Joint Policy for Cumbria Partnership Foundation Trust & North Cumbria University Hospital NHS Trust

Feed at Risk - Adults

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Policy On A Page

SUMMARY & AIM

The aim of this policy is to provide the guidance and information required to ensure safe and effective nutrition and hydration where there are acknowledged clinical risks.

TARGET AUDIENCE:

The risk feeding policy applies to all clinical staff coming into contact with patients who are feeding at risk.

- Speech and Language Therapists
- Dietitians
- GPs
- Acute medical staff
- Acute nursing staff

TRAINING:

Not applicable.

KEY REQUIREMENTS

1. Dysphagia risk assessment by Speech and Language Therapist.
2. If dysphagia is not felt to be transient or treatable initiate risk feeding pathway.
3. Capacity assessment
4. Collaborative decision making
5. Authorisation of process – form to be signed off by medical professionals and patient or representative
6. Clear documentation and handover within the acute
7. Discharge planning to the community
8. Community handover to GP and community teams

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1. INTRODUCTION

Nutrition forms a key priority for many organisations. These are patients within the acute and community care setting who resist or are indifferent to food, fail to manage the food bolus adequately once it is in the mouth (oral phase dysphagia) or aspirate when swallowing (pharyngeal phase dysphagia).

The challenge arises when these patients are deemed unsuitable for alternative nutrition or hydration (ANH) following a multidisciplinary team (MDT) discussion usually involving the medical team, the dietitian and the Speech and Language Therapist (SLT).

A patient may be an inappropriate candidate for ANH if the procedure risk outweighs the benefit; the patient themselves decline ANH or there is poor prognosis or a short life expectancy as discussed in NICE guidelines CG32 (August 2017) 'Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition' and NICE guidelines (November 2012) 'Nutrition support in adults'. Clinicians are then faced with the dilemma of how best to manage these patients who are unsuitable for ANH but at risk of choking on food/fluid and developing an aspiration pneumonia.

The decision-making process regarding whether to introduce artificial nutrition and hydration or continue to allow food and drink orally once their swallowing becomes unsafe, provokes difficult ethical decisions for professionals, patients and carers (Chaklader, 2012).

The risk feeding policy has been devised to guide teams through an organised decision making process, encompassing patient choice and multidisciplinary clinical input to what appears to be an ethically fraught area.

2. PURPOSE

The policy addresses capacity, ethics, and quality of life issues, providing the MDT with a patient centred framework to facilitate decisions on nutrition planning. There is no ethical calculus that can determine what is 'right' in some situations (RCP, 2010).

A multidisciplinary nutrition support team of healthcare professionals, mostly led by a doctor with special expertise in nutrition, must be available to work with patients and their families when oral feeding difficulties occur (RCP, 2010). The risk feeding policy ensures that all aspects of care and outcomes are considered. This approach results in respectful and dignified patient centred decision which is made following serious thought and over a reasonable time frame.
If a patient is deemed unsafe to eat and drink and is found to be unsuitable for alternative nutrition and hydration (ANH), then risk feeding must be considered. The risk feeding policy is also indicated if the patient has capacity, understands fully the high risks of aspiration of oral intake, but chooses to continue to eat and drink.

The risk feeding policy outlines the reasons why a person may be a candidate for risk feeding. This is followed with a section for the assessment of the patient's capacity in making a decision regarding nutritional management. There is the authorisation endorsed by the signatures of the Consultant/Speciality trainee/GP and the SLT that the MDT discussions have taken place and information shared with the patient/family. Risk reducing recommendations are also included to ensure the patient receives the appropriate diet and fluids.

The policy covers the risk feeding process through the pathway from hospital admission to discharge and referrals to the community teams. The roles and responsibilities of the MDT are outlined within this.

