

Risk Feeding Policy

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Name of originator / author:	Angela Shimada, Jennifer Whiley (adapted with permissions from Heart of England NHS Trust FAR Policy)
Name of responsible committee:	Effective Practice Assurance Group
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Distributed via	Website

Risk Feeding Policy
Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New Policy	November 17	
2	Full policy	LCHS and ULHT Risk Feeding Policies combined. Updates to section 5.1; information on MCA lead. Equality Analysis form updated.	October 2019	Emily Gelder
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Summary

The aim of this policy is to provide documentation and guidance for all professionals working with patients for who risk feeding is a management option.

1.0 Introduction

1.1 Purpose

Patients who are deemed to have an unsafe swallow and at risk of aspiration are not always placed Nil By Mouth (NBM). Publications from the Royal College of Physicians and British Society of Gastroenterology (2010) highlight the increasing evidence-base which suggests that non-oral feeding is not always clinically or psychologically beneficial nor ethically sound in patients who are towards the end of their life.

In cases where non-oral nutrition is appropriate, every adult patient has the right to decide about their own treatment, and it may be that a decision is made to continue with oral intake, accepting of aspiration and choking risks. This is known at Lincolnshire Community Health Services and United Lincolnshire Hospitals Trust as risk feeding and may apply to any patient with dysphagia at any stage of their life.

The introduction of the Mental Capacity Act (2005) has led to improvements in the care and management of patients who are proven not to have capacity to make their own decisions. In cases where patients are unable to make decisions such as those related to their nutrition and hydration, decisions are made on behalf of the patient. The decision will take into consideration the patient's previous beliefs and wishes, views of the family, clinical evidence-base and quality of life. In some cases, a decision is made against non-oral nutrition and hydration. Good practice in decision-making towards end of life is evidenced in the GMC (2010) publication Treatment and Care Towards End of Life.

1.2 Context

Anecdotal evidence suggests that decisions to feed at risk are being made regularly. However there are often issues with these decisions including them not being made in a timely manner, relevant people not being involved (i.e family/patient/professionals) and/or the decision not being appropriately documented.

1.3 Objectives

Provide a clear pathway for risk feeding to guide professionals through risk feeding decision making process thereby fostering consistency, efficiency and improved communication.

1.4 Scope

1.4.1 Any registered member of staff who has a role with patients where risk feeding decisions are considered.

1.5 Compliance

1.5.1 This policy complies with the legislation, standards, guidelines, codes of conduct, and any other relevant document listed in the Referenced Documents' section.

2.0 Roles and Responsibilities

The multidisciplinary team plays a key role in the assessment, management and decision-making with patients who are being fed at risk. Professionals who most often take key roles are outlined below.

2.1 Speech and Language Therapist

The SLT has an advisory and educating role. SLT may be the first professionals to indicate that risk feeding is a possibility for a patient once they have assessed their swallow. The SLT must inform the medical team if they feel that the patient is not appropriate for risk feeding and the reasons why this is the case (for example, if they feel that risk feeding would be too distressing for the patient).

Members of the SLT team are responsible for:

1. Assessing the patient's swallow function in accordance with professional guidelines set out by the Royal College of Speech and Language Therapy and the Lincolnshire Community Health Services Dysphagia policy.

2. Evaluating the risk of aspiration that the patient is placed at by oral intake.
3. Assessing the benefits/disadvantages of compensatory strategies for reducing the risk of aspiration.
4. Identifying the need for further assessment, which may include instrumental techniques
5. Forming an opinion based on clinical evidence, regarding prognosis for swallow recovery.
6. Communicating these findings to the multi-disciplinary team (MDT).
7. Contributing to discussions with the patient, family and MDT regarding non-oral feeding, where appropriate.
8. Facilitating more effective discussions between the MDT and patients who have impaired communication skills.
9. Assessing or facilitating communication to aid decisions regarding mental capacity where appropriate.
10. Making recommendations to reduce the risk of aspiration if possible once a decision to risk feed has been made.

SLTs may not be involved with all patients who are being risk fed. On occasion the MDT may complete the whole process of risk feeding themselves, eg. Patients who have fluctuating responsiveness and therefore SLT unable to assess, patients who have capacity and have chosen to risk feed, patients who intermittently refuse oral intake, patients nearing the end of their lives where there is no distress involving eating and drinking.

