Lewisham and Greenwich NHS
NHS Trust

A SAFER APPROACH TO RISK FEEDING

Timely MDT decision making within a supportive framework of care

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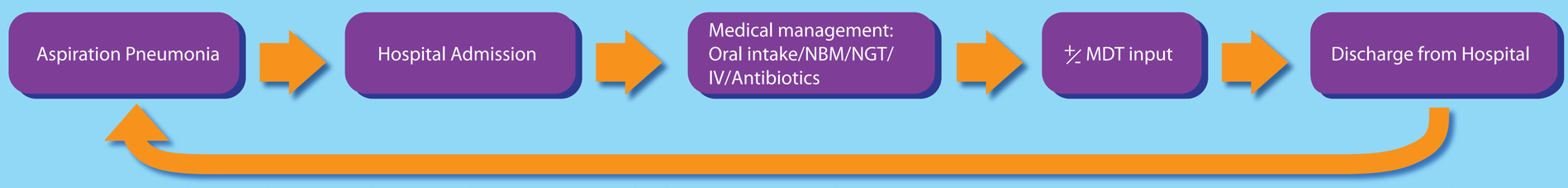
BACKGROUND

Ageing does not necessarily cause dysphagia, but the potential for developing dysphagia becomes increasingly common with advancing age (Leder & Suiter, 2009). The rising incidence of dysphagia for older people in hospitals, particularly those over 80 years of age, has many health implications including malnutrition, dehydration, poor oral hygiene, choking, and aspiration pneumonia. Pneumonia is one of the principle causes of admission in the ageing population, associated with increasing severity of cognitive impairment and dementia (Sampson et al 2009).

A historical and familiar model of care is reflected in the diagram below



A patient may be an inappropriate candidate for artificial nutrition and hydration (ANH) if the procedure risk outweighs the benefit; the patient themselves decline ANH or there is poor prognosis/a short life expectancy. Clinicians are then faced with the dilemma of how best to manage these patients who are unsuitable for ANH but at risk of choking on food/fluid and developing an aspiration pneumonia.

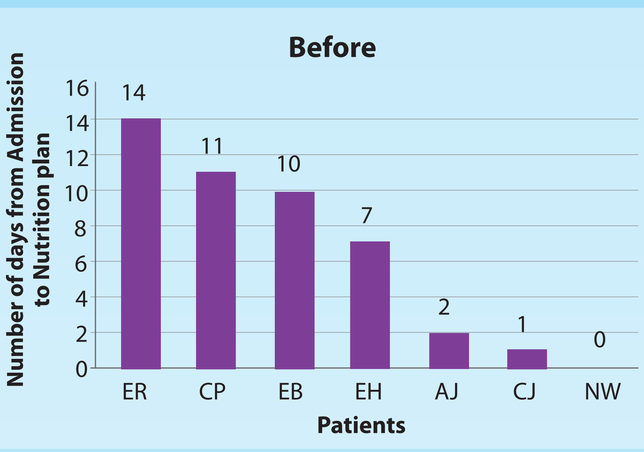
The decision-making process regarding whether to introduce ANH or continue to allow food and drink orally once the individual's swallow becomes unsafe, encompasses difficult ethical decisions for professionals, patients and carers.

RETROSPECTIVE AUDIT

The aim of the audit was to establish the number of days from admission to when a nutrition plan was put in place. Case note reviews were undertaken to retrieve this information.

The crucial finding from this audit was that there were obvious delays in nutrition planning for five out of the seven patients. Further analysis of the medical notes revealed that following beside dysphagia assessment by SLT, the patients were found to be unsafe on all oral intake and at significant risk for development of aspiration pneumonia. A MDT discussion was essential to establish a plan for nutrition. The time taken towards clinical decision making resulted in significant delays in the process.

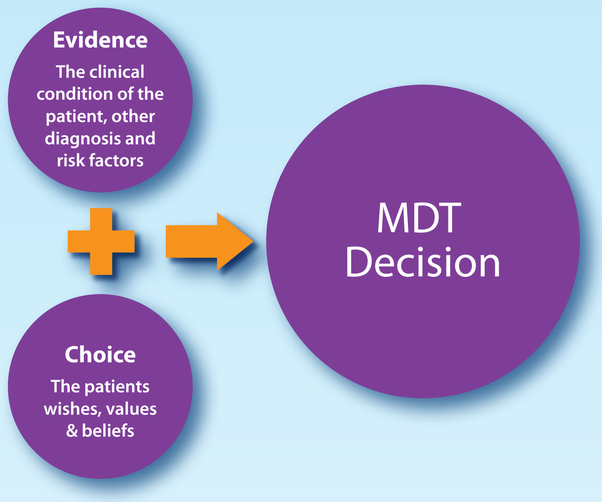
The other key finding related to the inconsistencies of the diet regime for this cohort population. Some patients were placed on a normal diet and fluid and referred to SLT when there was reduced oral intake while others were left nil by mouth with IV fluids, compromising safety and comfort.



These findings highlighted the need to introduce a process to better manage nutrition and hydration in this patient group. It seemed integral to develop a system that would inform and hasten the decision making process which led to the development of a 'risk feeding' protocol.

RISK FEEDING

A risk feeding protocol was devised to guide acute teams through an organised decision making process, encompassing patient choice and multidisciplinary clinical input to what is acknowledged to be an ethically fraught area.

