to relevant other professionals if dysphagia is suspected. ii) Medical investigation into the cause of dysphagia and treatment if appropriate. iii) Consideration and implementation, when appropriate, of a plan for alternative nutrition or hydration when a patient is unable to achieve adequate oral nutrition or hydration. iv) Duties of management team to ensure appropriate training of staff. v) Advise on appropriate administration of medication for patients with dysphagia
Nurses	i) Observe for symptoms of dysphagia.

	ii) Nutritional screening using nutrition screening tool. iii) Initiation of timely referral to appropriate professionals. iv) Implementation of swallowing recommendations through the development and review of care plans (informed by multi-disciplinary team recommendations) to maximise safe and adequate nutrition and hydration. v) Support to patient/ carer/ parent to participate in care plans. vi) Recording of oral intake, tolerance and day to day difficulties and liaison with other members of the multi-disciplinary team. vii) Provision of alternative hydration and nutrition when required in liaison with the Department of Nutrition and Dietetics. viii) Maintenance of good oral hygiene.
Speech and Language Therapists	i) Assessment, diagnosis and monitoring of oro-pharyngeal swallowing problems within appropriate time scales. ii) Taking into consideration risks, patient choice, best interests and quality of life. iii) Therapy, support and advice to patient, carer and team regarding appropriate consistencies and compensatory strategies and positioning. iv) Arrangement of supply of thickener for community patients through the subsidised products scheme v) Multi-disciplinary training on the management of dysphagia. vi) Videofluoroscopic examinations of swallow with Radiology. vii) FEES assessments of swallow in ENT. viii) Documentation in correct systems.
Dietitians	i) Assessment and monitoring of nutritional requirements (including adequacy of nutritional intake or requirement for supplementary food) with consideration of S&LT recommendations. ii) Provision and monitoring of tube feeding regimes for those who need enteral tube feeding. iii) Arrangement of supply of enteral feeds and dietary supplements for community patients through the subsidised products scheme iv) Multi-disciplinary training on ensuring adequate nutrition for patients with dysphagia.
Nutrition Nurse Specialist	i) Assessing suitability for enteral and parenteral nutrition. ii) Facilitating placement of enteral feeding devices. iii) Collaborative working with MDT for best patient outcomes. iv) Provide education and support for patients and families.
Occupational Therapist	i) Assessment and management of the impact of physical, environmental, social, behavioural and cognitive/ perceptual factors associated with dysphagia. ii) Advice regarding adaptive equipment and positioning at mealtimes.
Psychologist	Assessment and management of the socio-emotional, behavioural and psychological components of dysphagia.
Catering staff	Provision of attractive, nutritious and suitably fortified foods of suitable consistencies.

3.5 Identification and Screening for Dysphagia

All members of the MDT will be aware of the indicators of dysphagia summarised in table 2. When an dysphagia is suspected, a referral for assessment will be made to the appropriate professional.

Table 2: Indicators of Dysphagia

Indicators of dysphagia	**Oro-pharyngeal stages**	**Oesophageal stage**
Difficult, painful chewing or swallowing at level of larynx	✓	
Regurgitation of undigested food		✓

Nausea/vomiting		✓
Difficulty controlling food or liquid in the mouth	✓	
Drooling	✓	
Pooling of food, or food residue in the mouth.	✓	
Hoarse voice	✓	
Coughing or choking before, during or after swallowing	✓	✓
Globus sensation	✓	✓
Nasal regurgitation	✓	
Feeling of obstruction below laryngeal level		✓
Unintentional weight loss	✓	✓
Change in respiration pattern	✓	✓
Unexplained temperature spikes	✓	✓
Wet voice quality	✓	
Xerostomia (dry mouth)	✓	
Heartburn		✓
Change in eating habits, e.g. eating slowly	✓	✓
Frequent throat clearing	✓	✓
Recurrent chest infections	✓	✓

Factors which may increase the risk for those at risk of aspiration:

- reduced dentition
- psychotropic medication
- polypharmacy
- lack on interest of attention when eating and drinking
- overloading food into the mouth
- speed of eating
- pace/agitation whilst eating
- holding food in the mouth
- swallowing without chewing
- mood levels
- levels of alertness
- poor insight into difficulties
- poor oral hygiene

3.6 Referral to Speech and Language Therapy

Patients with symptoms of oro-pharyngeal dysphagia will be referred for Speech and Language Therapy assessment. The service has an open referral policy and will accept referrals from anybody involved in the patient's care.

Referrals to Speech and Language Therapy are made via Speech and Language Dysphagia Referral Form, or by letter from the medical teams or GP and sent to adultSLTReferral@gov.je . A copy of the referral form is in Appendix 2 and 3. The department will also accept self-referrals from patients which can be made by calling 01534 443030. Please refer to the Adult Speech and Language Therapy Operational Policy which is in process (14).

