

Speech and Language Therapy is not always required when a resident is showing signs of a possible difficulty swallowing. Please follow the guidance and management suggestions below prior to making a referral.

Safe Swallowing Guidelines

If you have identified that a resident is having difficulties with eating & drinking, please ensure that:

- They are **alert** enough to be eating/drinking.
- They are sitting as **upright** as possible for all food and drink.
- They are not being assisted to eat/drink if they are able to do this independently/with support.
- If they are being assisted, sit at eye level & assist at a slow pace, watching for each swallow & ensuring mouth is clear before offering more.
- Their mouth is clean and free from infection/sores.
- If appropriate, they are wearing their dentures and they fit well – use fixative if necessary.
- They do not have a spout on their beaker unless there is a clear reason for this.
- Check the mouth is clear of food residue at the end of meals.

Changes to food only

There is no need to refer to SLT if:

You have made changes to food texture, and this has improved the signs of risk that you had been concerned about **and** they are still meeting their nutritional requirements.

and either:

- a) They have capacity and have agreed to this change
- b) A decision has been made in their best interests, consulting the GP and any involved next of kin/power of attorneys.

Please note:

- Modify the texture to the least restrictive option possible e.g., don't move straight from a normal diet to a pureed diet.
- Only restrict for as long as necessary e.g., if struggling due to infection, review once infection cleared
- Document in the care plan, including reason for modifying and plan to monitor/review.

Use of thickener

Thickener should only be used after assessment by a speech & language therapist. The use of thickener comes with risks and so should only be used with caution, weighing up the risks and benefits.

The resident does not want to follow previous recommendations / consistency changes made to their diet or fluids:

If they have capacity

- it is their right to decline the recommendations, so long as the risks have been clearly explained to them and they understand.
- document your capacity assessment and the patient's decision clearly in the patient's care plan and inform the GP.

If they do not have capacity

- a best interests decision needs to be made.
- whether this is to continue with the recommendations or not needs to be clearly documented, along with capacity assessment, risk-reducing measures, and advanced care planning if aspiration or choking occurs.
- this requires multidisciplinary discussion between the staff, next of kin, power of attorney and GP.

The person is known to be 'eating and drinking at risk'.

- this means that assessment has already shown that whatever consistency modifications the resident has been recommended, there is still a high risk that they will continue to have swallowing difficulties and that they may aspirate and get chest infections now and in the future.
- there should already be clear guidelines in place for that patient from an SLT or medical professional, so refer back to these.
- the patient (if they have capacity), GP, staff, next of kin and power of attorney should agree future management in these circumstances e.g., whether or not to admit into hospital for chest infection treatment.
- if there has been a significant change in the person's medical status or wishes, which make the existing eating and drinking at risk guidelines no longer appropriate, refer to GP to discuss management. Referral to SLT can then be made if appropriate.

Guidance notes: Referrals to Speech and Language Therapy for swallowing/dysphagia

Common difficulties and suggested strategies/action:

Concern identified	Suggested action
Difficulty swallowing tablets – no other concerns re swallow	<ul style="list-style-type: none"> – Offer tablets with thicker consistency e.g., yoghurt, smoothie. – If unsuccessful, request meds review from GP.
Difficulty chewing due to lack of teeth/loose dentures	<ul style="list-style-type: none"> – Try fixative to see if this helps – Consider taking dentures out for meals – Offer easier to chew consistencies
Difficulty chewing	<ul style="list-style-type: none"> – Modify diet to softer consistencies
Chewing meat for a long time	<ul style="list-style-type: none"> – Offer soft, moist meat, cut up small with plenty of sauce/gravy – Offer minced & moist meat – Offer pureed meat
Resident prefers to eat a softer diet	<ul style="list-style-type: none"> – Patient choice – no need for swallow assessment
Coughing with dry, crumbly consistencies e.g., pastry, biscuits, crisps, toast	Offer soft, moist alternatives e.g., Jaffa cake instead of biscuit, melt in the mouth crisps e.g., Skips, Quavers, toast if lightly toasted & well buttered
A one-off coughing incident	Monitor – if no further concerns, no need to refer to SLT
Coughing occasionally when eating/drinking	If no distress to resident & no impact on health (e.g., regular/recurrent chest infections, reduced food/fluid intake, weight loss, no avoidance of food or drink, no intervention to clear the throat/mouth e.g., back slaps) then there is no need to refer to SLT
Coughing frequently with drinks	<ul style="list-style-type: none"> – Follow general guidance above – upright, alert, no spout – Offer chilled drinks, fizzy drinks, strong flavours, sour flavours e.g., lilt/Vimto/ginger beer/tonic water. – Offer naturally thicker drinks e.g., pineapple juice, milky coffee. – If resident is distressed and reluctant to drink, or is having recurrent chest infections, refer to SLT

Common difficulties and suggested strategies/action:

Concern identified	Suggested action
Losing weight/small appetite – no swallowing issues identified	<ul style="list-style-type: none"> – Follow 'Food First' pathway. – Offer small portions more often throughout the day. – Offer preferred flavours. – Offer high calorie/nutritious drinks in place of sugar free squash, water etc. – Consider referral to dietitian
Declining main meal but eating puddings	<ul style="list-style-type: none"> – Try adding extra flavour to main meals e.g., tomato sauce, brown sauce, salt & pepper, sweet chilli sauce, honey, sugar. – Offer 2 x puddings
Spitting out bits in food e.g., mince, pea shells	<ul style="list-style-type: none"> – Avoid textures known to cause difficulty e.g., fruit/veg skins. – Serve mince in thick sauce/gravy. – Consider modifying texture of meals to smooth puree – may still enjoy soft sandwiches, cake etc. if no bits.
Holding food/drinks in mouth	<ul style="list-style-type: none"> – Reduce distractions e.g., sit in quiet space for meals. – Increase oral awareness e.g., cold, strong flavours, fizzy drinks. – Vary the size of mouthful but avoid over large mouthfuls. – Alternate food & drinks – Verbal prompts to swallow. – Offer empty spoon to 'trick' a swallow
Taking a long time to eat/drink but finishing meals	<ul style="list-style-type: none"> – Allow extra time. – Offer encouragement/prompting. – Consider insulated cups/plates/bowls. – Consider moving to a less distracting environment for meals. – Monitor food/fluid intake
Stopped eating and drinking as they approach end of life	<ul style="list-style-type: none"> – Offer regular oral care, keep lips and mouth moist. – No need to refer to SLT
Declining food/minimal intake via a spoon but still drinking well	<ul style="list-style-type: none"> – Offer high calorie, nutritious drinks in place of squash/water. – Offer fortified liquidised diet/soups/smoothies etc. via a cup