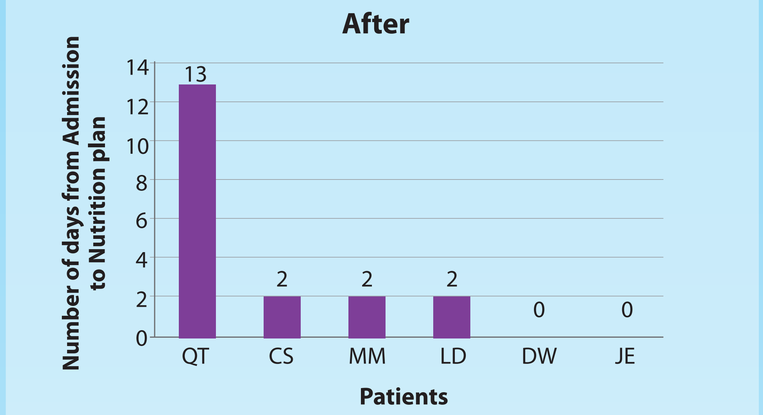


The risk feeding process seeks to overcome or minimize the difficulties faced by patients who are at risk when eating and drinking. It underpins a decision making process which promotes patient choice and quality of life. Once the document was devised and had passed through local governance, ethics and legal boards, extensive training was conducted on the risk feeding process.

IMPACT

In order to establish the impact of the risk feeding document a repeat audit was conducted after 6 months.

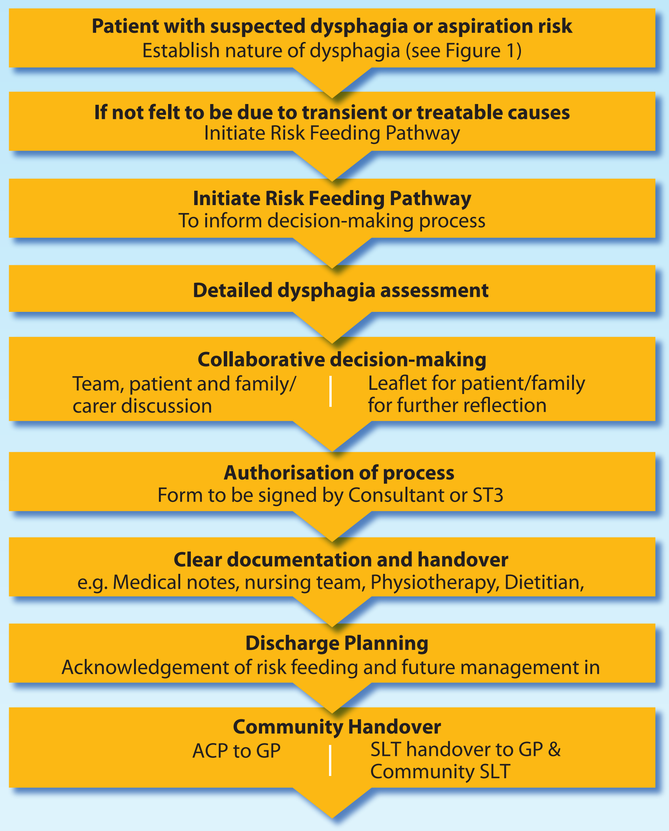
A retrospective audit was conducted on 6 patients, from an elderly care ward, where the risk feeding process was being used during the month of February. Not all patients had a confirmed diagnosis of dementia but all lacked capacity to make an informed decision to have oral intake with acknowledged risk of aspiration.



Despite the slightly smaller number of patients involved in the second audit, a significant decrease of 50% in the number of days taken to put a nutritional plan in place was reflected. The reduction to approximately 2.5 days as the average wait time for nutritional planning is substantial and according to the literature, has a significant impact on patient outcomes.

According to the NAO (2016), unnecessary stays in hospital, increase the long term care needs of the patient. This in turn results in comprised health outcomes for patients and wastes already strained NHS resources. It is therefore essential to offer a framework of care which encompasses a supported discharge from hospital including SLT follow up if indicated and inclusion of GP to reinforce future care planning. This duty of care enables the patient and those around them to be cared for in their own environment, preventing the revolving door of readmissions. It allows cohesive care of community patients in collaboration with GP practices and enables the patient who is risk feeding to be supported and managed at home.

Supportive Framework of care



LOCAL DEVELOPMENTS IN RISK FEEDING

- An information leaflet was devised for the patient/carer to be able to make an informed decision about a nutritional plan
- A risk feeding policy has been developed which carefully considers all aspects of the risk feeding process.
- Clinical alerts are now set up on the electronic patient system to indicate risk feeding and the diet /fluid regime
- A local risk feeding register has been maintained since March 2014, with 184 patients to date

EFFICIENCY SAVING

A recent audit of nutrition planning times in this population conducted over the month of April 2016 evidences 50% of patients to have had a nutrition plan set up within 1 day of admission and 40% within a 2 day period. For 10% of these patients, a nutrition plan was agreed and put in place on the day, avoiding admission. These statistics reveal the effectiveness of having a structured and supportive framework in place in guiding ethical decision making in this cohort along with accruing cost savings to the health service.

The NHS spends around £820 million a year treating older patients who no longer need to be in hospital, with the cost of care per day outlined to be £303 (NAO, 2016). According to a study looking at dementia in the acute setting, pneumonia was the principle cause of admission in 41.3 % of the cohort (Sampson, 2009). The UK National Audit Office has highlighted the need to reduce emergency admissions in the frail elderly in order to improve outcomes for these patients and increase significant cost savings to the health service. According to Sampson et al (2009), pneumonia falls within 'ambulatory care sensitive conditions' thought to be avoidable or treated in the community.

The risk feeding pathway of care guides clinicians in timely decision making and supportive patient care, thus reducing emergency and prolonged admissions in the frail elderly leading to better quality of life for these individuals for a meaningful length of time. Although significant training and educational awareness on risk feeding needs to continue to occur across the acute and community sector, the risk feeding pathway illustrates a timely and cohesive framework of care across the respective settings.

REFERENCES

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NAO (2016) www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf
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Quality of Life ✔ Admission Avoidance ✔ Cost savings ✔