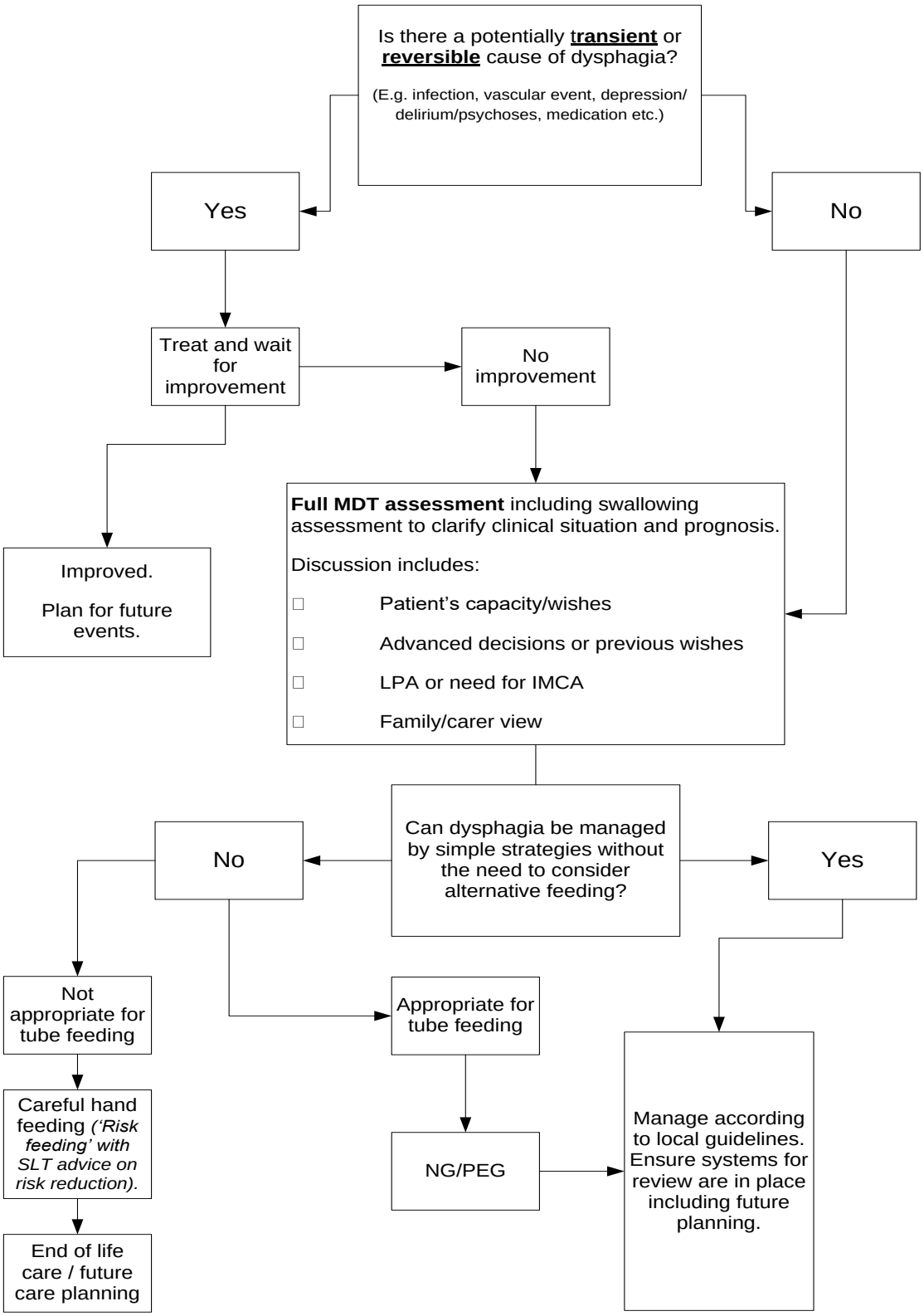
3. POLICY DETAILS

3.1 Clinical Decision Making

It is essential that the initiation of the risk feeding policy is preceded by detailed information gathering to establish the nature of the dysphagia. This includes identifying whether the patient's clinical picture is **transient in nature or not likely to change in spite of management**, and consideration of how future management will impact on quality of life in that individual.

Figure 1 shows a flow chart, adapted from Smith et al (2009), which guides professionals though the early processes of clinical decision making in risk feeding.

FIGURE 1


Is there a potentially **transient** or **reversible** cause of dysphagia?
(E.g. infection, vascular event, depression/ delirium/psychoses, medication etc.)
Yes
No
Treat and wait for improvement
No improvement
Improved.
Plan for future events.
Full MDT assessment including swallowing assessment to clarify clinical situation and prognosis.
Discussion includes:
Patient's capacity/wishes
Advanced decisions or previous wishes
LPA or need for IMCA
Family/carer view
Can dysphagia be managed by simple strategies without the need to consider alternative feeding?
No
Yes
Not appropriate for tube feeding
Careful hand feeding *('Risk feeding' with SLT advice on risk reduction).*
End of life care / future care planning
Appropriate for tube feeding
NG/PEG
Manage according to local guidelines. Ensure systems for review are in place including future planning.

Dementia and dysphagia in acute hospital care decision-making (adapted from
Smith et al, Clinical Medicine, 2009).
http://www.clinmed.rcpjournal.org/content/9/6/544.full.pdf

3.2 Initiation of the Policy

The risk feeding policy can be found on the organisation(s) intranet. In the event that the medical team initiates this policy prior to SLT assessment, they are able to access the protocol and print out the documentation. This prevents delay in appropriate management. A SLT referral must always inform the risk feeding decision so that risk reducing consistencies and strategies can be established.

3.3 Capacity Assessment

An appropriate Medical Team member is responsible for conducting a capacity assessment which explores whether the patient has capacity regarding nutrition planning and the risks involved in eating and drinking.

All four aspects outlined within the Mental Capacity Act (2005) listed on the risk feeding form will need to be assessed. This must follow the principles of care set out in section 1.5 of NICE guidelines CG138 (February 2012) 'Enabling the patient to actively participate in their care'.

Whilst conducting a swallow assessment, the SLT will establish the patient's baseline communication and a consistent, reliable means of communication. From the assessment, the SLT will ascertain if the patient has understood the information. Risks will be explained to the patient to determine if they have the ability to weigh up information. Measures must be used to facilitate the discussion, such as alternative supportive communication boards/pictures and/or easy read information, if needed, to optimise the patients understanding of the information discussed.

The SLT must discuss the capacity status and swallow assessment findings with a member of the Medical Team before a risk feeding decision is documented. Where the patient is deemed to have capacity to make this decision, professional colleagues alongside the patient must discuss and agree the outcomes and management plan with family/next of kin/care team. Those present during the discussion may include the medical team, SLT and Dietitian.

Where the patient lacks capacity, a best interest multidisciplinary decision must be taken, and this may include a best interest meeting with the family/next of kin/care team. This must be clearly documented in the patient medical records. The guidelines must be signed by a Consultant/Specialty trainee/GP who will ultimately make the best interest decision on risk feeding.