The referral will be triaged by a Speech and Language Therapist and response time from is two week for urgent assessment and 6 weeks for soon. On a rare occasion, the referral may be classed as routine in which case response time is 8-12 weeks.

Please note that all Adults with Learning Disabilities must be referred to the Specialist Speech and Language Therapist in Learning Disabilities who has responsibility for these clients.

Appendix 4 highlights the referral processes for other members of the MDT who might need to be involved in patient care.

3.7 Speech and Language Therapy Assessment

Assessment will be undertaken with the consent of the patient, and where this is not possible assessment may be undertaken in their best interest with agreement of the MDT.

A detailed case history of the patient's swallowing difficulty and associated medical history will be taken. Assessment will be undertaken with the patient which will include consideration of the level of alertness and assessment of oro-facial and laryngeal function.

On the basis of the findings of this preliminary assessment, the therapist will give oral trials of food and drink, observing all phases of the swallowing process. Compensatory strategies may be employed during the oral trials which may include modification of consistencies, bolus size and positioning and use of airway protection techniques.

Onward referrals may be suggested, for example, to Community Physiotherapy, Community Occupational Therapy, and Psychology or to the Dieticians. The Speech and Language Therapist will write a referral letter when appropriate.

The Speech and Language Therapist may request videofluoroscopy or FEES assessment to contribute to the assessment and management process (see Videofluorscopy and FEES policies 15, 16).

Assessments will be documented in the patient's Speech and Language Therapy Care Partner notes. In addition, recommendations will be documented for different settings as required, for example, in the patient notes in Care Home Settings. Recommendations are documented in a letter form for all community patients.

3.8 Management of Dysphagia

The key outcome from the multi-disciplinary assessment process will be a co-ordinated management plan devised by the multi-disciplinary team in partnership with the patient and carer. This will take into consideration prognosis, quality of life and ethical issues.

3.9 End of Life Considerations

At the end of life, even if the patient is deemed to have "an unsafe swallow", a risk management approach may offer the patient the best quality of life. This will raise ethical

and moral questions regarding the appropriateness of non-oral feeding vs. risk feeding and this must always be individually assessed. Best practice is that the risk of aspiration is taken at the end of life for oral comfort, if patient alertness levels are sufficient. Please see 'Risk Feeding' below.

3.10 Risk Feeding

CHOICES is a tool developed by Hazel Ferreira, Speech and Language Therapist and is used in areas of the NHS (17). It guides the principles of decision making should there be a risk with continued oral intake due to dysphagia, when alternative feeding is not appropriate. It is guided by the principles in Supporting people who have eating and drinking difficulties: A guide to practical care and clinical assistance, particularly towards the end of life RCP (2021) (18) and eating and drinking difficulties with acknowledged risk: MDT guidance for the shared decision making process – adults (RCSLT 2021) (19).

Risk feeding may be appropriate in the following situations:

- The benefits of oral intake out weight the risk (consider QoL, chest infections, weight loss)
- Alternative feeding is not appropriate e.g. given nature of patient's condition, and will not improve QoL or outcomes
- Approaching end of life, but not imminently dying
- Patient wishes to continue with oral intake despite the risk of aspiration, and decides not to have any alternative feeding

Appendix 5 outlines the main factors to be considered when making the decision with a patient associated with continued oral intake in the context of dysphagia. It provides a process for the decision making and appropriate documentation.

C – Centred around the patient
H – Holistic
O – Options
I – In the best interests
C - Communicated
E – Evidenced
S – Shared

Best practice is that the Consultant, Nurse, Speech and Language Therapist, Dietician and Nutrition Nurse are the core members of the team supporting the patient and their family with these complex decisions (see Appendix 5). All decisions are documented and shared with patient and their family.

3.11 Capacity

Every individual should be deemed to have capacity unless proven otherwise. Please see the Capacity and Self Determination (Jersey) Law Jersey 2016 (20).

A patient may choose not to follow the recommendations made by the Speech and Language Therapist, and choose to feed orally 'at or with risk'. In these instances the patient should be supported to eat and drink as they wish, ensuring that they have all the

information required to make an informed decision. All discussions will be documented on the differences and the advice given by the Speech Therapist, and communicated to the GP and medical team responsible for the patient. The use of CHOICES is appropriate in this instance.

If a person is deemed not to have capacity to make this decision, then a best interest meeting will be held with all the relevant individuals involved. Any relevant advanced decisions to refuse treatment are legally binding. Otherwise, in situations without an advanced directive, the wishes and beliefs of the patient when competent, their current wishes, their general wellbeing and their spiritual and religious beliefs will be taken into consideration. People close to the patient (relatives, carers and friends) may be able to give information on some of these factors and will be consulted to contribute to decisions about management. The use of CHOICES is appropriate in this instance.

