Cumbria Partnership NHS
NHS Foundation Trust

Paediatric Dysphagia Policy

Document Summary

To promote an equitable and standardised approach to the management of babies and children with dysphagia or suspected dysphagia using evidence based best practice

POLICY NUMBER	POL/001/081
DATE RATIFIED	October 2017
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ACCOUNTABLE DIRECTOR	Executive Director of Quality & Nursing
POLICY AUTHOR	Suzanne Giles, Charlotte Smith, Helen Dixon
VERSION NUMBER	1.0

Happier | **Healthier** | Hopeful

Contents

1. SCOPE

The policy is written to inform and guide all Speech and Language Therapists within the service, parents of children with feeding difficulties and other professionals who work in related fields who are involved with the child in question e.g. Paediatricians, Health Visitors and school staff in relation to assessment and management of dysphagia in children.

2. INTRODUCTION

“Dysphagia is the term used to describe a swallowing disorder usually resulting from a neurological or physical impairment or the oral, pharyngeal or oesophageal mechanisms. The normal swallow has four phases;

1) oral preparation
2) Oral
3) Oropharyngeal
4) Oesophageal

Disorders of swallowing are associated with increased likelihood of aspiration, chest infections and pneumonia. Dysphagia is associated with increased morbidity, mortality and reduced quality of life.

Dysphagia can be transient, persistent or deteriorating according to the underlying pathology.”

“Dysphagia is always secondary to another primary condition, and the cause of dysphagia can be multifactorial. For this reason, Multidisciplinary Team (MDT) working is imperative and MDT colleagues should be consulted throughout the assessment, treatment and monitoring process”

Specialist Speech and Language Therapists possess a sound knowledge of the structure and function of the vocal tract. They are skilled in the assessment and remediation of voice and speech disorders arising from neurological, structural and psychological aetiologies. Knowledge and skills developed in this area have been extended and applied to the assessment, treatment and management of patients with dysphagia. There has been an increase in Speech and Language Therapists’ involvement in the field of dysphagia, both in the number of Speech and Language Therapists undertaking this work and the percentage of their time spent in this area of clinical activity.

a) dysphagia can occur in all age groups

b) dysphagia can arise from a wide range of aetiologies including neurological disease, structural abnormality and psychological causes

c) dysphagia affects the patient's quality of life and general health; in severe cases it may be life threatening

d) the management of dysphagia should involve close multi-disciplinary collaboration.

e) the Speech and Language Therapist has a role to play in aspects of the assessment and treatment of dysphagia as a member of this multi-disciplinary team.

"The multidisciplinary management of individuals with dysphagia ensures a timely, efficient, integrated and holistic period of care"

Evidence

Bach DB, Pouget S, Belle K, Kilfoil M, Alfieri M, McEvoy J, Jackson G, (1989)

Logemann JA, 1994

Siktberg LL and Bamts DL (1999)

Goldsmith T (2000)

RCSLT Clinical Guidelines"

3. STATEMENT OF INTENT

The policy should be read in conjunction with Royal College of Speech and Language Therapy (RSCLT) Clinical Guidelines and the Interprofessional Dysphagia Framework and should guide work into the clinical area of dysphagia at all times

4. DEFINITIONS

RCSLT- Royal College of Speech and Language Therapists

MDT – Multi Disciplinary Team

SCBU – Special Care Baby Unit

SLT – Speech and Language Therapist

RCSLT Resource Manual for Commissioning and Planning Services for SLCN (2009 updated 2014)

5. DUTIES

Chief Executive:

The Chief Executive has ultimate accountability and responsibility for the physical health of service users and the implementation of this policy. This is delegated through organisational structures and accountability frameworks to ensure staff providing direct clinical care are provided with the appropriate tools and training.

Managers:

Service and team managers have responsibility to ensure that all healthcare staff working with children with dysphagia are aware of and adhere to this policy.

Clinical Staff:

Clinical staff who are involved in the care of a child with dysphagia have the responsibility to be aware of the individual needs of the child with regard to their condition and to work with the speech and language therapist to minimise risk.

