Kerry Parents & Friends Association

Dysphagia Policy

Written by:	**Clinical Nurse Specialist**
Reviewed by:	**Clinical Nurse Specialist**
Approved by:	**Neil Ashworth, Chief Executive**
Effective from:	**September 2009**
Reviewed:	**May 2015, November 2019 January 2023, January 2026**
Next Review Date:	**January 2029**
Distributed to:	**All Organisation**
Monitoring Mechanism:	**Clinical Nurse Specialist**

Date Printed:

KERRY PARENTS AND FRIENDS ASSOCIATION

DYSPHAGIA MANAGEMENT POLICY

1. INTRODUCTION

Dysphagia is a difficulty in swallowing food and/or drink. This policy will:

(a) Give further information regarding dysphagia.

(b) Identify risk factors that contribute to dysphagia.

(c) Define responsibilities in managing dysphagia difficulties.

(d) Identify how to access specialist assessment and treatment.

2. DYSPHAGIA

Dysphagia can arise from a wide range of neurological, structural, psychological and behavioural causes. These would include the following but is not an exclusive list:

- Stroke
- Parkinson Disease
- Dementia
- Other progressive diseases such as Muscular Dystrophy
- Epilepsy
- Medication relation side effects
- Cerebral Palsy
- Cancer
- Physical Intellectual Disabilities

2.1 Dysphagia may affect one or more of the four stages of the swallowing process.

Stage 1 – Oral Preparatory Stage.
The placement of food and/or drink into the mouth e.g. lip control.

Stage 2 – Oral Stage.
The preparation of food and/or drink in the mouth prior to swallow e.g. tongue control.

Stage 3 – Pharyngeal Stage.
Protection of the airway, the trachea, by closure of the vocal chords. Movement of the food and/or drink through the pharynx towards the final stage.

Stage 4 – Oesophageal Stage.
Transfer of food and/or drink through the oesophagus into the stomach.

Stages one and two are voluntary, stages three and four are involuntary. This means that the individual has a degree of control over one and two but not over three and four. Swallowing involves the co-ordination of 25 muscles and 5 nerves. We all swallow approximately 580 times per day. Consequently, there are many opportunities for risk factors to impact on an individual's wellbeing.

3. IDENTIFYING POTENTIAL RISK

3.1 Consequences of unidentified dysphagia problems.

Failure to identify dysphagia problems will have a devastating effect on the individual. These may include:

- Poor nutrition
- Re-current chest infections
- Aspiration pneumonia
- Choking
- Cognitive difficulties
- Respiratory Depression

3.2 Pre-existing conditions.

Person with pre-existing conditions such as those noted earlier in this policy, will potentially have a high risk of dysphagia. Swallowing difficulties may not be evident in the early stages of the illness. This needs to be a risk factor that is considered and reviewed as part of the risk management process.

Signs and Symptoms of Dysphagia – General:

- Difficulty managing saliva and drooling
- Absent or weak voluntary cough or swallow
- Changes in voice quality e.g. hoarseness; gurgly voice
- Decreased mouth and tongue movements
- Poor oral hygiene
- Changes in eating patterns e.g. reluctance to eat/drink; lengthy meals
- Raised temperature
- Weight loss and/or dehydration
- Re-current chest infections

3.3 Signs and Symptoms of Dysphagia – during eating and/or drinking.

These are possible indicators of a Dysphagia difficulty. A person we support may not experience all of these factors. The presentation may vary.

- Initiation of the swallow may be slow or delayed
- Un-coordinated chewing or swallowing
- Multiple swallows for each mouthful
- Pocketing of food in the cheeks.
- Oral or nasal regurgitation of food/drinks
- Extended time eating / drinking
- Choking, coughing or sneezing during/following eating/drinking
- Changes in pallor
- Eyes blinking and/or watering
- Laboured breathing

3.4 Signs and Symptoms of Dysphagia – after eating and/or drinking.

- Gurgly or hoarse voice
- Fatigue
- Changes in respiratory pattern
- Delayed regurgitation
- Coughing after eating or drinking

4. MANAGING RISK

4.1 All staff supporting people should be made aware of the signs and symptoms listed above. Staff have a responsibility for considering these factors when planning the delivery of a service to an individual.

4.2 All people who have been identified as having possible Dysphagia difficulties should be referred to the Speech and Language Therapy Department for specialist assessment.

4.3 The Speech and Language Therapist will require a referral from the responsible medical practitioner.

4.4 The outcome of the Dysphagia assessment may show no Dysphagia difficulties. In this case decisions regarding further investigations / management should be made in discussion with the person, members of the multi-professional team and family / carers as appropriate.

4.5 Management of the Dysphagia difficulty will include the individual, members of the multi-disciplinary team and family / carers. Maintenance of the persons physical and emotional well being are key considerations in Dysphagia management and should be paramount in the decision making process.

4.6 The manager / social care leader should insure that advice regarding the management of Dysphagia is recorded and available to the person we support and to other people responsible for caring for the individual.

4.7 All recommendations are documented in their individual mealtime support plan and update as required.

4.8 Training on Dysphasia will be scheduled as necessary.

5. CAPACITY, CONSENT AND SUPPORTED DECISION-MAKING

Where a person we support may have difficulty understanding, retaining, or communicating a decision about dysphagia assessment or treatment, staff must presume capacity and take all practicable steps to support the person to make the decision themselves. This includes providing information in accessible formats, allowing sufficient time, using familiar communication supports, and drawing on knowledge from those who know the person best to help interpret their will and preferences.

Consent must be understood as a process, not a one-off event. The person's consent or refusal may be expressed verbally, behaviorally, or through consistent patterns of response over time. These expressions must be recognised, respected,

and documented in line with the organisation's Consent Guidance and the person's *My Choices & Decisions* booklet.

Any rationale for capacity must relate only to the decision at hand and not be based on the person's diagnosis or on disagreement with their choice. If, despite appropriate supports, it is unclear whether the person can make this specific decision, staff should contact their line manager for support and direction.

Staff must always act in accordance with the person's known will and preferences, including any Advance Healthcare Directive or documented decision-making supports, and use the least restrictive option available. Relevant decision supporters, multidisciplinary team members, and—where appropriate—family members may be consulted to support understanding of what the person would likely choose for themselves.

Any intervention must be proportionate, clinically justified, and clearly documented, including:

- the supports provided to assist decision-making,
- how the person's will and preferences were identified,
- the rationale for the decision taken,
- and plans for review.

Legal advice should only be sought where required under the ADM Act or where there is significant uncertainty, dispute, or risk that cannot be resolved through supported decision-making processes.