Information about the policy must be presented in an accessible way and patients and relatives/carers should be given a copy of the information leaflet

on risk feeding so that they have further opportunity to reflect on and process this information.

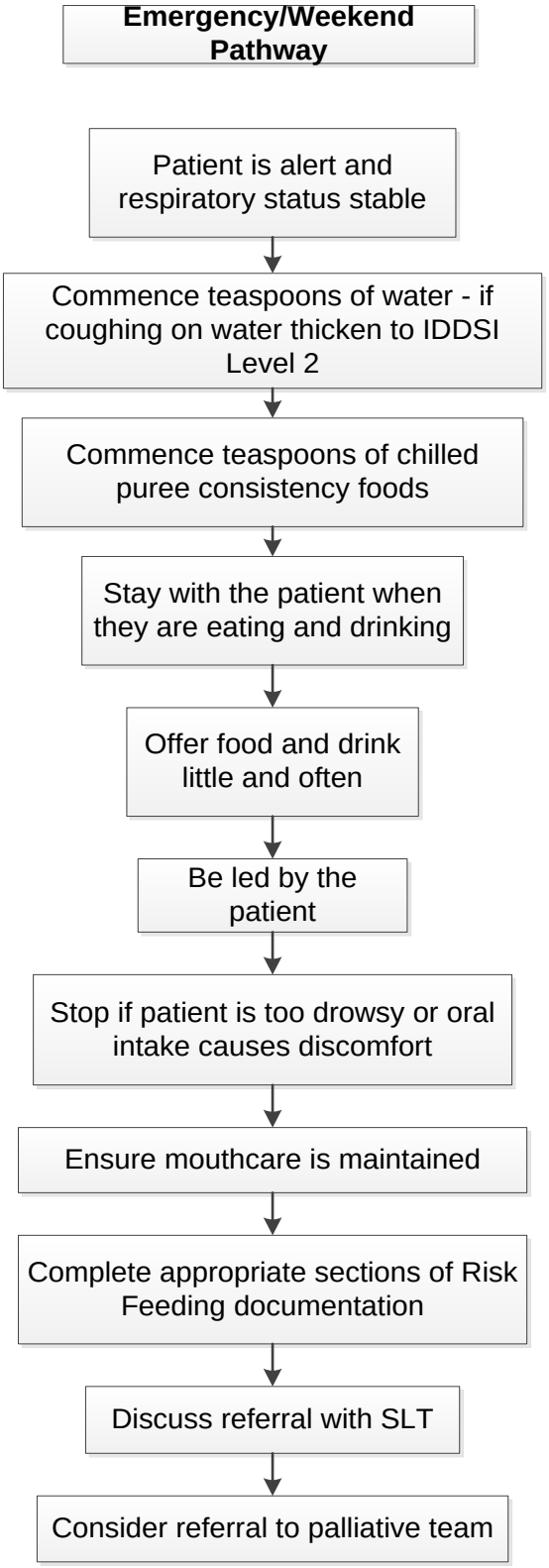
3.4 Risk Feeding – Local Guidelines at Weekend

If a patient is placed on the risk feeding policy over a weekend, then all the steps need to be followed by a medical team member. Research indicates that aspiration pneumonia can develop as a consequence of a combination of contributory factors such as poor oral hygiene, high dependency levels, (for positioning, eating and drinking, and mouth care) and the need for oral suctioning (Langmore, 2002, Hibberd et al 2013). Whilst some of these variables cannot be managed, the risks can be reduced, if these factors are appropriately supported through strict oral care routines, optimal positioning and careful hand feeding at mealtimes.
In this population of patients, where the swallow is also deemed to be unsafe, it may be safest to allow the patient to consume a puree (level 4) diet and water until the Speech and Language Therapist can complete a full assessment. Unthickened water does not pose a significant risk for aspiration pneumonia particularly where scrupulous oral hygiene is maintained (Panther, 2005, Wynn, 2014, Langmore, 2011).

In the absence of a clinical bedside swallowing assessment, puree (level 4) food is suggested as it may adequately address issues such as choking risks, poor dentition, reduced ability to masticate, cognitive feeding issues where the patient is averse to texture or lumps, efficiency at mealtimes, fatigue and poor bolus control. The introduction of puree diet can impact on palatability, functional muscle memory and quality of life in some cases, but in this instance it is only suggested as a standby/interim treatment until SLT assessment.

This policy in no way implies that puree food is suitable for all patients who are risk feeding. Each patient will need to be assessed and managed on an individual basis.

It is the responsibility of the medical team to assess the burden and benefit of treatment, taking into account the patient's wishes, in determining the management plan (RCP, 2010). In the patient who lacks capacity, an attempt should be made to establish what they might construe as worthwhile.



Based on Buckinghamshire Healthcare NHS Trust (2017) Feeding Guidelines (see reference in 8 below)

For in-patient cases a sign for display of “Eat and Drink for Comfort” above the patient’s bed is contained in Appendix 4.

3.5 Documentation

The risk feeding decision needs to be documented clearly in the medical notes and EMIS record or other electronic patient records used within the county. Within Cumbria Partnership NHS Foundation Trust, all patients on the risk feeding pathway are identified on their electronic record. This register serves as an outcome measure to monitor readmissions and to allow for data analysis and interpretation.

3.6 On-going Management

Appropriate nursing handover must take place to ensure the risk is acknowledged and minimised with scrupulous oral care and optimum seating position and when required, careful hand feeding is offered.