Speech and Language Therapists:

Carry out a detailed assessment which can assist with a differential medical diagnosis.

Ensure safety, reducing or preventing aspiration with regards to swallowing function.

Liaise closely with other MDT members and make onward referral should further investigation be required.

Identify any unmet needs that can impact on swallowing and refer/signpost to other appropriate agencies.

Consider factors e.g. sensory, physical, learning and communicative environments that may have a bearing on feeding skills and any techniques or advice given to support an individual child.

Provide advice, awareness and training to carers of children presenting with feeding difficulties.

Maintain clinical competencies in line with RCSLT and NICE guidelines, attend clinical supervision sessions, attend Clinical excellence network meetings.

6. DETAILS OF THE POLICY

6.1 THE AIMS OF THE SERVICE

The aims of the service are:

- to provide a comprehensive and responsive service to children presenting with feeding and swallowing disorders in accordance with referral criteria.
- to facilitate intervention as part of a multi-disciplinary team.
- To provide others with basic training in awareness of feeding and swallowing disorders and the role of the SLT within the multi disciplinary team.
- to become engaged in planning future paediatric services for those presenting with feeding and swallowing disorders.

6.2. WHO MAY ACCESS THE SERVICE

- Babies under the age of 12 months
- Where young babies on SCBU are referred, they will be assessed according to the level of competency afforded by the speech and language therapist, any assessment carried out by the speech and language therapist will be underpinned by a paediatrician, who will have responsibility for the baby's overall care.
- Children up to 19 years in special education
- Children up to 18 years in mainstream education

6.3 REFERRAL

Referral must be on the appropriate referral form with complete information including the impact of the difficulty and the expectations from the referral.

Initial referral requests are appropriate for children who have;

- failed to develop and maintain sucking, swallowing, chewing skills at an age appropriate level;

- been receiving long-term non-oral feeds and some oral feeding is being considered
- been identified as being high risk for developing long-term feeding difficulties. failed to control secretions i.e. drooling;
- Obvious signs of chewing and / or swallowing difficulties eg choking / coughing / eyes watering / colour change/ respiratory distress / gurgly voice quality
- History of prematurity and difficulty in establishing oral feeding
- Medical conditions and syndromes which are impacting on chewing and swallowing
- History of frequent chest infections in association with any of the above

Assessment by speech and language therapy cannot be offered to children with:

- Difficulties associated with weaning e.g. refusing solids, spitting out / refusing lumps, where there is no associated medical or neurological condition
- Difficulties which are behavioural e.g. food refusal / fussy eaters / restricted diet
- Poor appetite

6.4 RESPONSE TIME

- A pre-clinical evaluation will be carried out within 5 working days of receipt of referral
- Once the referral is accepted the child will be seen within 2 working weeks
- Clinicians reserve the right to prioritise referrals in line with their professional judgement, according to the information received to determine the risk and urgency of response.

6.5 ASSESSMENT

a) The clinical assessment will be undertaken having regard to RCSLT clinical guidelines in close collaboration with the multidisciplinary team and parents / carers

b) If clinical assessment highlights a risk of aspiration, a request for Instrumental assessment such as videofluoroscopy is required. This should be made through a tertiary centre and may require a medical referral depending on the policy of the tertiary centre.

c) The result of local assessment will be compiled in a written report, including recommendations. This will be guided by results from videofluoroscopy if available and appropriate. The report will be shared with the carer and other professionals involved with the child.

   In the event that videofluoroscopy is refused by any party the local Speech and Language Therapist will put in writing to the medical practitioner the constraints on continuing management of the case.

6.6 MANAGEMENT

a) Any planned intervention will be discussed first with parents/carers and the multi-disciplinary team. Recommendations will then be made and documented. The frequency of monitoring/intervention will be explicit and agreed.

b) When a child is being fed non-orally, the Speech and Language Therapist should be consulted before any trial swallows are attempted.

c) The Speech and Language Therapist remains responsible for any proxy intervention, in line with their recommendations.

d) National Guidelines of food and drink descriptors will be adhered to

Where Speech and Language Therapy Guidelines are to be implemented by the other team members or family/carers, then the Speech and Language Therapist will ensure the following:

- written recommendations and advice will be demonstrated by the Speech and Language Therapist to the appropriate 'named person'. An understanding of this advice will then be demonstrated to the Speech and Language Therapist

6.7 DISAGREEMENT

Where there is disagreement between the patient or family/carers and the team, every effort will be made to resolve it through discussion. It is important to have full co-operation for management to be carried out effectively. If the patient or family/carers refuse to consent/agree to the planned management, this will be documented and communicated to members of the team and/or the medical practitioner (GP/consultant) in overall charge of the patient.