When a patient in the community is not competent to consent to recommendations and/or a carer chooses not to follow recommendations, the team will evaluate if the patient is being put at risk. When indicated a referral will be made to the Safeguarding Team.

3.12 Recommendation of Nil by Mouth

When the Speech and Language Therapist's assessment indicates that a patient is at high risk of aspiration from oral intake, this will be documented in the patient's notes and communicated with the patient's GP and Consultant if the patient is being managed by other teams, for example Neurology or Elderly Mental Health.

When the Doctor decides a patient is to remain nil by mouth, decisions need to be made as to whether the patient needs to be admitted to hospital for consideration:

- the need for alternative hydration and nutrition
- the need for non-oral administration of drugs

Please refer to the management of patients with dysphagia admitted to the Jersey General Hospital in the Dysphagia Policy: Adult In-Patients (20).

It might be that a hospital admission is not appropriate, for example due to end of life or advanced care decisions. In which case a risk feeding approach will be considered to keep the patient in the community settings.

In some cases the Speech and Language Therapist may recommend that the patient is trialled with small quantities of oral intake. If the Dietetic assessment indicates this is insufficient to meet nutritional requirements, consideration for long alternative hydration and nutrition will also need to be considered if appropriate. The use of CHOICES may be appropriate in this instance.

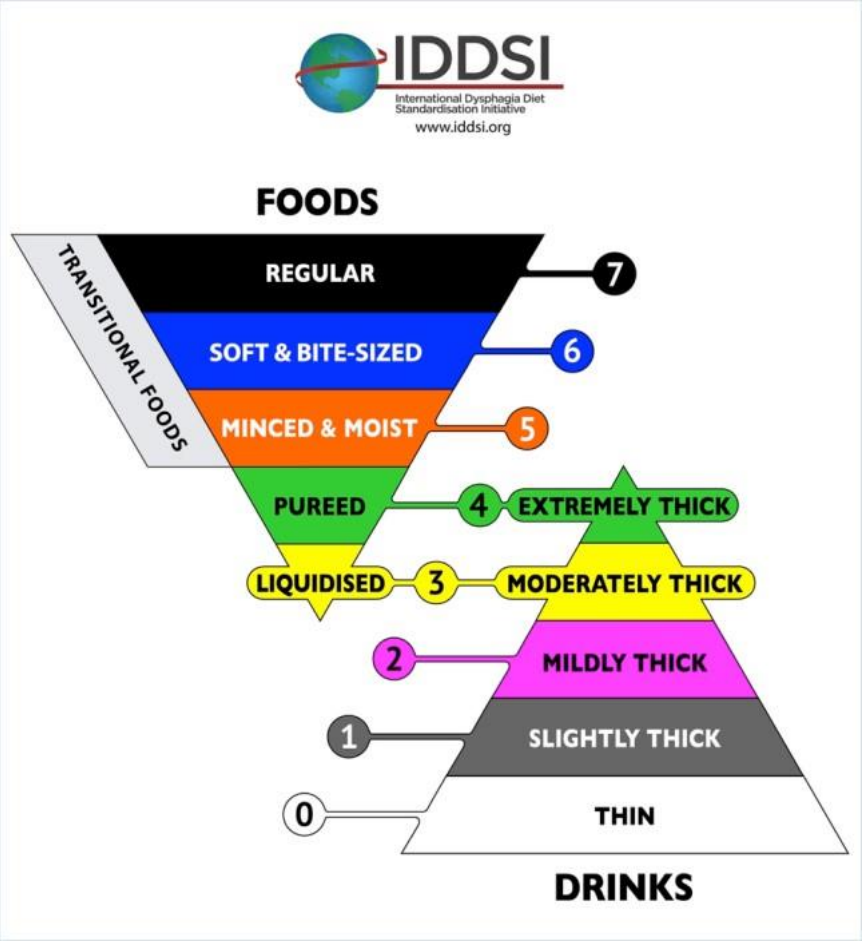
3.13 Alternative Feeding

If a patient is deemed to have unsafe swallow, then alternative feeding should only be considered if deemed appropriate by GP or medical team. Best practice for those with progressive illnesses is that this is considered prior to deterioration of swallow. The multi-disciplinary team will provide timely information about the potential on the progression of dysphagia and the range of management options for the future.

The type and route for artificial feeding will depending on the patient's clinical condition and past medical history. Please see 'The safe insertion and ongoing care of a Nasogastric (NG) feeding tube in adults' (22).

