Swallow Resource Pack

Frequently Asked Questions by Nursing and Care Home Staff

NHS Solent NHS Trust

Q) What are clinical indicators that someone may be aspirating?

Refer to Dysphagia (Swallowing Difficulties) Factsheet.

Q) What is the SLT role?

- To carry out a detailed assessment identifying specific level of impairment and to provide a specialist care plan.
- Assisting with differential medical diagnosis.
- Detecting, reducing and preventing aspiration.
- Carrying out intervention and stimulating improved swallow with appropriate exercises and techniques.
- Assess and refer if appropriate for instrumental investigations.

Q) What is the difference between coughing and choking?

Choking: This is when the airway becomes blocked and breathing stops or exhibits stridor. This requires intervention from someone else e.g. back slaps and abdominal thrusts, because the individual is unable to cough. Refer to Choking Factsheet.

Coughing: This is a reflexive response when food or drink tries to penetrate the airway. It is not life threatening at the time. However, if observed to happen regularly when eating and drinking, it may indicate an aspiration risk. Coughing may also occur when the airway is irritated by small particles, strong tastes, mucus and infection. Some people have 'habitual coughing' which also occurs when they are not eating or drinking.

Q) What is thickener used for?

A key element in reducing the risk of aspiration when drinking is to modify the texture of the fluid consumed by people with dysphagia. Thickened fluids are easier to swallow as they enter the pharynx slowly, allowing time for the pathway to the lungs to be closed off to avoid aspiration.

Q) Our resident is coughing when drinking normal fluids. Can we try them with thickened fluids? Do we still need to refer to SLT for an assessment if they are managing well on the thickened fluids?

If there are no other adverse clinical signs eg. Shortness of breath post swallow, wet voice, recurrent chest infections, refusing oral intake not related to progression of Dementia, thickening fluids is not always the required action. Often modifications such as changing the utensil used e.g. open cup instead of a beaker spout or straw, upright positioning, and the pace and amount given when being fed can be what is required.

- Refer to Safer Swallowing for fluids, Feeding Safely Routines, and Positioning for Feeding Fact Sheets.

- If indicated commence trials with naturally thickened fluids e.g. fruit juice or full fat milk.

- If you find this reduces coughing, request Thickener e.g. Nutilis Clear from their GP, as all non-naturally thickened fluids will need to be thickened to this Level 1 (1 scoop per 200ml)

Once you have completed the above and establish that your resident requires thickened fluids, please refer to SLT.

Q) Our resident is on thickened fluids but is now coughing on the recommended Level. Can I increase the level?

Yes, as you are taking proactive steps to reduce your residents risk of aspiration e.g. if on Level 1 move on to Level 2. Ensure all trials are supervised and documented. You may find that your resident can return to the previous level if they improve medically. They may also benefit from being managed on both Levels dependent on factors such as alertness, fatigue, positioning and mood.

Q) Our resident is on modified diet and managing well, can I increase the texture?

Check previous SLT reports for mention of silent aspiration or poor cough reflex. If there are none, and no new clinical signs they are an aspiration or a choking risk, you can upgrade their diet. However, you can only upgrade one level at a time. Ensure that trials are supervised and not one- off observations. These trials need to be documented. If you note any medical changes or difficulties such as reduced oral intake, return to their previous consistency. To upgrade:

Current Diet resident is managing	Trial on
IDDSI Level 4 Pureed (Previously known as Thick Puree Texture C)	IDDSI Level 5 Minced and Moist (Previously known as Pre-mashed Texture D)
IDDSI Level 5 Minced and Moist (Previously known as Pre-mashed Texture D)	IDDSI Level 6 Soft and Bite Sized (Previously known as Fork Mashable (Texture E)
IDDSI Level 6 Soft and Bite Sized (Previously known as Fork Mashable Texture E)	IDDSI Level 7 easy to chew This level is not suitable for anyone with dysphagia.

Q) Our resident is holding food in the mouth/ taking a long time to chew/ spitting out their food/ drink. Do I need to refer to SLT?

No, refer to the Referral Flow Chart. Complete the Managing Dysphagia checklist. Follow the Advice for Managing Challenging Eating and Drinking Behaviour, and Feeding Safely Routines advice sheets.

Q) If we have made diet modifications to make their swallowing easier and our resident is managing well e.g. moved from IDDSI Level 5 to IDDSI Level 4 diet, do I need to get SLT to confirm what I have done?

No – just make sure you clearly document what you have done and why. If the reason for the diet changes was a temporary medical deterioration e.g. UTI, and not general decline, and they have now recovered, trial them on their previous consistency. You do not want to keep them on a less textured diet unnecessarily.

Q) CQC requirements?

Refer to CQC and Speech and Language Therapy statement in folder.

Q) What qualifies as recurrent chest infections?

Three or more chest infections within a year, which may or may not require antibiotics. If your resident is having recurrent chest infections that are not related to colds and longstanding respiratory issues e.g. COPD/ asthma, this may suggest they are aspirating.

Q) Our resident keeps saying it hurts when they swallow or it feels like food is getting stuck. What should we do?

Review the Managing Reflux and Oesophageal Dysmotility advice sheet and follow recommendations. Check for oral thrush, dental decay and/ or other medical conditions – refer the individual to GP if issues are found. If no reason is found, and dietary modification does not help, refer to SLT to rule out oropharyngeal dysphagia.

Q) Our resident is having difficulty or refusing to take their medication. Should I refer?

No. Queries regarding medications should be raised with the pharmacist or the resident's GP. A review may reduce the number of tablets required and/or consider giving them in a soluble or liquid form. If your resident is on thickened fluids ensure that tablets are given with thickened fluids, one tablet at a time and ensure they are in an appropriate upright position.

Q) Can we give medication within a carrier such as smooth yoghurt? Is it being covert?

Queries regarding medications should be raised with the pharmacist or the resident's GP. When appropriate, medication can be given within a semi- solid carrier if there is no drug: food interaction. You must inform the resident. If they do not have capacity this becomes a best interest decision which should be made and documented as per your local policy.

Q) Should I refer to SLT regarding issues such as positioning, utensils, alertness etc.?

As your first step refer to the Feeding Safely Routines Fact Sheet to help manage these issues. Ensure you document what modifications you have made and why. If suggested modifications are not successful, or if your resident also presents with clinical signs of dysphagia, complete the Managing Dysphagia checklist then refer for a specialist Speech and Language Therapy assessment if necessary.

Q) We are aware of the SLT swallow recommendations for our resident and we are following them but the resident's family want to bring in or give our resident non recommended items. What should we do?You need to ascertain and document whether your resident has capacity to make a decision to eat and drink contrary to SLT recommendations.

If the resident does have capacity then it is his/her right to choose to eat and drink what he/she chooses, with an understanding of the risks involved. This discussion needs to be clearly documented and the manager/senior nursing staff should be involved in the discussion.

If the resident does not have capacity to choose to eat and drink at risk then a best interests decision should be made, with senior staff, family and GP as appropriate.
The decision should be clearly documented.

Q) Our resident is 'eating and drinking with acknowledged risk' What does this mean?

This means that despite the fact the resident is on the safest consistencies possible, with strategies in place to manage the risk, there remains a risk of aspiration and/or choking, which is unlikely to change. Advanced care planning should be in place regarding whether the resident should be treated and/or admitted to hospital for a chest infection or other complications ensuing from aspiration. This should be discussed with the resident, GP, family and care staff as appropriate.

The resident may also choose to eat and drink 'at risk' against SLT recommendations if he/she can demonstrate capacity to make and communicate this decision. This should be fully discussed and documented, as above.