For process, see Appendix 1

TRAINING

Competencies

Speech and Language Therapists working in Dysphagia should be competent with reference to the RCSLT Dysphagia Competency Framework. They should receive regular dedicated supervision and be operating at an appropriate level for their competence. This will be maintained through supervision and training. It is vital that therapists working in the field of dysphagia work with sufficient numbers of children to maintain their competencies in specific areas eg neonates.

A county wide group of clinicians involved in paediatric dysphagia meets at least twice a year to consider equity across the county in service provision and peer review.

Speech and language therapists will attend training when appropriate to maintain and further develop competencies as highlighted through the appraisal system.

MONITORING COMPLIANCE WITH THIS DOCUMENT

[Mandatory text and table to be inserted]

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Audit of the following standards: Numbers of babies referred into the service Numbers of babies referred onto tertiary centres Evidence of assessment and clinical reasoning and outcomes in records Evidence of clinical supervision undertaken by speech and language therapists who undertake assessment and treatment of babies and children with	Notes audit of a stated percentage of babies referred with dysphagia. Data collection through Rio. Monitoring of self - assessment and maintenance of CPD through management supervision	CSM/team managers/AHP lead	2 yearly	Children and Families Dysphagia group, Care group CEAC, Children and Families Clinical Governance	Network C&F Director of Operations

dysphagia. Evidence of self-assessment of Speech and Language Therapists against the RSCLT competency framework					

REFERENCES/ BIBLIOGRAPHY

Royal College of Speech and Language Therapists. 2003. *Communicating Quality* 3.RCSLT:London.

Royal College of Speech and Language Therapists. 2006. *Clinical Guidelines.* RCSLT: London.

Royal College of Speech and Language Therapists. 2009. *RCSLT Resource Manual for Commissioning and Planning Services for SLCN.* Dysphagia. RCSLT: London.