Medical and nursing staff are responsible for monitoring patients' progress with risk feeding, and refer back to SLT if considered appropriate.

3.7 The Discharge Process

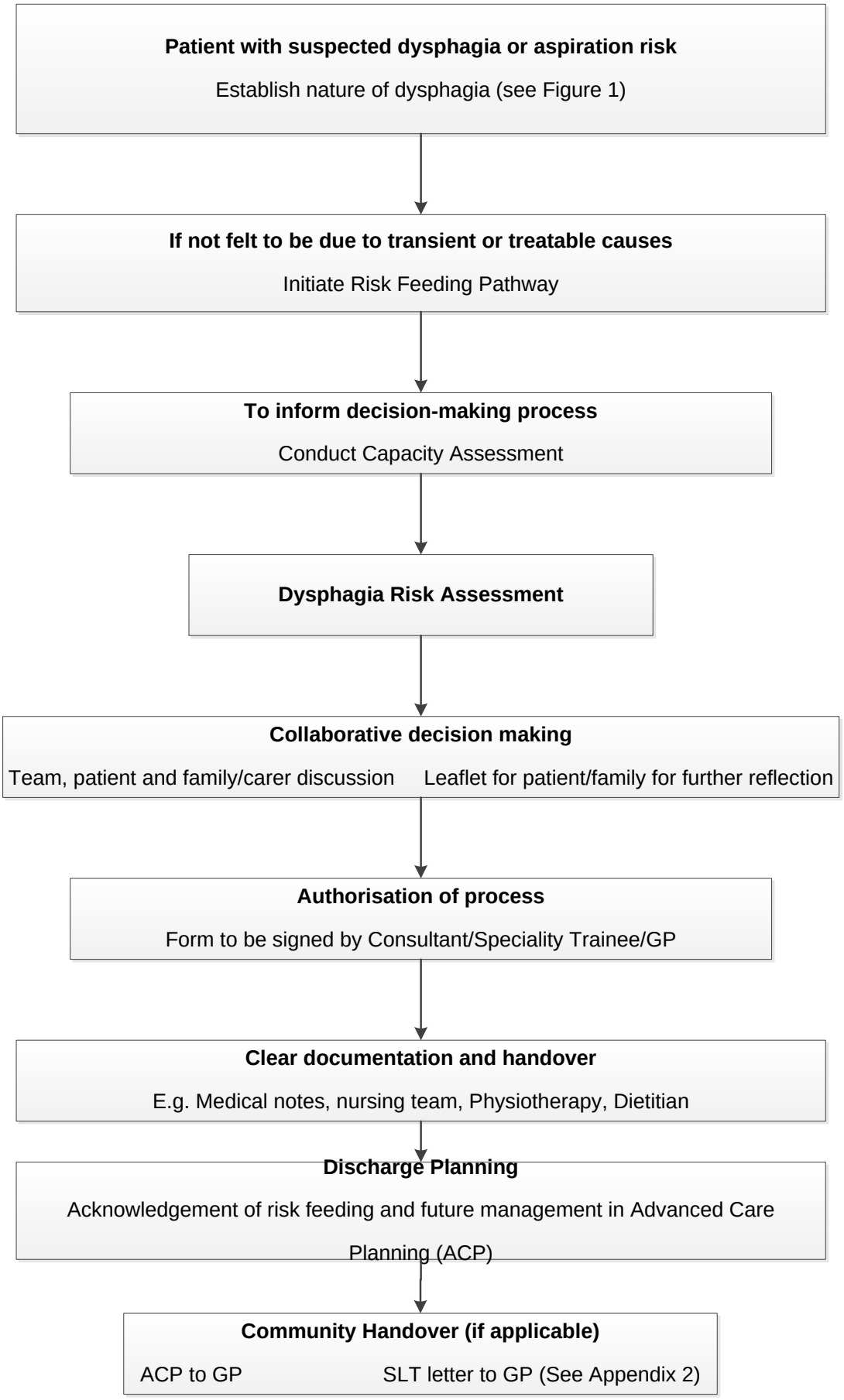
The SLT must work closely with the medical team members in ensuring that risk feeding is appropriately reflected in the discharge summaries, hospital passports or advanced health care plans. The medical team will decide whether or not to readmit the patient for acute hospital treatment should they be diagnosed with aspiration pneumonia by the GP. This forms a crucial stage in the process allowing the patient to leave the acute setting with a clear plan in place informing future management. A letter must be sent out to the GP with guidance and information leaflets sent to the home/nursing home. This allows cohesive care of community patients and in collaboration with GP practices can support the patient who is being risk fed to be managed at home. These steps are vital to avoiding aspiration related readmissions within this patient group.

If risk feeding is likely to be part of lifelong management, an alert is set up on the electronic patient system by the SLT on discharge. Should the patient be readmitted, this alert will highlight to admitting teams that this patient is being risk fed and that SLT should be contacted in order to maintain continuity of care.

3.8 Process Summary

The following flowchart serves as a summary of the key steps involved in the decision making process for risk feeding. All stages can be initiated by either the medical team or SLT, except the detailed dysphagia assessment which must be carried out by SLT. In this instance the multidisciplinary team should comprise of medical team members, SLT and may include representation from Dietetics, respiratory Physiotherapy and Palliative Care.

It is essential to acknowledge that the Consultant responsible for the care of the patient will collate the information gained from the process and will ultimately by the person who makes the decision regarding the plan for risk feeding.