3.14 International Dysphagia Diet Standardisation Initiative (IDDSI)

IDDSI was rolled out in Jersey in April 2019 following the international development of the food and fluid levels detailed in the chart below.



All staff who serve food to patients with dysphagia will have undertaken training to understand the food and fluid consistencies that may be recommended. Information can be accessed on the resources page on the IDDSI website www.iddsi.org (23). Each setting should familiarise themselves with the IDDSI information when managing clients requiring modified diets.

3.15 Ensuring Appropriate Consistencies of Food

Health and Community Services have adopted the IDDSI standards for food and fluid textures. This has led to Jersey adopting Nutilis Clear as thickening agent except in rare circumstances (e.g. a patient wishes to use Nutilis powder, or the Nutilis powder provides a safer consistency).

Nursing staff will also liaise with families to ensure that they understand the recommendations and the importance of food brought from home complying with these recommendations.

For all Health and Community Services residential settings including private nursing and residential homes, the manager of the setting will be responsible for ensuring that all staff working with patients with dysphagia are aware of recommended dietary and fluid consistencies.

Each setting should familiarise themselves with this information when managing clients requiring modified diets. All staff who serve food to patients with dysphagia will understand the food and fluid consistencies that may be recommended. Information can be accessed on the resources page on the IDDSI website www.iddsi.org.

For adults living in the community, the Speech and Language Therapist will provide the patient and carer with written information about suitable foods and how to prepare modified diets and drinks.

Please note level 7 food choices can be made easier to chew by cutting the food up and avoiding high risk foods and / or adding sauces and gravies, this is on a needs basis.

3.16 Ensuring Appropriate Consistencies of Fluids

The manager of the setting will be responsible for ensuring that all staff working with patients with oral feeding difficulties are trained in thickening fluids to the appropriate consistency.

As set out in IDDSI, all drinks are to be made up to 200ml with the thickener added before the fluid:

- 1 scoop of Nutilis clear for level 1 (slightly) thick
- 2 scoops of Nutilis clear for level 2 (mildly) thick
- 3 scoops of Nutilis clear for level 3 (moderately) thick
- 7 scoops of Nutilis clear for level 4 (extremely) thick

For patients living in Care Home settings, appropriately trained staff will ensure that liquids are modified to the recommended consistency using fluid thickener.

For patients living in the community, the Speech and Language Therapist will provide advice on thickening fluids and arrange a supply of thickener through the subsidised products scheme.

3.17 Recommendations for Adequate Nutrition

Following the Speech and Language Therapy recommendations on safe food and fluid consistencies, the Dietitian will advise on methods to ensure that the patient achieves adequate levels of nutrition. Patients at risk of malnutrition should be screen with the Malnutrition Screening Tool (MUST). Whenever possible, a “food first approach” will be taken with increased nutrition provided by additional ‘normal high calorie foods. When required the Dietitian may prescribe oral nutritional supplements (ONS). It is the

responsibility of the Care Homes to refer patients requiring support to the Dietetic service. Please see Nutrition and Dietetic Service Operational Policy and Referral Procedure (23).

All care home settings will ensure that there is sufficient time given to patients who take a long time to eat an adequate meal. In addition, there will be sufficient staff at mealtimes to assist and, when necessary, feed patients who require support.

3.18 Monitoring and Review

All members of the MDT team have a responsibility to monitor the patient's swallowing to ensure that adequate nutrition and hydration is maintained. Any change in status will be recorded and liaison with the Speech and Language Therapist will take place before changes to existing recommendations are made. Health Care Assistants will report any deterioration or improvement in the patient's swallowing to their supervising nurse, and staff in nursing and residential homes will report to their manager.

Any professional members of the MDT can request a Speech and Language Therapy review if a change in status in the patient's swallowing function is observed. See referral process in section 3.6.

The Speech and Language Therapist will document the timing of any planned reviews. Patients requiring ongoing thickening of fluids will be reviewed when they get in touch for repeat prescriptions of thickener, either face-to-face or through telephone consultation with the patient or their primary carer. It is the primary carer's responsibility to notify the Speech and Language Therapist, giving at least two weeks' notice, when a new prescription for thickener is required.

When a patient's dysphagia has resolved or when recommendations have been implemented to achieve safe and adequate nutrition and hydration, the patient will be discharged from Speech and Language Therapy.

3.19 Staff Competency and Training

Speech and Language Therapists managing patients with dysphagia will have passed their competencies as set out by the Royal College of Speech and Language Therapists as a minimum requirement. Speech and Language Therapists will work under the close supervision of a senior colleague whilst they are completing these competencies.

Senior Therapists with responsibility for specialist areas of dysphagia will have undertaken further appropriate professional development to ensure they are competent in their specialist area.