2.2 The Medical Team

The medical team should, where appropriate, be involved with:

- Identifying the need for a comfort/risk feeding decision
- Discussions with the patient, family and MDT
- Making onward referrals where necessary
- Agreeing the final decision regarding risk feeding
- Completing documentation
- Considering the future management of patients who are being risk fed (for example, management of potential aspiration events, dehydration, malnutrition)
- Communicating decisions with GP regarding future management of patients who are being risk fed (for example, re-admission to hospital as a result of chest infections)

Medics should refer to GMC and RCP guidelines for further details.

2.3 Nursing Staff

Trained nurses are likely to be involved in decision-making but are also key at the point of delivery. Nursing staff involved with patients who are being risk fed should be aware of these guidelines, the risk pathway and associated documentation. Any changes in the patient's response and comfort during oral intake should be documented and reported to an appropriate member of the MDT.

2.4 The Multidisciplinary Team

Risk feeding decisions should be decided as an MDT with the consultant/GP having the ultimate responsibility for the patient's care. If the consultant/GP is not immediately available and in situations where all those involved are in agreement it should then be documented by a responsible clinician who has been involved in the making of the decision. If delegated the Consultant/GP must be informed at the earliest opportunity.

2.5 Other members of the MDT

May include: Dietitians, Specialist Palliative Care Team, Clinical Nurse Specialists (eg. Parkinson's Disease, palliative care), physiotherapists and pharmacists.

3.0 Definitions

Swallowing: The entire act of deglutition from placement of food in the mouth through the oral and pharyngeal stages of the swallow until the material enters the oesophagus through the cricopharyngeal juncture (Logemann, 2011).

Dysphagia: Eating and drinking disorders which may occur in the oral, pharyngeal and oesophageal stages of deglutition (RCSLT, 2006).

Aspiration: The entry of food and fluid into the airway beyond the level of the vocal folds.

Non-oral feeding: The provision of nutrition via enteral or parenteral means, for example Naso-Gastric Tube (NGT),

Total Parenteral Nutrition (TPN), Percutaneous Endoscopic Gastrostomy (PEG), Radiologically Inserted Gastrostomy (RIG).

Artificial Hydration: The provision of hydration via enteral or parenteral means, for example intra-venous access, sub-cutaneous access, nasogastric tube.

Risk feeding: A decision made to provide a patient with oral intake (hydration and/or nutrition) despite a high risk of aspiration. This may be made by the patient or in their best interests if they lack capacity (please see section on Legal Issues: Capacity).

4.0 Risk Feeding Pathway

4.1 The pathway is intended to guide health professionals through the Risk Feeding decision-making process thereby fostering consistency, efficiency and improved communication.

It is accepted that this pathway is not exhaustive and other considerations may be taken into account in order to put the patient at the centre of the decision-making process.

As with any other medical decision you must consider reviewing and/or repeating this pathway if a change in circumstance arises (for example if a patient's capacity or clinical presentation changes).

Refer to appendix one for the pathway.

4.2 Risk Flow Proforma

A proforma has been developed to provide a clear and efficient way of recording the decision that has been made. This should be completed and kept at the front of the medical notes behind any DNACPR or Respect form (see Appendix Two).

If it is agreed not to use this form the decision must be clearly documented in the medical notes. Information should include:

- The final feeding decision
- The rationale/reason for the decision
- Those involved in the decision-making
- Any reason that the patient was not involved (e.g. their capacity to make feeding decisions at the time)
- Those who have been informed of the decision but not directly involved (e.g. the patient's discharge destination, GP, community healthcare professionals).

If the risk feeding decision is cancelled, mark the decision through with 2 parallel lines, and write the word 'cancelled'. Record the date, time, your name and the reason for cancellation of the decision. File the cancellation form in the correspondence section of the medical notes.

4.2.1 Completing the risk feeding proforma

These are the guidelines for completing the Risk Feeding Proforma Form for use across all providers in Lincolnshire, section by section.

There are also brief guidance notes available on the back of the form.