Patient with suspected dysphagia or aspiration risk
Establish nature of dysphagia (see Figure 1)
If not felt to be due to transient or treatable causes
Initiate Risk Feeding Pathway
To inform decision-making process
Conduct Capacity Assessment
Dysphagia Risk Assessment
Collaborative decision making
Team, patient and family/carer discussion
Leaflet for patient/family for further reflection
Authorisation of process
Form to be signed by Consultant/Speciality Trainee/GP
Clear documentation and handover
E.g. Medical notes, nursing team, Physiotherapy, Dietitian
Discharge Planning
Acknowledgement of risk feeding and future management in Advanced Care Planning (ACP)
Community Handover (if applicable)
ACP to GP
SLT letter to GP (See Appendix 2)

4. TRAINING AND SUPPORT

All relevant staff must be aware of the policy. Further advice can be sought from the appropriate Speech and Language Therapy Department.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
Risk feeding Care Plan	SLT Department	Annual Audit from EMIS	Annually	Collection undertaken by CPFT/NCUH Information Services

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the SLT adult team meeting minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

Buckinghamshire Healthcare NHS Trust (2017) Feeding Guidelines https://www.chilternccg.nhs.uk/wp-content/uploads/2017/01/815.1
CHAKLADER, E. (2012) Dysphagia management for older people towards the end of life. British Geriatric Society: http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/2328-bpgdysphagia
HARWOOD, R.H. (2014) Feeding decisions in advanced dementia. Journal of the Royal College of Physicians, Edinburgh, 44, 232-237
LANGMORE, S.E., SKARUPSKI, K.A., PARK, P.S., FRIES, B.E. (2002) 'Predictors of aspiration pneumonia in nursing home residents'. Dysphagia 17 (4): 298-307
LANGMORE, S.E. (2011). 'Why I like the free water protocol'. SIG 13 Perspectives on Swallowing and Swallowing Disorders (Dysphagia), 20: 116-120
HIBBERD, J., FRASER, J., CHAPMAN, C., MCQUEEN, H., WILSON, A. (2013) 'Can we use influencing factors to predict aspiration pneumonia in the United Kingdom'. Multidisciplinary Respiratory Medicine 8.39
MENTAL CAPACITY ACT (2005) http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf
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https://www.nice.org.uk/guidance/cg138
PANTHER, K. (2005) Frazier water protocol. USA:
http://www.slpnetwork.org/archives/Meeting%2011-06-08/Frazier%20Protocol.pdf
ROYAL COLLEGE OF PHYSICIANS (2010) Oral Feeding Difficulties and Dilemmas: particularly towards the end of life. Royal College of Physicians & British Society of Gastroenterology, London.
SMITH, H.A. et al. (2009) Swallowing problems and dementia in acute hospital settings: practical guidance for the management of dysphagia. Clin Med, 9 (6), 544-548
WYNN, R. (2014). Free Water Protocol: For or Against.
www.dysphagiacafe.com/2014/05/05/free-water-protocol-for-or-against

7. ASSOCIATED DOCUMENTATION:

- Consent to Examinations and Treatment
- End of Life and Bereavement Policy
- Mental Capacity Act Policy
- Nutrition and Hydration for Adults Policy

Please also see relevant Cumbria Partnership Foundation Trust Policies

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

8.2 Executive Director Responsibilities: Executive Medical Director

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee. For this policy the executive director is Vincent Connolly.

8.3 Managers Responsibilities:

Line managers are responsible for ensuring their staff understand and adhere to this policy.

8.4 Staff Responsibilities:

Roles	Responsibilities within the Risk Feeding Pathway
Medical practitioner	• To initiate the dialogue regarding risk feeding management and commence a capacity assessment • To refer to SLT for a swallowing assessment • To ensure anticipatory health care plans are completed when needed • To provide risk feeding guidelines in the discharge summary
SLT (Speech and Language Therapist)	• To conduct a detailed assessment of swallow • To conduct or facilitate a capacity assessment if needed • To discuss findings of the assessment with the MDT • If a decision is taken to risk feed, inform the physiotherapist • To send letters to the GP and community SLTs on discharge
Consultant	• To make the ultimate decision once the patient is clinically discussed with the MDT and options shared with patient and family
Advanced Nurse Practitioner	• To highlight the need and refer on as appropriate for a Risk Feeding' assessment
Dietitian	• Nutritional risk is identified by the Malnutrition Universal Screening Tool (MUST) • Provide a detailed nutritional assessment and care plan to promote patients' wellbeing in relation to nutrition • If appropriate recommend alternative nutrition and hydration such as Enteral feeding/Parenteral nutrition • Liaise with MDT • Review and update Nutrition Care Plan
Physiotherapist	• To discuss chest management with the medical team and ceiling of care with respiratory needs
Nurses	• To highlight to the medical team/SLT if a patient is likely to be a candidate for risk feeding • To ensure risk reducing recommendations are being adhered to
Palliative Care	• To inform the MDT if the patient has been placed on the end of life pathway

8.5 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

9. ABBREVIATIONS / DEFINITION OF TERMS USED

Keep lists in alphabetical order

ABBREVIATION	DEFINITION
ANH	Alternative Nutrition or Hydration
CPFT	Cumbria Partnership Foundation Trust
EMIS	Electronic patient record system
GP	General Practitioner
MDT	Multidisciplinary Team
NCUH	North Cumbria University Hospital
NICE	National Institute of Health and Care Excellence
RCP	Royal College of Physicians
SLT	Speech and Language Therapist

