Swallow Resource Pack

NHS Solent NHS Trust

Guidance - When to refer to Speech and Language Therapy for Swallow Difficulties

How and when to refer to SLT?

Refer to the Nursing and Care Home Swallow Resource Pack
https://www.solent.nhs.uk/our-services/services-listings/adult-speech-and-language-therapy-portsmouth/

1. Review the Referral Flow Chart found in the pack.
2. Complete the Managing Dysphagia Check List.
3. Refer to appropriate Fact Sheets and Frequently Asked Questions to support your decision making.
4. If referring contact SPA on 0300- 300 2011 and make sure you provide all requested information to help with triage.
5. Email copy of completed Dysphagia Checklist to snhs.slt.community@nhs.net. This document will support your reason for referral.

When to refer?

- Difficulty with fluids that may require them to be thickened. If presenting with adverse clinical signs, do not leave them while waiting to be managed by SLT. Refer to Frequently Asked Questions for advice on how to manage.

- You have followed the guidance in the Swallow Resource Pack and taken steps to manage any risks and your resident continues to present with swallowing difficulties not related to challenging behaviours, positioning issues or purely medication.

- Complex Neurological condition e.g. Huntington's Disease, MND.

- New dysphagia and presenting with multiple dysphagia warning signs e.g. chest infections, wet voice.

What can you manage without a specialist SLT assessment. No need to refer.

- Diet texture change – to make it easier to swallow. No more than 2 dietary Levels. Trial a lower Level IDDSI diet, one step-change at a time e.g. Level 7 Normal Diet, Level 6 Soft Bite Sized to Level 5 Minced Moist. Refer to Frequently Asked Questions in Swallow Resource Pack.

- Diet texture change – increase complexity due to improvement. No previous concerns of choking risk. Trial higher level IDDSI diet one step-change at a time.

- Best interest – SLT recommendations are in place with a known risk of aspiration or choking but patient and/or family requesting upgrade in diet and/or fluids. The home will need to arrange an MDT meeting with GP and NOK to agree a care plan ensuring that a balance is maintained between independence, safety, nutritional requirements and quality of life.

What is an inappropriate referral?

- Issues with dentition impacting chewing, absence of other swallowing difficulties.
- Issues with swallowing medication, absence of other swallowing difficulties.
- Issues with challenging eating and drinking behaviours and no clinical signs of dysphagia.
- Already has a SLT care plan in place and not being followed.
- Agreed Eating and Drinking with Acknowledged Risk in place.
- Weight loss in the absence of swallowing problems e.g. Gastro..
- Vomiting or gastro-oesophageal problems in the absence of other swallowing difficulties.
- Resident wants to eat a softer diet.
- Too drowsy to eat and drink.
- One off choking incident – refer to Choking versus Aspiration Fact Sheet.
- Poor positioning .
- Specialist SLT assessment not required, referral for completion and endorsement of Nursing/Care Home documentation.
- A resident deemed to have Mental Capacity for choices around eating and drinking, who chooses to eat or drink against SLT recommendations.
- End of Life – if your resident is considered palliative, medication has been stopped and/or they are declining or too drowsy to eat and drink consider if SLT input will be of benefit to the individual. Declining oral intake is a natural part of the dying process.

The Solent Nursing and Care Home Swallow Resource Pack is a comprehensive resource that will guide you and ensure only residents that require a specialist SLT assessment are referred.