Risk assessment

Dharinee Hansjee and colleagues share a consultation on the term 'risk feeding'

ILLUSTRATION BY **Joe Waldron**

The decision to continue eating and drinking despite the risk of developing aspiration pneumonia is referred to in the literature as 'risk feeding' (RCSLT, 2005). In clinical practice, the term 'feeding at risk' is also frequently used to describe this scenario. Although addressing end-of-life care, the terminology has wider application within a diverse adult caseload. Implementing a risk feeding policy and model of care at Lewisham and Greenwich NHS Trust in 2016 prompted rich discussions with services nationwide and internationally. The use of the term 'risk feeding' is a recurring concern from SLTs, regarding appropriateness and application across client groups.

Survey

In October 2017, we undertook a multidisciplinary (MDT) consultation regarding the term 'risk feeding' via an online survey tool. Questions addressing the most common concerns were disseminated via clinical forums and social media, yielding 367 responses: 91% SLTs, 6% doctors, 2% dietitians, and 1% nurses.

Multiple settings were represented: 44% inpatient, 18% community adults with a learning disability, 16% general adult community, 10% mixed post, and 12% other. Quantitative and qualitative data were captured from nine survey questions.

1. What is your discipline? Please describe your setting.
2. Do you use a consistent term for service users who eat and drink with acknowledged risk of aspiration across settings (e.g. transferring from acute to community)?
3. Do you use a different term depending on the audience (i.e. MDT team vs. family vs. nursing staff/care homes)?
4. What are your feelings or thoughts about the term 'risk feeding'?
5. If you wanted to signpost a service user or relative to further reading on the internet, what would you advise they search for?
6. What feedback have you sought or been given by service users and their relatives regarding the term 'risk feeding' or use of the word 'risk'?
7. How has this feedback been collated?
8. Do you think there needs to be a nationally agreed term recognised in all settings for all service users who eat and drink with acknowledged risk of aspiration?
9. What are your suggestions for identifying a suitable term acceptable to all those involved in this aspect of service user/client management?

Results

The results showed that 71% of respondents used a consistent term: 39% used 'risk feeding'; 21% 'feeding at risk'; 7% 'eating and drinking at risk'; while the remaining 33% used terms with a 1% or smaller consensus, e.g. 'pragmatic feeding', 'best interest feeding', and 'quality of life feeding'.

Thoughts and feelings on the term 'risk feeding' were thematically analysed into the categories shown in the table below:

Category	*Example*
Positive	"It is **open about the risk** that they are facing" "It **accurately describes** what is happening" "It's a term that is **concise and succinct**" "**More honest** than comfort feeding"
Negative	"**Feeding** animals at the zoo" "**Scary** for the individual and their families" "Implies **killing** people with every spoon" "Loaded with **anxiety and guilt**"
Neutral	"**Appropriate for the acute setting**...don't think it works well for the community setting" "Ambiguous – requires **guidance to go alongside it**" "It **communicates the importance** of the situation but can make people nervous"

Analysis

Further analysis of the survey results within these categories highlighted a number of factors influencing professionals' opinions on the term 'risk feeding':

■ The use of 'risk'

Although some professionals explained the usefulness in being explicit about the risks involved, there were others who raised concerns over the fear and anxiety that may be evoked by the use of the word 'risk'. It is of note that 67% of survey participants from a range of settings suggested terminology that included the word 'risk', with respondents acknowledging their duty of care in identifying the 'level of risk' and 'being explicit', particularly to inform decision-making about long-term alternative nutrition and hydration (ANH).

■ Setting

There was acknowledgement that the setting influenced terminology, scope and nature of discussions. The professionals who felt positively about the term (43%) were from a variety of settings, but 62% were from an acute inpatient setting. They expressed the usefulness of having a concise term to describe the management plan.

■ Impact

Strong concerns were raised by some (29%) that using the term 'risk feeding' is 'scary', instead preferring 'quality of life' and 'tastes for pleasure'. However, the survey evidenced limited formal feedback (24%) being sought from service users and families about the term or use of the word 'risk'. Other concerns regarding carers and the legal standpoint of supporting those at high risk of aspiration were raised, reflecting survey findings that clinicians recognise carers' anxiety and the need to address this through education.

■ Ambiguity

A number of professionals (28%) felt that 'risk feeding' could be attributed to various clinical dilemmas. The term can be applied to the individual with capacity who declines ANH and chooses to eat and drink with choking risks, and the individual who is nearing the end of their life, where the overriding choice is quality of life. Arguably, if someone has ANH in place, the risk of developing chest infections remains and this could also be referred to as 'risk feeding'. Respondents requested the need for expansion in the terminology to specify the goal of intervention.

■ 'Risk feeding' as a label

Concerns were voiced about a tendency to label people as 'risk feeding', leading to assumptions which might predetermine management, e.g. no longer for active treatment, lacking capacity, etc. There were 82% who felt that a consistent term is needed as it signifies to the interdisciplinary team their respective duties of care within a coordinated care pathway. A consistent term would signpost professionals to guiding principles (Hansjee, 2018) encompassing the primary goal of intervention, a focus on quality of life and patient-centred advance planning.

Suggested solutions from survey

1. Terminology to be used only when there is a supportive, person-centred framework in place to guide decisions on eating and drinking at risk.
2. Consider replacing 'feeding' with 'eating and drinking' in terminology used.
3. A robust MDT training programme must accompany the implementation of a model of care to guide decisions.
4. Use information leaflets to support discussions with individuals and carers as internet searches could be misleading due to variations in terminology (Department of Health, 2003).
5. Involve service users/carers/groups to gather formal feedback on terminology.
6. Engage systems-wide professional bodies, e.g. General Medical Council, Royal College of Physicians, British Dietitic Association in development of interprofessional national guidelines.

Conclusion

The survey has highlighted both enablers and barriers to the use of the term 'risk feeding', as well as some solutions for consideration. Consensus on terminology will need to be collaborative, requiring systems-wide involvement from the respective disciplines. Our duty of care is to objectively guide individuals and families, with an emphasis on the value of the discussion and the interdisciplinary model of care underpinning these decisions. Locally agreed terminology should be the way forward until a national consensus is agreed. ■

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