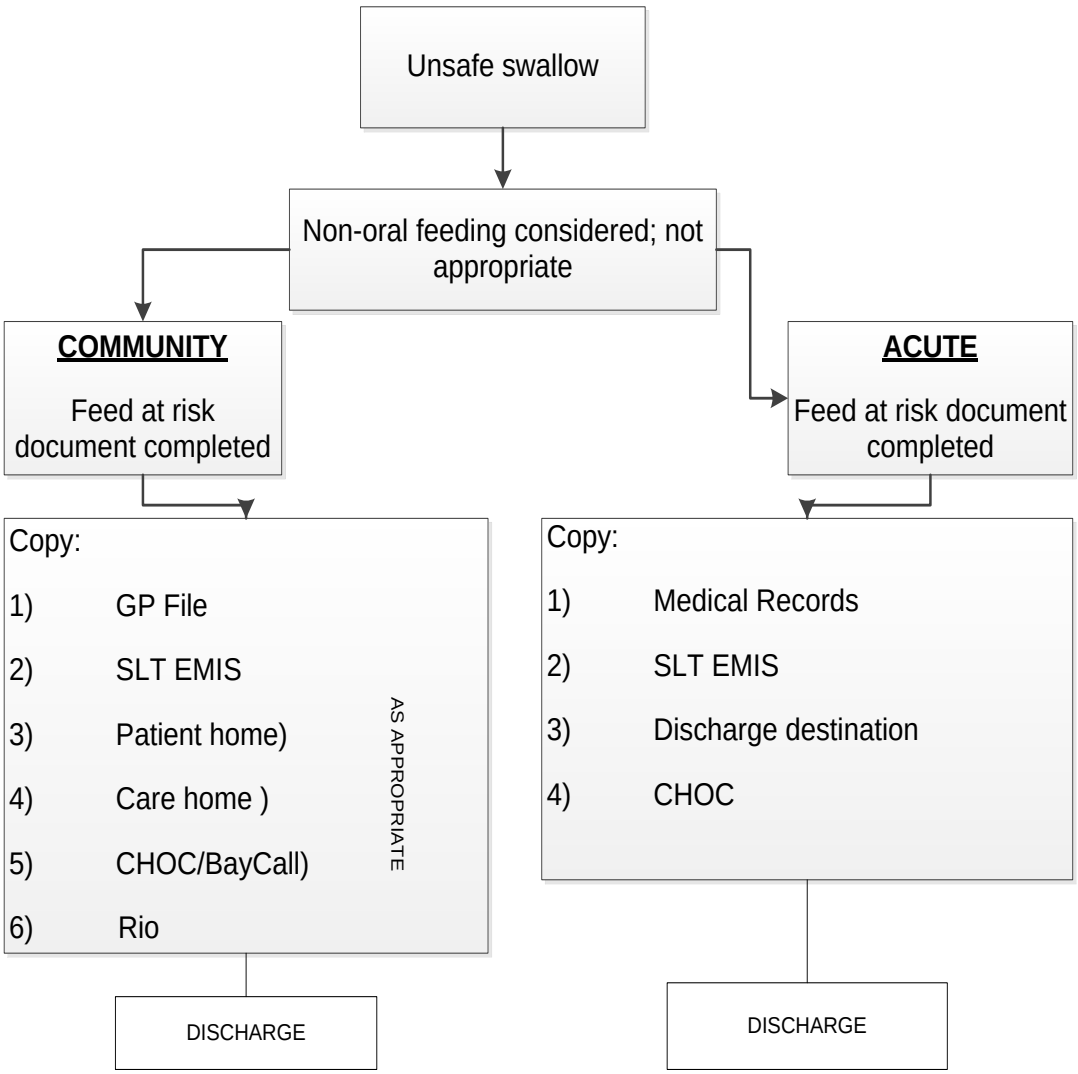
Terms of reference	Definition	Further information
Advanced health care plan	A process of discussion between an individual and their care providers to make clear a person's wishes, often in the context of anticipated deterioration	www.endoflifecareforadults.nhs.uk
Alternative Nutrition or Hydration (ANH)	Giving an individual nutrition and fluid by another means other than the mouth	
Aspiration	Where food or drink passes the vocal folds and enters the lungs	
Aspiration pneumonia	An infection in the lungs caused by food, fluid, saliva containing bacteria, or vomit entering the lungs	
Bolus	The substance which is being swallowed, e.g. mouthful of food or drink	
Capacity	Being able to make your own decisions	http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/mental-capacity.aspx
Careful hand feeding	Where the individual is fed by the care giver or given hand over hand support to eat and drink. A skilled approach which recognises the vulnerability of dependent individuals.	Finucane TE, et al. Tube feeding in patients with advanced dementia: a review of the evidence. *J Am Medical Association 1999; 282:14,1365-370* Palecek EJ, et al. Comfort feeding only J Am Geriatric Society Mar 2010; 58(3): 580-584.
Cognitive feeding issues	Where behaviours associated with deteriorating cognition or mental function impact on eating and drinking	Royal College of Physicians (2010) *Oral feeding difficulties and dilemmas,* RCP London
Independent Mental Capacity Advocate	The IMCA is a role developed by the Mental Health Capacity Act 1985. A local Council or NHS Body has a duty to involve an IMCA when a vulnerable	

