Risk feeding: The story continues

Dharinee Hansjee discusses the review of her risk feeding protocols and processes

ILLUSTRATION BY **Dale Edwin Murray**

The decision-making process regarding whether to provide a person with artificial nutrition and hydration or continue to allow food and drink orally once their swallowing becomes unsafe, provokes difficult ethical decisions for professionals and patients (Chaklader, 2012).

In 2011, I devised a protocol to coordinate a multidisciplinary decision on feeding with the acknowledged risk of developing aspiration pneumonia. This addresses capacity, ethics and quality of life issues, providing the multidisciplinary team with a patient-centred framework to facilitate decisions on nutrition planning. Publication of this initiative in the February 2013 Bulletin, sparked national and international interest, with more than 50 organisations requesting a copy of the protocol. In October 2014, I delivered a presentation at the South African Speech Language Hearing Association's 50th Congress.

In February 2015, I conducted an international survey on the protocol and processes involved in risk feeding. I emailed a link to the survey to 64 practitioners who had expressed interest and requested a copy of the protocol. With a 90 % response rate, the cohort comprised of clinicians from 49 NHS trusts and international participants from Australia, New Zealand, Gibraltar and Spain. From the 58 participants who responded, 19 indicated that a risk feeding protocol was in place, while 24 were in the process of setting one up. Although keen on establishing a pathway, 15 respondents said they had not yet done so.

Adaptations

The survey results revealed some participants to be using the tool in its original form, while others had made minor adaptations to make it relevant to their respective settings. Some clinicians modified the document for use with patients fed via percutaneous endoscopic gastrostomy tube but who choose to have tastes for pleasure. Participants reported altering the wording slightly; one indicated receiving assistance from their mental health team on the inclusion of a flow chart to facilitate decision making.

There was another noted adaptation where a signature space was included for the patient or carer to acknowledge that a discussion on the risks involved had taken place. One particular NHS trust used the protocol as part of a 'bundle' of care. Although the document continues to be utilised predominantly for the dementia population, all participants using the tool, denote that they use it across a range of diagnoses and settings.

The process

What was evident from the survey results is the ongoing need for multidisciplinary team training to develop skills and knowledge in identifying when a patient is suitable for the risk feeding pathway. Within my local setting, extensive formal training continues with the medical teams on the admission wards and the nursing staff on the older people's wards.

Further along in my implementation, I included an important step in the process by devising an information leaflet for discussion with the patient/next of kin. Some clinicians reflected using an information leaflet as part of the process whereas others indicated that although a

leaflet was utilised in discussions with carers, a protocol had not yet been established. Within this setting we have created a risk feeding register where we log patients who are on the pathway.

This captures their primary diagnosis, reason for initiation of the protocol and a record of any subsequent readmissions. While some organisations choose to discharge a patient once they are risk feeding, within this acute setting, we monitor the patient through to discharge in order to complete the loop of care.

I have worked closely with the geriatricians in adapting discharge summaries and advanced healthcare plans to include risk feeding as a prompt to attach the necessary paperwork on discharge. This forms a crucial stage in the process, allowing the patient to leave the acute setting with a clear plan in place informing future management.

On discharge, the patient's GP receives a letter and information leaflets and guidance go to their home/nursing home. Several survey respondents outlined this step within their implementation of the pathway.

We have drawn up a flowchart for management of risk feeding in the community, in collaboration with the community team.

A referral to the community team is made for every patient with a risk feeding plan in place. Our community teams report they are able to manage the numbers of referrals because it usually involves a one-off visit to support the carers if needed, steps to ensure carers/GPs are aware of the patient being risk fed and further checks to ensure the associated paperwork has been completed. An alert set up on the hospital electronic patient system identifies patients who are being risk fed – an aspect other participants survey have highlighted. All these steps are vital to avoiding aspiration-related readmissions within this client group.

Continuity of care

With the rising incidence of dysphagia in older people in hospitals (Leder and Suiter, 2009), geriatricians are more frequently seeking advice from their multidisciplinary team colleagues on nutrition planning (Chaklader, 2012). The survey results reflect this, indicating older people's teams are supportive of the pathway and find the protocol beneficial.

Although the survey participants noted a reduction in wait times for a nutritional plan to be put in place, a number were in the early stages of the introduction of a protocol – therefore, formal audit results were unavailable. However, all participants using a protocol expressed positive, coordinated management of the patient with increased awareness from the multidisciplinary team of risk feeding and a pragmatic approach to management.

I am using our own risk feeding register as an outcome measure in monitoring readmissions with chest infections. As raised in the survey, capturing readmissions is a challenge; however, having an electronic system did facilitate retrieval of readmission data and the reasons for readmission. Some organisations are capturing data regarding the length of time the patient was placed nil by mouth until risk feeding commenced, but had nothing formal to report on.

Next steps

I have scheduled a local meeting with the commissioning lead and the acute/community leads to review documentation and improve the pathway of care.

I am also devising a patient/carer experience questionnaire to evaluate the risk feeding pathway and am working on a risk feeding policy to include alongside the protocol to ensure robustness. Once this is complete, as a way of generating income for the trust, a risk feeding pack will be available for purchase. This will include the protocol, policy, information leaflets and patient experience questionnaire.

As risk feeding, is an under-researched area that still needs evaluation, I have put a proposal to the RCSLT requesting a clinical guideline for risk feeding. The RCSLT has responded with plans to work alongside NHS England and key strategic stakeholders to agree the high-level principles around working with patients with dysphagia and managing risk. ■

Risk feeding protocol timeline

2011
risk feeding protocol coordinates decision on feeding with acknowledged risk of aspiration pneumonia

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2013
more 50 than organisations request copy of the protocol after Bulletin exposure

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2015
58 practitioners respond to survey on use of the protocol

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References & resources

Hansjee D. A safer approach to risk feeding. *RCSLT Bulletin* February 2013; 730, 20-21.

Chakladar E, *Dysphagia management for older people towards the end of life*. 2015 Available at: http://tinyurl.com/qh4vdas

Leder SB. Suiter, DM. An epidemiologic study on aging and dysphagia in the acute care hospitalized population 2000-2007. *Gerontology* 2009; 55; 714-718.