Box	Issue	Guidance
1.	Patient Details	Full name, Date of Birth and NHS number will all be entered. An addressograph label may be used providing it contains all 3 identifiers
2.	Date of decision	Enter the date that the risk feeding decision was discussed and made.
3.	Location	Enter the location where the decision was discussed and made.
4.	Reason for risk feeding decision	Tick appropriate box (or boxes) and specify why this decision was made.

5.	Capacity Assessment	The MDT is responsible for conducting a decision specific capacity assessment to establish a method of nutrition. Ensure that Trust Capacity Paperwork has been completed and inserted into the medical notes All records documenting the decision have been documented in patient Medical notes Ensure the patient has been involved with the decision making process
6.	Record of Discussion	The medical team are responsible for making decisions around advanced planning in relation to chest infections and further hospital admissions. These should be clearly documented in the medical notes, discussed with the patient/family/carers/significant others and detailed in the EDD. Has consideration been made for use of antibiotics to treat future chest infections? If the patient develops an aspiration pneumonia will this be treated at home or will the patient be readmitted to hospital?
7.	Risk Reducing Recommendations	If appropriate a speech and language therapist can make risk reducing recommendations to include modified diet, fluids and strategies to reduce the risk of aspiration. These should be documented here.
8.	Team Members Involved in the Decision	Write down all the names of the team members involved in the decision making process. A consultant/GP must sign the document as they have overall responsibility for the risk feeding decision.

4.3 Future Treatment

Once a risk feeding decision has been made, it is often beneficial to discuss the potential of future complications and how these may be managed. Any decisions/guidance should be clearly documented in the medical notes. Examples include whether or not a patient should be actively treated in the event of a chest infection; should the patient be re-admitted to hospital with subsequent chest infections.

4.4 Discharge from hospital

It is essential that any risk feeding decisions are communicated effectively to the patient's primary carers and health professionals who will be involved in their care upon discharge from hospital.

Some of the benefits of this include: consistency in the management of nutrition and hydration from hospital to home; support to those who are involved in feeding at the point of delivery and; avoidance of inappropriate hospital re-admission.

Information for patient/relatives/carers/other health care professionals is available in appendix three.

5.0 Legal issues

5.1 Capacity

You must work on the assumption that every adult patient has the capacity to make an informed decision about their oral feeding. If a patient's capacity to make decisions is impaired, the patient must be provided with all the appropriate help and support to maximise their ability to participate in the decision-making process (MCA 2005).

Please see the MCA Code of Practice (2007), GMC Guidelines (2010:12-24) and [LCHS policy on MCA](#) for additional information and advice on decision-making with patients who lack capacity. The following factors may indicate the need for involvement of a more experienced professional with specialist skills and escalation to the Trusts MCA Lead:

- The gravity of the decision or its consequences
- Where the person concerned disputes a finding of incapacity

- Where there is disagreement between family members, carers and/or professionals as to the persons capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what she\he thinks they want to hear.
- Where the persons capacity to make a particular decision is subject to challenge, either at the time the decision is made or in the future
- Where there may be legal consequences of a finding of capacity
- The person concerned is repeatedly making decisions that put him\her at risk, or that result in preventable suffering or damage

It is the role of the multidisciplinary team to clearly document decisions made about a patient's capacity in relation to their ability to make an informed risk feeding decision.

In situations where the patient lacks capacity then a Best Interest Decision needs to be made.

5.2 Emergency Procedures

In the event of difficulties leading to a life-threatening situation, a positive duty to act arises and health professionals are then required to do whatever would be reasonably expected of them in the circumstances. The MDT should follow Health and Safety guidelines, ensure they are adequately prepared for such an event and be familiar with emergency procedures for choking.

Health professionals need to be aware of a patient's DNACPR status prior to feeding as this will determine the course of emergency treatment a patient will receive. In the event of a choking incident, a patient will always receive emergency treatment (as directed by the clinician on the scene) for choking and/or respiratory arrest. If this progresses to a cardiac event, the DNACPR procedure should be followed.

6.0 Competence

6.1 Speech & Language Therapy

All SLTs who are involved with risk feeding decision-making must have completed their dysphagia training (in-house or an appropriate post graduate dysphagia course). SLTs working within their first year of dysphagia training must discuss risk feeding decisions with a senior colleague.