All Speech and Language Therapists must be aware of the extent and limits of their role and understand that they may not always have a contribution to make, e.g., with patients who refuse to eat and drink or patients with oesophageal problems.

4. DEVELOPMENT AND CONSULTATION PROCESS

A record of who is involved in the development of this document. This may include HCS committees, service users and other agencies.

4.1 Consultation Schedule

Name and Title of Individual	Date Consulted
Laura Foster, Macmillan Specialist Oncology Dietitian	January 2023
Dr Helen Thomas, GP	January 2023
Debbie Hill, Lead Physiotherapist	January 2023
Sam McManus, Occupational Therapist	January 2023
Dr Ng and Dr Duku, Gastroenterolgy	January 2023
Toby Farlan, Capacity Assessor	January 2023
Roz Angier, Lead Speech and Language Therapist	January 2023

Name of Committee/Group	Date of Committee / Group meeting
PPRG	Sept 2021

5. REFERENCE DOCUMENTS

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14. Adult Speech and Language Therapy Operational Policy (Jersey)

15. Videofluoroscopy Policy (Jersey)

16. FEES Policy (Jersey)

17. CHOICES: Guideline for supporting and documenting complex decision making in those with eating, drinking and/or swallowing difficulties. North West Anglia Foundation Trust (2022)

18. Supporting people who have eating and drinking difficulties: A guide to practical care and clinical assistance, particularly towards the end of life RCP (2021)

19. Eating and drinking difficulties with acknowledged risk: Multipdisciplicary team guidance for the shared decision making process – adults (RCSLT 2021)

20. Capacity and Self Determination (Jersey) Law Jersey 2016

21. Dysphagia Policy: Adult In-Patients (Jersey)

22. The safe insertion and ongoing care of a Nasogastric (NG) feeding tube in adults (Jersey)

23. www.iddsi.org

24. Nutrition and Dietetic Service Operational Policy and Referral Procedure

6. BIBLIOGRAPHY

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7. GLOSSARY OF TERMS / KEYWORDS AND PHRASES

GP: General Practitioner.
MDT: Multi-Disciplinary Team
S&LT: Speech and Language Therapy
FEES: Fibreoptic Endoscopic Evaluation of Swallowing
Videofluoroscopy: Modified Barium Swallow
QoL: Quality of Life

