ILLUSTRATION BY **Rosan Magar**

Risk feeding: from protocol to model of care

Dharinee Hansjee explains how her risk-feeding protocol, established to guide decision-making regarding feeding options with the frail elderly population, has evolved into a model of care

Swallowing difficulties are common in the frail elderly (Smithard, 2016), and decision-making regarding feeding options are complex. An extensive literature search on the management of nutrition in this population group reveals evidence against tube feeding and proposes careful risk feeding (eating and drinking despite the risk of developing aspiration pneumonia) as the preferred route of intake (Smith et al, 2009; RCP, 2010). In addition, nutritional decisions at the end of life are ethically complex, particularly if the individual lacks decision-making capacity (Clarke et al, 2015). To bring clarity to these complex feeding decisions, I devised a risk-feeding protocol, which has since evolved into a model of care and is now available as a toolkit.

Devising the protocol

According to NICE clinical guideline 32, 'Nutrition support for adults' (NICE, 2006), the person's individual beliefs, preferences, needs and best interests should be central to the decision-making process when determining feeding options. Establishing a protocol to guide decision-making addresses these key aspects. Through the use of our risk-feeding protocol, we have ensured consistent, open discussions about the risks associated with eating and drinking, which form an essential part of the individual's care. In addition, information leaflets explaining the management options and risks have been devised to support the individual or their carers in making informed decisions about their nutrition.

The protocol stimulates a problem-solving approach from the multidisciplinary team (MDT) and individual/significant other. Aside from discussions with the nurses, doctors and dietitians, there is involvement from physiotherapy regarding chest management and establishing a ceiling of care. The palliative care team also provides input on end-of-life care, while social services and discharge teams are proactively involved in the consideration of risk feeding within discharge planning. This process promotes robust communication between the acute and community settings, which is essential for a safer and co-ordinated discharge (NICE, 2015). Throughout the process, the individual and/or significant other are involved in decisions about their care.

Learning and development

Since the inception and implementation of the risk-feeding protocol, there have been some substantial developments. These illustrate the evolution of the risk-feeding protocol into a model of care.

As this is a population group at high risk of aspirating, a review of their medication is essential. We therefore added a prompt for a full medication review to the original risk-feeding protocol to ensure medication is provided in a form that is easier to swallow. In this way, risks of possible aspiration of medication are also considered. This review could be carried out by a pharmacist in the acute setting or a GP in a community setting.

A considerable learning point has been the need to have a risk-feeding policy in place to accompany the roll-out of the protocol. The complexity of implementing a risk-feeding pathway lies in engagement and ownership of the individual roles of the MDT to ensure the pathway is robust. The policy is therefore crucial in empowering the hospital team and wider pathways in understanding the purpose, scope and their role within the risk-feeding process.

One further addition to the protocol was the consideration of an advanced care plan, if appropriate. The risk-feeding process invites the MDT and individual to discuss future management in the form of an advanced care plan or PEACE (Proactive Elderly Advance CarE) document. For individuals who experience recurrent aspiration pneumonia-related admissions, this has led to clarity of personal/family wishes, and empowers the individual and/or their carers to be involved in their care, while simultaneously allowing the professional to improve end-of-life care for that individual. The documentation of decisions on current and future nutritional management allows accurate handover to receiving teams, such as GPs, care homes, and health and social care services.

So, what started off as a protocol has evolved into a model of care. This approach reflects the principles inherent within the NICE clinical guideline 27 (NICE, 2015) for improving transfers of care between community and hospital settings. The risk-feeding model of care offers a decision-making process that supports the person in their current setting, allowing for an individualised plan of care that is more than just managing swallowing and its disorders. This model of care is about contributing to safer, high-quality, end-of-life care.

What is the risk-feeding protocol?

The risk-feeding protocol provides the MDT with a person-centred framework to facilitate decisions on nutrition planning. It outlines the reasons why a person may be a candidate for risk feeding, with the document addressing capacity, quality of life and multidisciplinary discussions with the person/family. The management plan is authorised by signatures from the consultant and SLT. Risk-reducing recommendations are included to ensure the person is on the least distressing diet and fluid regime.

To ensure best practice, we have developed a risk-feeding toolkit, which contains:

- the protocol;
- the policy (outlining the roles and responsibilities of the MDT, and therefore is essential to accompany the implementation of a protocol);
- an information leaflet on risk feeding;
- a bed sign to indicate 'Eating & drinking for comfort'; and
- a letter template for communication with the GP following discharge.

Guiding principles

What has become evident in the evolution of this model of care is the application of the following guiding principles:

- Establish the primary goal of intervention/care
- Establish the mental capacity of the individual at the centre of decision-making
- Ensure a comprehensive clinical assessment of swallowing is completed in order to determine risk-reducing recommendations
- Facilitate thorough communication with MDT members to foster holistic patient-centred care
- Set out an advance care plan, where appropriate, and in keeping with the wishes/best interests of the individual

Impact

An analysis of the data from an audit of our risk-feeding model of care revealed various areas of impact:

- A reduction in length of stay for hospital admissions in this cohort
- The value of SLT input into accident and emergency impacting on admission avoidance
- Qualitative data from service users/carers reflecting the significance of this model of care in considering the individual's quality of life and inclusion in future planning
- Cost savings across the NHS

We will be sharing more information about the impact of a risk-feeding pathway at our next study day, 'From protocol to model of care', at Lewisham Hospital on 22 January. If you would like to come along and find out more, please email lucytaylor7@nhs.net to secure your place. ■

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