6.2 Medical and Other Clinicians

Risk feeding decisions are the ultimate responsibility of the consultant/GP in charge of the patient's care. If the consultant/GP is not immediately available, this responsibility may be delegated to the multidisciplinary team and documented by a responsible clinician. If delegated the Consultant/GP must be informed at the earliest opportunity.

Any clinician accepting this responsibility must be aware of the risk feeding guidelines including the pathway for decision-making and the MCA Code of Practise, and feel competent to apply the content to the complex and critical situation.

7.0 Application of the Guideline

All members of the multidisciplinary team who are involved in a comfort/risk feeding decision must be aware of and up to date with the ULHT/LCHS, GMC and RCP guidelines related to non-oral / withholding / withdrawing feeding.

8.0 Implementation, Monitoring and Review

Outline how the document will be disseminated to relevant staff and implemented within the Trust. Will any training be required? The policy will be highlighted through trust newsletters. SLT will provide awareness training for Matrons and Doctors for this to be disseminated.

Are there any costs associated with implementation of the policy? Implementation of the policy should save the trust money by reducing number of inappropriate hospital admissions. No additional costs

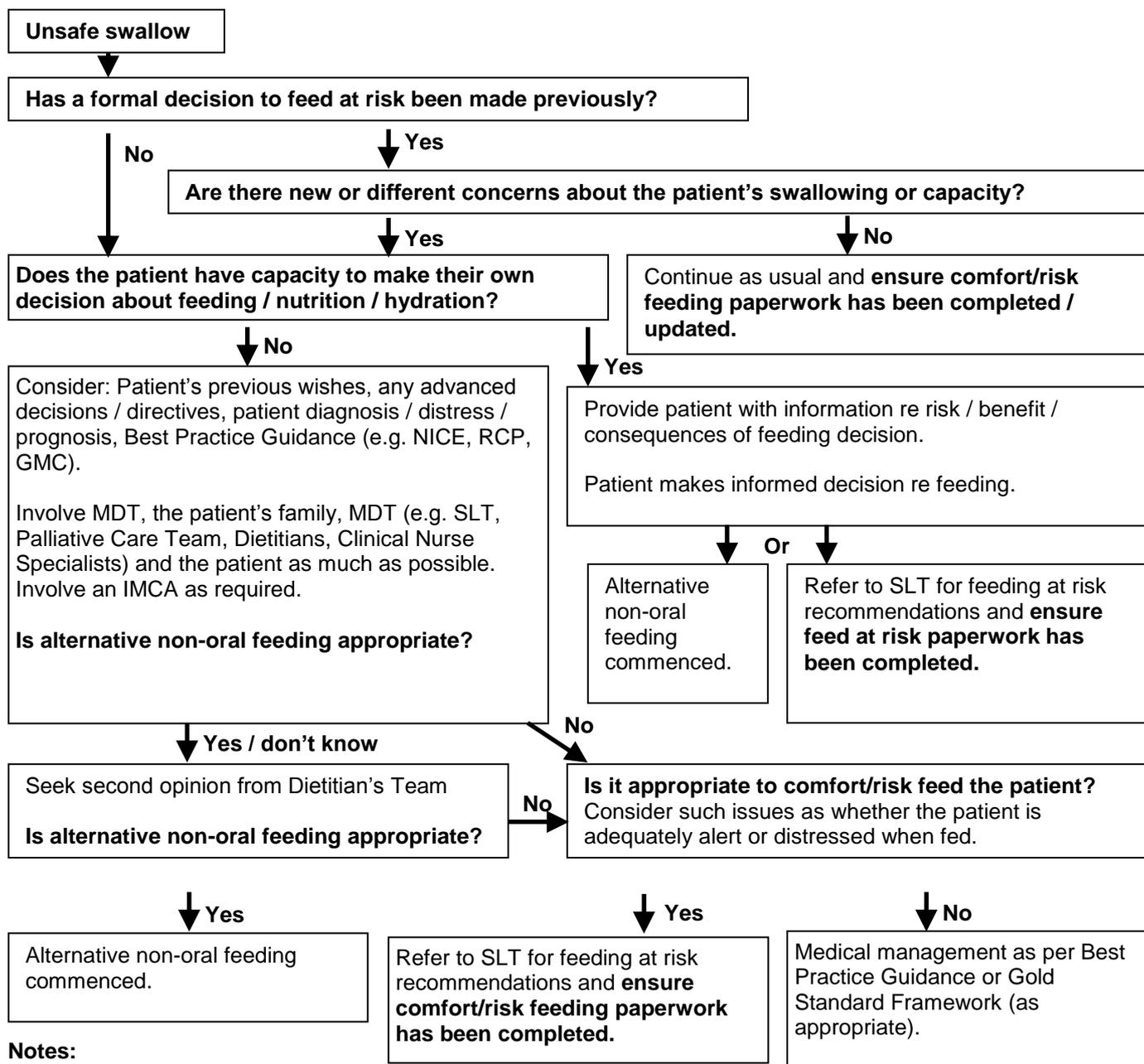
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? Ward audit can be implemented to ascertain whether documentation being used for risk feeding policy.