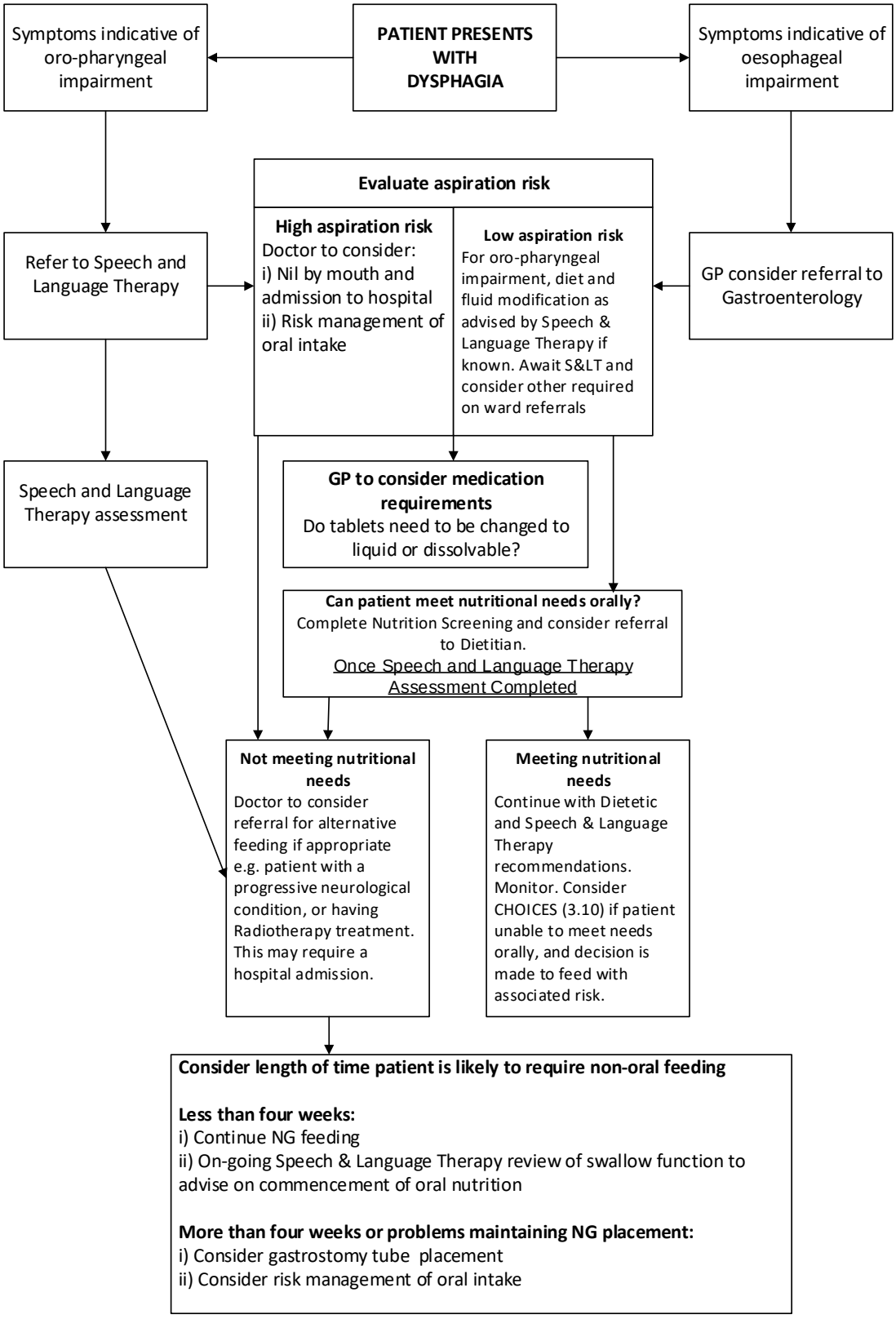
8. IMPLEMENTATION PLAN

A summary of how this document will be implemented.

Action	Responsible Officer	Timeframe
Share with relevant parties e.g. GP surgeries, Nursing Homes	Laura Flynn	Immediate from ratification
Training sessions for CHOICES	Laura Flynn	To be implemented in training sessions throughout 2023

9. APPENDICES

Appendix 1: Summary of Multi-disciplinary Pathway for Dysphagia in the Community



Appendix 2: Speech and Language Therapy Service Community Dysphagia Referral Form

Speech and Language Therapy Service Community Dysphagia Referral Form

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<table>
<tr><td colspan="3">Patient Details
Forename: Surname:
Title: D.o.B:
Address: URN:
GP:
Telephone: Ethnicity first language:
Gender:
Interpreter required: Yes / No</td><td>S&LT use only
Date:
Coded by:
Status (circle): R A G
Clinician allocation:</td></tr>
<tr><td colspan="4">Primary diagnosis:

PMHx:</td></tr>
<tr><td colspan="2">Reason for referral:</td><td colspan="2">Medications:</td></tr>
<tr><td colspan="4">Average day
Breakfast:
Lunch:
Dinner:

Current IDDSI recommendations (circle if known):</td></tr>
<tr><td colspan="2">Diet level:
level 7 (regular) diet
level 6 (soft and bit sized)
level 5 (minced / moist)
level 4 (puree)</td><td colspan="2">Fluids level:
0 (thin) fluids
1 (slightly) thick
2 (mildly) thick,
3 (moderately) thick
4 (extremely) thick</td></tr>
<tr><td colspan="2">Dentition / mouthcare (circle):
Own teeth / dentures
Dependent for oral care: Y / N
Oral thrush (Y / N),
Dry mouth (Y / N)
Ulcers (Y / N)
Other: …………………</td><td colspan="2">Mealtimes (please circle)

Alertness levels for E&D: adequate / poor

Level of support:
full
assisted hand over hand
self-feeding
requires encouragement

Positioning for meals: in chair / bed</td></tr>
<tr><td colspan="3">Communication impairment: Yes/No
Current Communication: verbal/non verbal
Diagnosis (if known) e.g. Aphasia, dysarthria, dyspraxia, cognitive impairment</td><td>Patient Consent:
Yes ☐ No ☐
If no, reason:
……,,</td></tr>
<tr><td>Safeguarding concerns:</td><td colspan="3">Referrer: …………………………..….Telephone: …………..

Relationship to patient: ……….…. Date of referral: ..…….</td></tr>
<tr><td colspan="4">Post: Speech and Language, Enid Quenault Health and Wellbeing Centre, La Route des Quennevais, St Brelade, JE3 8JW
Email: adultSLTReferal@gov.je
This form is for use by JGH secondary care outpatient clinics only</td></tr>
</table>