(IMCA)	person, who lacks mental capacity, needs to make a decision about a serious medical treatment or accommodation move.	
Lasting Power of Attorney (LPA)	Is a legal document that lets a person, "the donor" appoint one or more people (known as "attorneys") to help make decisions or make decisions on a persons behalf.	
Masticate	The act of chewing food	
MUST	Malnutrition Universal Screening Tool. The 'MUST' is a calculator that can be used to establish nutritional risk using either (a) objective measurements to obtain a score and a risk category or (b) subjective criteria to estimate a risk category but not a score (www.bapen.co.uk).	
Nutrition	Nutrition is the intake of food, Considered in relation to the body's dietary needs. Good nutrition – an adequate, well balanced diet combined with regular physical activity – is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity (WHO, 2017).	
Optimal positioning	Where the individual is well positioned, upright with head/trunk/feet supported	Mastros, M., Miller, K., Eliasson, A.C. and Imms, C. (2007) Goal-directed training: linking theories of treatment to clinical practice for improved functional activities in daily life. Clinical Rehabilitation 21 , 47-55. Kellett, R. et al (2012) Communication and Mealtimes Toolkit (Helping people with dementia to eat, drink communicate – A guide for carers), NHS Dumfries and Galloway.
Oral care routines	The daily routine of keeping an individual's mouth clean.	
Oral phase dysphagia	Any difficulty eating/drinking which occurs as the bolus reaches the lips or whilst in the mouth.	
Pharyngeal phase dysphagia	Any difficulty managing food or drink as it passes through the throat. This includes preventing food and drink entering the lungs.	
Puree diet	National descriptor for smooth sieved food – B/C	www.thenacc.co.uk/assess/downloads/170/fooddescriptorsforindustry
Risk	Where an individual continues to eat	www.rcslt.org/speech_and_language_therapy/professionalis

feeding	And drink in spite of the risk of food and fluid entering the lungs	m/bulletin_feb_2013_pg20-21dysphagia

APPENDIX 1 -

STANDARD OPERATING PROCEDURE: FEED AT RISK



APPENDIX 2 -

Cumbria Partnership NHS Foundation Trust

Happier | Healthier | Hopeful

PRIVATE AND CONFIDENTIAL

GP Address

Dear Dr

GP Actions:
1. Please monitor for signs of aspiration given known risk on all oral intake.
2. Please prescribe (locally used thickener) for long term daily use.
Other:-

Patient Name:
Date of Birth:
Address:
NHS Number:

Medical diagnosis:
Speech and Language Therapy (SLT) diagnosis:
(X) was referred to our service by (name, title). He / She was seen for a swallowing assessment on (date). The findings are as follows:
Mr/Mrs (X) is at high risk of aspiration on all consistencies, which may lead to choking, chest infections, pneumonia, malnutrition and dehydration. The risks of aspiration and associated complications with (X) has been discussed with (X), their family/carers and medical team/doctor. A decision has been reached that artificial feeding is not in (X)'s best interests and wish to continue oral feeding for quality of life (despite risk of aspiration). Please find the completed risk feeding protocol included.

The recommendations below may reduce, but not eliminate, the risk of aspiration.

Risk Feeding Guidelines

(Insert diet recommendation) DIET and (Insert fluid recommendation) FLUID

(**Thickener requirements e.g. 1 scoop per 200ml fluid)**

- Sit as upright as able and comfortable
- Only feed if awake and alert
- Regular oral care
- Seek GP advice if temperature spikes or becoming chesty

Further Management

(X) would benefit from advanced planning for end of life care and this may include whether or not to admit for acute hospital treatment in the event of deterioration in chest status and consideration of suitable Supported Care Pathway.

Delete as applicable

***As further Speech and Language Therapy intervention is not indicated at this time, (X) has been discharged from our service. (X) and their family/carers are aware of how to contact the service should they require further assistance.*

***This patient will be followed up by the Community Speech and Language Therapy service for ongoing support.*

Please do not hesitate to contact the department if you have any queries or if you require any further information.

Yours sincerely

Speech and Language Therapy
Tel.:

CC: Medical File
Patient
Community Speech and Language Therapy

APPENDIX 3

Carlisle
Speech & Language Therapy – Adult Services
Cumberland Infirmary
Newtown Road
Carlisle
CA2 7HY
Tel.: 01228 814730

Whitehaven
Speech & Language Therapy Adult Services
West Cumberland Hospital
Homewood Road
Hensingham
Whitehaven
CA28 8JG
Tel.: 01946 523112

Carlisle and Eden
Learning Disability Services
Cedarwood, Carleton Clinic
Carlisle
Cumbria
CA1 3SX
Tel.: 01228 603189

Risk Feeding

Patient Information Leaflet

Disclaimer

The information in this leaflet is for guidance purposes only and is in no way intended to replace professional clinical advice by a qualified practitioner.

Unsafe swallowing

Swallowing problems (dysphagia) may result from dementia, stroke, various neurological disorders (Parkinson's disease, multiple sclerosis, motor neurone disease, etc.) learning disability and a range of other acute and chronic health conditions.

If you or your relative is experiencing swallowing difficulties, there may be a high risk food or fluid and saliva **'going down the wrong way'**. This is when it enters the wind pipe or lungs. **This is known as aspiration**. Aspiration can be uncomfortable for you or your relative, although sometimes it happens with no immediate signs or symptoms (silent aspiration). Aspiration can be dangerous as it can lead to pneumonia (an infection in the lungs).