Monitoring Compliance

Minimum requirement to be monitored – monitoring against standards set out in policy	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit/ reporting	Responsible individuals/ group/ committee for review of results and determining actions required
ULHT Identify number of patients being risk fed on at least 2 wards on each hospital site, how many complying with standards set out in policy.	Audit	Nutritional Steering Group	Yearly	Nutritional Steering group

Appendix One

Comfort/Risk Feeding Pathway



Notes:

1. This form should be completed in accordance with the Comfort/Risk Feeding guidelines.
2. Comfort/Risk Feeding decisions are the ultimate responsibility of the consultant/GP in charge of the patient's care. If the consultant is not immediately available, this responsibility may be delegated to the multidisciplinary team and documented by a responsible clinician. If delegated the consultant must be informed at the earliest opportunity.
3. The Comfort/Risk Feeding decision will remain in place unless the patient's wishes change or oral feeding is no longer in their best interests. In the event, the decision-making process must be reviewed.

4. When Comfort/Risk Feeding decision is cancelled, mark the decision through with 2 parallel lines, and write the word 'cancelled'. Record the date, time, your name and the reason for cancellation of the decision. File the cancellation form in the correspondence section of the medical notes.
5. Clinical judgement can override a Comfort/Risk Feeding decision, e.g. if a patient is drowsy, refusing, distressed or if they are NBM for another reason (e.g. surgical / gastro).

Once completed, this form should be kept at the front of the medical notes behind any DNACPR forms.

Guidance Notes

This Risk Feeding Proforma is intended to be used countywide across Lincolnshire by all Healthcare Providers.

This form should be completed legibly in black ball point ink and used in accordance with the risk feeding policy.

All discussions relating to the decision to risk feed must be documented in the patient's clinical notes.

This form remains the property of the patient and it is transferrable to other healthcare settings. If the patient moves to a different location, the original copy of this form MUST go with the patient, but a black and white photocopy can be retained in the medical records. The clinical team responsible for the patient must ensure their professional colleagues receiving the patient are aware of the decision.

Box	Issue	Guidance
1.	Personal Details	Full name, Date of Birth and NHS number will all be entered. An addressograph label may be used providing it contains all 3 identifiers
2.	Date of decision	Enter the date that the risk feeding decision was discussed and made.
3.	Location	Enter the location where the decision was discussed and made.
4.	Reason for risk feeding decision	Tick appropriate box (or boxes) and specify why this decision was made.
5.	Capacity Assessment	<p>The MDT is responsible for conducting a decision specific capacity assessment to establish a method of nutrition and hydration.</p> <p>Ensure that Trust Capacity Paperwork has been completed and inserted into the medical notes</p> <p>All records documenting the decision have been documented in patient medical Notes</p> <p>Ensure the patient has been involved with the decision making process</p>
6.	Record of Discussion	<p>The medical team are responsible for making decisions around advanced planning in relation to chest infections and further hospital admissions. These should be clearly documented in the medical notes, discussed with the patient/family/carers/significant others and detailed in the EDD.</p> <p>Has consideration been made for use of antibiotics to treat future chest infections?</p> <p>If the patient develops an aspiration pneumonia will this be treated at home or will the patient be readmitted to hospital?</p>
7.	Risk Reducing Recommendations	If appropriate a speech and language therapist can make risk reducing recommendations to include modified diet, fluids and strategies to reduce the risk of aspiration. These should be documented here.