Dysphagia Symptom Checklist	**Please indicate Frequency** Low/Moderate/High
☐ Drooling ☐ Losing **food / liquid / both** from mouth during meals ☐ Difficulty chewing ☐ Difficulty moving **food / liquid / both** in mouth (i.e. bolus is stationary in mouth) ☐ Difficulty initiating a swallow ☐ **Spitting / pushing / self-removal** of bolus from mouth ☐ Pocketing or retaining residue ☐ Need to avoid certain **foods / fluids / both** ☐ Coughing/choking on **food / liquid / saliva / all** ☐ Wet voice quality **before / during / after** meals ☐ Delayed **throat clearing / coughing** after swallowing ☐ Recurring chest infections ☐ Eye watering during meals ☐ Pain during swallow – **mouth / throat / lower** ☐ Sneezing or **food / liquid / both** coming out of nose ☐ Sensation of food sticking in **throat / chest / both** ☐ Thickened secretions ☐ Difficulties managing secretions – requires **medication** / **suction** ☐ Difficulty swallowing tablets ☐ Regurgitation **foods / fluids / both** ☐ Burping **during / after** meals	L M H

*****Frequency – Low = Every week, Moderate = Every day, High = Every mouthful

Appendix 3: Speech and Language Therapy Service Community Communication Referral Form

Speech and Language Therapy Service Community Communication Referral Form

Government of JERSEY

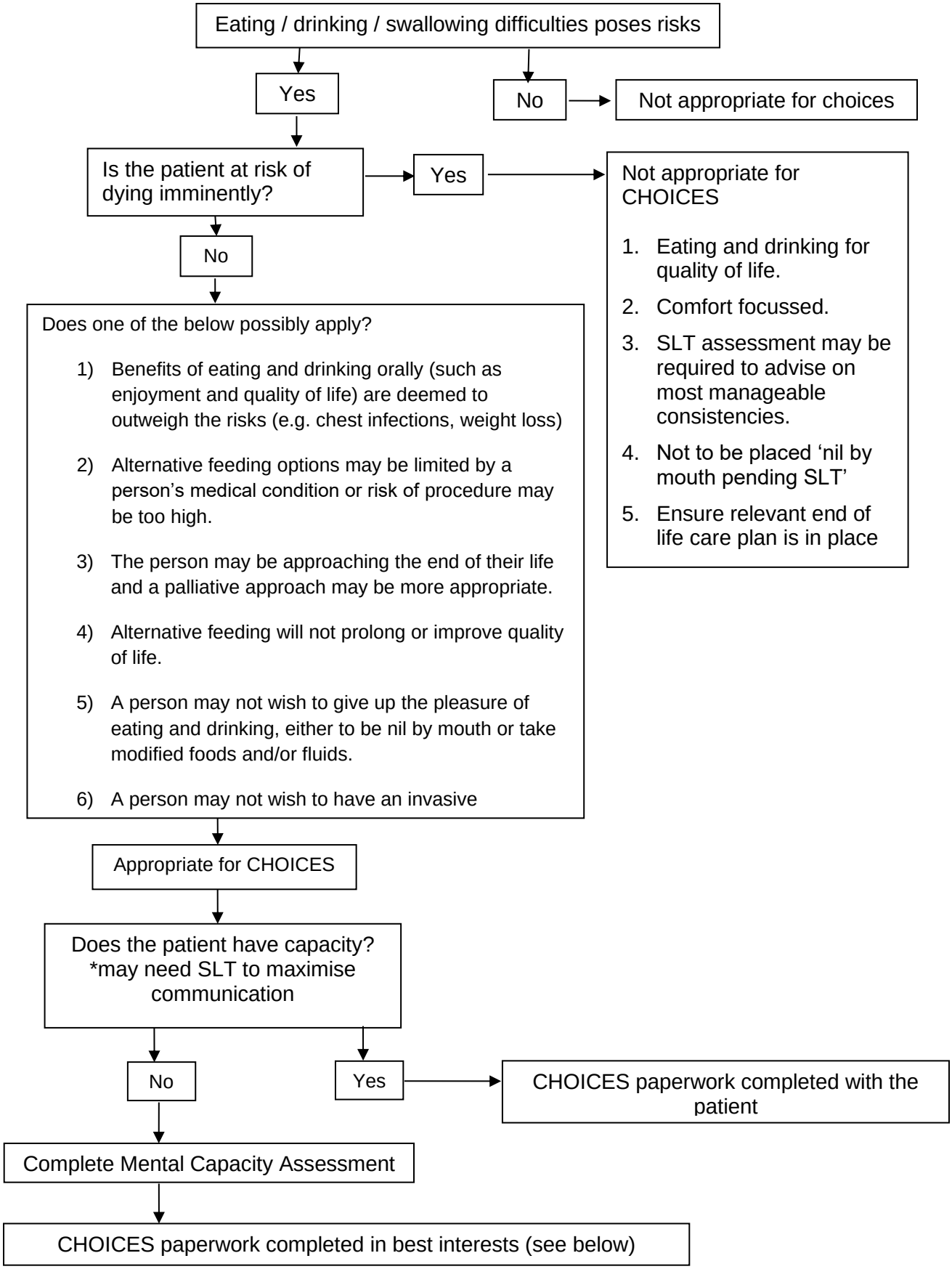
Patient Details Forename: Surname: Title: D.o.B: Address: URN: GP: Telephone: Ethnicity first language: Gender: Interpreter required: Yes/No	***S&LT use only*** *Date:* *Coded by:* *Status (circle): R A G* *Clinician allocation:*
Primary diagnosis: **PMHx:**	
Reason for referral:	**Communication impairment (please circle):** aphasia, dysarthria, dyspraxia, dysphonia, cognitive impairment, memory impairment Unknown at present
How has the patient's communication changed? **Onset communication problem (circle): Days / weeks / months / years**	
Situations communication breaks down:	**Alternative communication strategies used:**
Medications:	**Can the patient read and write?**
Is the patient employed?	**Patient Consent:** Yes ☐ No ☐ If no, reason…….
Safeguarding concerns:	**Referrer**……**Telephone** …….. **Relationship to patient**…… **Date of referral**……..…….
Post: Speech and Language, Enid Quenault Health and Wellbeing Centre, La Route des Quennevais, St Brelade, JE3 8JW ***This form is for use by JGH secondary care outpatient clinics or community settings only***	