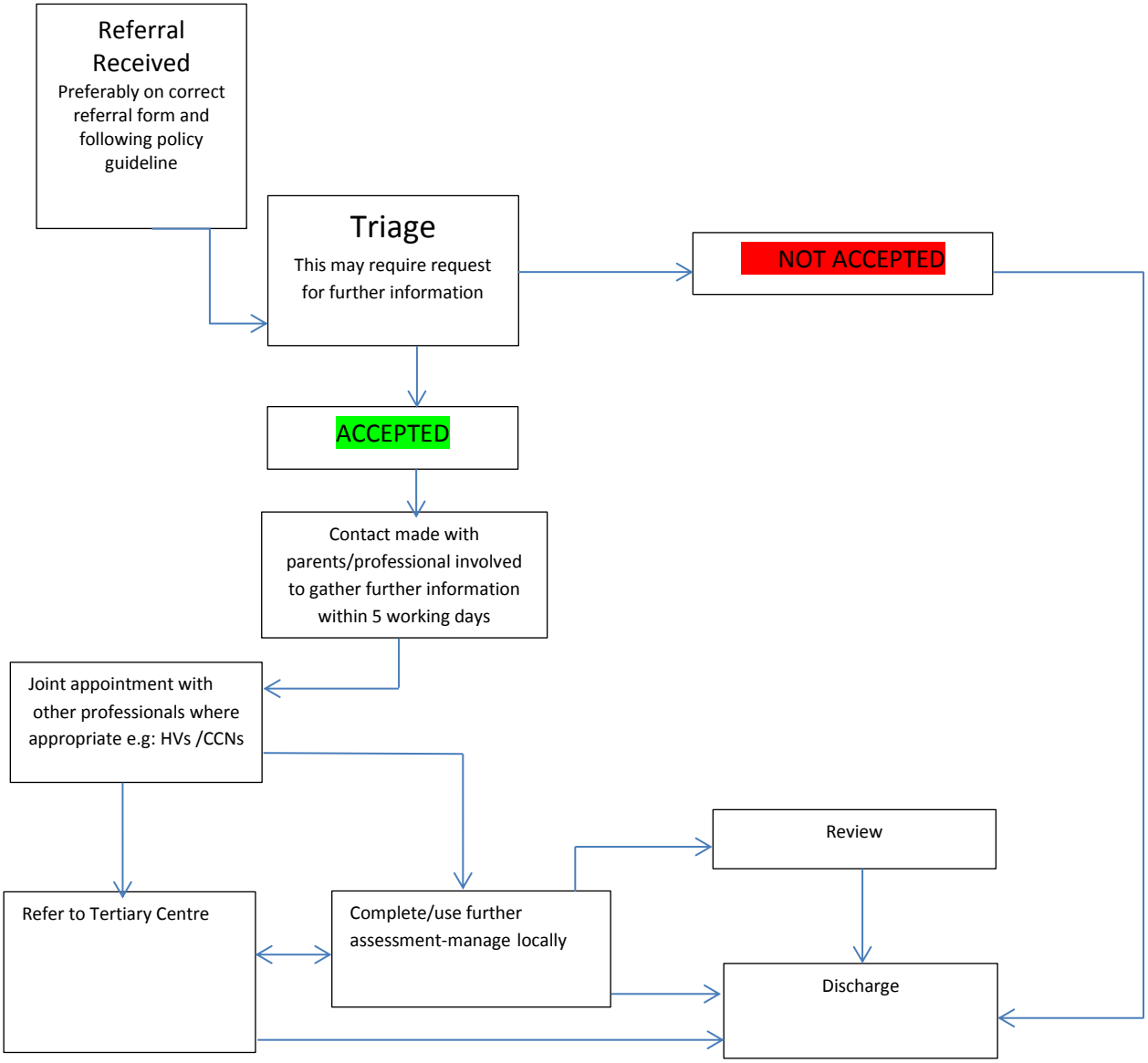
Cockerill, H.,Cullinan, K., Baker, L.,Jones, S.,(Eds) 2010. A Guide to Food and Drink Textures (revised edition).

Dysphagia Diet Food Texture Descriptors, 2011. NHS National Patient Safety Agency, http://www.thenncc.co.uk/assests/downloads/Food%20Descriptors%20for%20Industry%20Final%20-%20USE.pdf

RELATED TRUST POLICY/PROCEDURES

POL/001/073 Infant Feeding Policy

Appendix 1: Dysphagia Flowchart



BOX A – REFERRAL CRITERIA

Initial referral requests are appropriate for children who have:

- Failed to develop and maintain sucking, swallowing, chewing skills at an age appropriate to level.
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- Been identified as being high risk for developing long-term feeding difficulties Failed to control secretions i.e. drooling
- Obvious signs of chewing and / or swallowing difficulties e.g. choking / coughing / eyes watering / colour change / respiratory distress / gurgly voice quality.
- History of prematurity and / or difficulty in establishing oral feeding.
- Medical conditions and syndromes which are impacting on chewing and swallowing
- History of frequent chest infections in association with any of the above

BOX B – NOT APPROPRIATE FOR REFERRAL

Assessment by speech and language therapy cannot be offered for children with:

- Difficulties associated with weaning e.g. refusing solids, spitting out / refusing lumps.
- Difficulties which are behavioural e.g. food refusal / fussy eaters / restricted diet
- Poor Appetite

Version Control

Version	Amendment	Requested By	Undertaken By	Date
0.1	Original Document		HD	
0.2	Additional text and addition of Appendix 1	HW		27.07.16
0.3	Additional text	HW	SG and CS	10.10.16
0.4	Additions to section 5	HW	HW	30.05.17
0.5	EIA	HW	HW	30.05.17
0.6	Addition of appendices and monitoring compliance	HW	HW, BG	01.06.17

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