8.	Team Members Involved in the Decision	<p>Write down all the names of the team members involved in the decision making process.</p> <p>A consultant /GP must sign the document as they have overall responsibility for the risk feeding decision.</p>
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Appendix Three – Risk Feeding Advice for Patients / Carers / Relatives

Comfort/Risk Feeding

Information for Health Care Workers

This patient is being comfort/risk fed.

Dysphagia is a difficulty in swallowing. Difficulties in swallowing can put a person at increased risk of choking and chest infections because food and drink are aspirated onto the lungs instead of the stomach.

The term 'comfort/risk feeding' is used when a decision is made to allow a person to continue to eat and drink, accepting that they may suffer from choking episodes or repeated chest infections. This decision is usually made when alternative forms of nutrition are not appropriate and / or to help maintain a person's quality of life.

It has been agreed by the patient / family / hospital team (delete as appropriate) on _____ that they will continue to eat and drink, accepting the risk of aspiration. The patient should have a 'comfort/risk feeding' form inside their medical records.

In order to maintain comfort and ease whilst eating and drinking, the patient has been assessed by a Speech and Language Therapist (if involved) and the following recommendations have been made:

(SLT to insert feeding / consistency recommendations if involved)

When the patient is eating and drinking they may experience any of the following:

- Coughing
- Choking
- Colour change in their face
- A wet gurgly voice or breathing
- Shortness of breath after eating and drinking
- Recurrent chest infections / pneumonia
- High temperatures

If you observe any of the above symptoms then you may wish to stop and try again later.

There may be instances where food and drink are no longer accepted or tolerated by the patient or the patient's health deteriorates. It may be appropriate to take no further action, but this will need to be discussed with the patient's doctor.

The GP will be made aware of the 'Comfort/Risk Feeding' decision (via the EDD) and should be the point of contact for further management once the patient has been discharged from hospital.

Contact Details of Key Health Professional:

Name:

Profession:

Telephone number:

Please note:

Further Speech and Language Therapy involvement will be at the discretion of the Health Professionals involved but it unlikely to be significant benefit. Reasons for further involvement may be linked with significant improvement and / or significant change in medical condition (that are likely to affect swallow function).



Equality Analysis: Initial Assessment Form

Title: of the function to which the Equality Analysis Initial Assessment applies
 Risk Feeding

Describe the function to which the Equality Analysis Initial Assessment applies:

<input type="checkbox"/> Service delivery	<input type="checkbox"/> Service improvement	<input type="checkbox"/> Service change
x Policy	<input type="checkbox"/> Strategy	<input type="checkbox"/> Procedure/Guidance
<input type="checkbox"/> Board paper	<input type="checkbox"/> Committee / Forum paper	<input type="checkbox"/> Business care

Other (please specify)

Is this assessment for a new or existing function?	Existing
Name and designation of function Lead professional:	Emily Gelder, Speech and Language Therapist
Business Unit / Clinical Directorate:	Speech and Language Therapy

What are the intended outcomes of this function? (*Please include outline of function objectives and aims*):
 To provide a clear pathway and rationale for clinicians working with patients who may require a risk feeding approach in both acute and community settings.

Who will be affected? Please describe in what manner they will be affected?

Patients / Service Users:	Staff:	Wider Community:
Patients who have a swallowing difficulty but are not appropriate for long term tube feeding; patients who have a swallowing difficulty and refuse long term tube feeding. The policy provides clear guidance on the decision making process for these patients.	All clinical staff in both acute and community settings: provides clear guidance on process for consideration of risk feeding based on national guideline. Provides guidance on consideration of on-going treatment following risk feeding decision making e.g further treatment for chest infections, hospital admissions, treatment at home.	The wider community can be assured that this procedure is undertaken to the highest standard and in line with national standards.