Appendix 4: Potential Onward Referrals

Department	When	Policy / Referral
Nutrition and Dietetics	Screen all community patients using MUST.	See Nutrition & Dietetic Service Operational Policy and Referral Procedure for full guidance and information on inpatient and how to refer to the Nutrition & Dietetic Service.
Gastroenterolgy	When dysphagia is suspected to be oesophageal in origin, S&LT will suggest a referral to the Gastroenterology Medical Team requesting their assessment and advice.	The patient's GP will make this referral if they are in agreement with the S&LT advice.
Community Physiotherapy	Patients should be referred to physiotherapy when dysphagia is suspected to have resulted in aspiration with respiratory compromise, or when respiratory impairments are affecting the efficacy of swallowing. In addition, physiotherapy opinion should be sought in relation to movement and postural control and alignment, particularly with reference to positioning for eating and drinking and to optimise respiratory function. Physiotherapy referral should also be made for those with dysphagia who have coexisting	For community patients, referral to physiotherapy is via SPOR. Completed SPOR referrals should be sent to SPOR@health.gov.je & cc'd to WARCPhysioReferrals@health.gov.je

	impairments affecting their balance, mobility or functional independence, particularly if changes are noted relative to an individual's usual baseline.	
Community Occupational Therapy	Patients who have physical, perceptual, or cognitive impairments impacting on their ability to eat and drink may benefit from Occupational Therapy support for assessment for environmental, positional or adaptive equipment to support when eating and drinking and/or at mealtimes.	All referrals to the Occupational Therapy department are made via SPOR.
Videofluorscopy	If a videofluorocopy is indicated following S&LT assessment. Referral is made by the GP to Radiology on X Ray Request form	See Videofluoroscopy policy
FEES	If a FEES is suggested following swallowing assessment this will be arranged by S&LT Team and ENT	See FEES policy.

Appendix 5: CHOICES



Name		DOB		URN		Date	

Centred around the Person: (Past/present wishes and beliefs, implications for the individual – QoL, future recovery potential)

Holistic: (Consider in context of other co-morbidities, prognosis, reversible causes, frailty score, previous level of function)

Options: (List the choices in this case? Texture modification? Alternative feeding? Pros and cons of options? Advanced care planning options? How will future infections be managed?)

In best Interests:

Presumed mental capacity? Yes ☐ No ☐ If no = Mental Capacity Assessment ☐ IMCA needed? Yes ☐ No ☐
LPA Health & Welfare? Yes ☐ No ☐ (if yes- who. Place copy in notes).
Advance Directive? Yes ☐ No ☐ (if yes- Place copy in notes).

Communicated: Who have the choices been discussed with (name, relationship to person), how and when?

When (date): How:
Who:

Evidenced: (What are the risks? How do we know they exist? How frequent /severe are they? S&LT assessment +/- instrumental assessment, frequency of chest infections, weight loss history etc)

Shared: (Which professionals have been involved in this decision making process? Name and profession):

Who needs to know for the future?

CHOICE: (including wishes for future management of infections +/- hospital readmission)

Supporting Team Members

Team Member	Name	Involved yes/no
Lead Consultant*		
Ward Nurse*		
Speech and Language Therapist *		
Dietitian*		
Nutrition Nurse*		
Pharmacist		
Palliative Care Nurse / Consultant		
Gastroenterologist		
Physiotherapist		
Safeguarding Team		
Learning Difficulties Specialist Nurse		
Other Specialist Nurses, e.g. MS		
IMCA		
Family member		
Representative from nursing home		

*Core members