Speech and Language Therapists specialise in the assessment and treatment of dysphagia and in many cases are able to find ways to **reduce the risks for people** with swallowing difficulties.

However, for some patients, even with this support, their swallow is just not safe.

Alternative nutrition and hydration

There are many people, who have an unsafe swallow but are unsuitable candidates for tube feeding for the following reasons:

- The risks of long term tube feeding outweigh the benefits
- Tube feeding is refused by a consenting patient
- Tube feeding would not maintain or improve quality of life

Risk feeding should be considered when patients have an unsafe

Risk feeding

When a person continues to eat and drink with a risk of aspiration and/or choking, this is referred to as risk feeding. Risk feeding may be put in place for one or more of the following reasons:

- Advanced stages of illness
- The person's swallow is not safe and is unlikely to improve
- Preferred food and drink takes priority over swallow safety
- Tube feeding options are declined or inappropriate

A risk feeding decision should result in a plan which balances safety and quality of life as taking fully into account the personal, cultural and religious beliefs of the individual.

APPENDIX 4

NHS
Cumbria Partnership
NHS Foundation Trust

EAT AND DRINK FOR COMFORT

Happier | Healthier | Hopeful

APPENDIX 5

Patient details:

RISK FEEDING CARE PLAN

1. CAPACITY (To be completed by appropriately trained professional)

This patient is able to:	Yes	No
Understand the information relevant to the decision		
Retain that information		
Use or weigh up that information as part of the decision-making process		
Communicate the decision		

Based on the above assessment, the patient does / does not (delete as appropriate) have capacity in making a decision regarding nutritional management.

Signature of assessor: _____

Date of capacity assessment: _____

2. RISK ASSESSMENT (To be completed by Speech and Language Therapist)

This patient's swallowing has been assessed by Speech and Language Therapy. S/He has demonstrated the following risk factors when eating and drinking (tick as applicable).

PRESENTING RISKS			
Poor oral skills / secretion management		Aspiration pneumonia	
Delayed / absent swallow		Fever	
Weak swallows		Dehydration	
Shortness of breath / reduced SpO_2		Malnutrition	
Wet vocal quality when feeding		Weight loss	
Coughing / choking at meals		Problems with oral care	
Difficulty self-feeding / positioning		Variable alertness / cognitive problems	

Speech and Language Therapy assessment has shown that this patient is at risk of aspiration and choking because of a poor swallow but oral intake may be considered appropriate for the reasons outlined in 3 (over page).

3. FEEDING OPTIONS

A decision has been made. As discussed with the multidisciplinary team:

A. This patient has some form of non-oral feeding and has expressed a choice to continue with some oral intake as well. ☐

or

B. This patient is for oral feeding. Long-term non-oral feeding is *not* appropriate due to (tick as applicable): ☐

End of Life care (e.g. poor prognosis / short life expectancy / irreversible severe swallowing difficulties)	
PEG procedure risks outweigh benefits	
Patient has declined non-oral nutrition / hydration or has an advance directive	
Other:	

4. GUIDELINES FOR ORAL INTAKE (To be completed by Speech and Language Therapist following MDT decision)

FOOD		**DRINK**	
Level 3 - Liquidised		Level 0 – normal fluids	
Level 4 - Pureed		Level 1 – slightly thick fluids	
Level 5 – Minced and moist		Level 2 – mildly thick fluids	
Level 6 – Soft & bite-sized		Level 3 – moderately thick fluids	
Level 7 – Easy to chew		Level 4 – extremely thick fluids	
Level 7 - Regular			
Other information:			

Please see also specific patient guidelines from Speech and Language Therapy and from Dietetics.

5. OTHER RELEVANT CARE DOCUMENTS

(e.g. Advance Statement, Advance decision to Refuse treatment, Lasting power of attorney)

6. CHOC / Bay Urgent Care

CHOC / Bay Urgent Care advised if appropriate (tel: CHOC 0300 30 34 365 / Bay Urgent Care XXXXXX):

Yes ☐ **N/A** ☐ **Date:** _____

Completed by (Print):		Date:
Signed:	Designation:	
Name of supporting Consultant/GP (Print):	Consultant/GP Signature:	Date:
Name of Patient's Representative	Patient's Representative Signature:	Date:

Please contact Speech and Language Therapy if the management plan or risk feeding decision changes

APPENDIX 6

Contact us:

Carlisle
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Tel.: 01228 814730

Whitehaven
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DOCUMENT CONTROL

Equality Impact Assessment Date	
Sub-Committee & Approval Date	Nutrition Steering Committee 13/08/2019

History of previous published versions of this document:

Trust	Version	Ratified Date	Review Date	Date Published
CPFT	1	12/06/2018	31/07/2021	01/08/2018

Statement of changes made from previous version

Version	Date	Section & Description of change
	12/06/2018	New policy approved at CPMG
0.1	25/09/2018	• Moved onto new joint template
0.1	06/02/2019	• Amendments made as per requests at CPMG on 21 August: • Updated reference list to include relevant NICE guidelines • Updated terminology to comply with IDDSI standards • Updated address and contact details • Removed ambiguous terminology • Registered monitoring audit with clinical audit team
0.2	13/08/2019	• Formatting and spelling amendments

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Dr Shazhad Iqbal	Consultant in Stroke Medicine	June 18
Dr Rasool	Locum Consultant in Elderly Care	June 18
Vincent Connolly	System Medical Director	July 19
Helen Boit	Senior Quality and Safety Manager	May 19