What impact is the function expected to have on people identifying with any of the protected characteristics (below), as articulated in the Equality Act 2010? (Please tick as appropriate)

	Positive	Neutral	Negative	Please state the reason for your response and the evidence used in your
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				assessment.
Disability		X		<p>For patients with a Learning Disability, the trust employs Learning Disability liaison nurses who can be called upon to support as required.</p> <p>For patients with Mental Health difficulties, the trust has Mental Health Liaison nurses who can be called upon to support as required.</p> <p>For patients with sensory impairment, the trust provides sensory impairment translation services through a contracted provider.</p> <p>For staff who require this policy in alternative format, it will be provided upon request.</p>
Sex		X		A neutral impact for this protected characteristic is envisaged. A sex has no bearing on the application for this policy.
Race		X		A neutral impact for this protected characteristic is envisaged. A race has no bearing on the application for this policy. However, for people whom English is not their first language, the trust provides a full range of interpretation/translation service.
Age		X		A neutral impact for this protected characteristic is envisaged. An age has no bearing on the application for this policy.
Gender Reassignment		X		A neutral impact for this protected characteristic is envisaged. Gender Reassignment has no bearing on the application for this policy.
Sexual Orientation		X		A neutral impact for this protected characteristic is envisaged. Sexual Orientation has no bearing on the application for this policy.
Religion or Belief		X		<p>A neutral impact for this protected characteristic is envisaged. Religion or Belief has no bearing on the application for this policy.</p> <p>The trust provides a full pastoral, spiritual and religious support service who can be called upon to support if required.</p>
Pregnancy & Maternity		X		<p>A neutral impact for this protected characteristic is envisaged. A Pregnancy or Maternity has no bearing on the application for this policy.</p> <p>However, if required reference to supportive pregnancy and maternity policies would be made.</p>
Marriage & Civil Partnership		X		A neutral impact for this protected characteristic is envisaged. Marriage and Civil Partnership has no bearing on the application for this policy.
Carers		X		A neutral impact for this protected characteristic is envisaged. Carers have no

				bearing on the application for this policy. The trust is supportive and proactive in engaging with carers as outlined in the trusts carers policy.
Other groups identified (please specify)	X			No other groups have been identified.

If the answer to the above question is a predicted negative impact for one or more of the protected characteristic groups, a full Equality Analysis must be completed. (The template is located on the Intranet)

Name of person/s who carried out the Equality Analysis Initial Assessment:	Emily Gelder and Tim Couchman
Date assessment completed:	11.09.19
Name of function owner:	Emily Gelder
Date assessment signed off by function owner:	11.09.19
Proposed review date (please place in your diary)	September 2024

As we have a duty to publicise the results of all Equality Analyses, please forward a copy of this completed document to tim.couchman@ulh.nhs.uk.

References

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18. Sherman FT (2003). Nutrition in advanced dementia. Tube feeding or hand feeding until death? Editorial. *Geriatrics* 58, 11: 10.
19. Skelly RH (2002). Are we using percutaneous endoscopic gastrostomy appropriately in the elderly? *Current Opinion in Clinical Nutrition and Metabolic Care*. 5(1) 35-42.

Signature Sheet

Names of people consulted about this policy:

Name	Job title	Department
Dr Adam Brown	Palliative Consultant	ULHT
Dr Abdul Elmarimi	Stroke Consultant	ULHT
Dr Katharine Collett	Palliative Consultant	ULHT
Dr Georgina Keenleyside	Palliative Consultant	ULHT
Dr Gillian Garden	Palliative Consultant	St Barnabus
Professor Jagdish Sharma	PD Consultant	ULHT
Dr Neal Parkes	Acting Medical Director	LCHS
Sarah Scrace	CTL SLT	LCHS
Janet O'Neill	CTL SLT	LCHS
Katherine Green	Lead Dietitian	ULHT
Kathryn Kelly	Site lead dietitian	ULHT
Jo Hagens	Palliative Nurse	ULHT
Nicola Hine	Sister	ULHT
Emily Gelder	SLT	LCHS

Names of committees which have approved the policy	Approved on
ULHT Nutritional Steering Group	2016
ULHT Clinical Effective Steering Committee	2017
LCHS Adult governance committee	2017
LCHS Community Hospital Governance	July 2017