



HERITAGE HOUSE SCHOOL

DYSPHAGIA POLICY

Approved by: [FGB]

Date: [September 2024]

Last reviewed on: []

Next review due by: [Sept 2025]

1. Summary of Policy

- This Policy sets out to explain the appropriate actions should a child present with dysphagia.
- Physical and emotional needs should be considered when caring for a child with dysphagia.
- Dysphagia is defined as difficulty, discomfort, or pain in swallowing. It can also be defined as a condition where food is stuck or slowed in the passage from the mouth to the stomach. There may be difficulty in the oral preparation for swallowing, such as chewing and tongue movement.
- Liaison with expert health professionals such as a speech and language therapist and dietician may be appropriate for the management of a child presenting with dysphagia.

2. Introduction

- As part of dysphagia care, staff must be able to assess a child who has difficulty swallowing, whether this is on an emergency basis or part of a long-term difficulty.
- Disruption of swallowing can have serious effects, with complications such as malnutrition, pulmonary aspiration (fluid or food going into the lungs instead of the stomach), and the emotional and psychological problems associated with not being able to eat properly.
- Medical consent is required in addition to parental consent for new dysphagia referrals. Upon receipt of the referral, medical consent is requested from the GP or consultant; this may be acquired verbally or in writing depending on the urgency of the referral. Such cases are seen upon receipt of the medical consent and do not go onto a waiting list.
- Learners with confirmed historical dysphagia needs outlined on their Education, Health, and Care Plans (EHCPs) require only parental consent for review in the school setting, with feedback and liaison with medical professionals as appropriate.
- Dysphagia management must be specified in contracts of speech and language therapy staff who are overseeing, and / or reviewing, eating and drinking difficulties. This is necessary to outline duty of care and safeguard members of staff in working within their level of competence.
- School staff with specific duties relating to dysphagia support (e.g., modifying textures / consistencies, feeding individual learners, etc.) should receive specific training and should have these duties outlined within their roles.
- Management of the dysphagia caseload must be delegated to a clinical specialist who will take responsibility for prioritisation, frequency of review, and agreeing risk assessments and feeding recommendations.

3. Client group

- Heritage House's Multidisciplinary Team (MDT) Department accept referrals for children with eating and drinking difficulties who are in full time education, and / or of

statutory school age, or entering the reception school year and on roll at Heritage House School. This includes learners who are currently unable to attend the setting and receive support via the outreach service.

- Learners who are on roll, but not attending the setting, will be prioritised according to level of clinical need and clinical capacity of the dysphagia clinician.
- The client group includes (but is not limited to) children with medical diagnosis of cerebral palsy, cardiac disorders, gastro-oesophageal reflux, craniofacial conditions, learning difficulties, progressive neurological conditions (e.g., muscular dystrophy), trauma, and autism.

4. Competence (as set out in RCSLT Training and Competency Framework)

The Royal College of Speech and Language Therapists (RCSLT) competencies framework is for the use of the speech and language therapy profession only and has four sections:

Level A: Assistant Dysphagia Practitioner

- An Assistant SaLT working with a dysphagia caseload.
- A student on placement.
- A newly qualified practitioner (NQP).

Level B: Foundation Dysphagia Practitioner

- A student with extended clinical experience or placements.
- An NQP working on competencies in their first role with patients / clients with dysphagia.
- A therapist who is beginning to work with dysphagia after a break.
- A therapist who has worked in dysphagia but is now working with a new dysphagia patient / client group e.g., from adult acute to paediatric acute.

Level C: Specialist Dysphagia Practitioner

- A therapist who is a competent dysphagia practitioner and can manage a caseload independently.

NB: A student may have acquired knowledge to this level but will not be considered at this level until competencies at level A and B are achieved.

Level D: Consultant Dysphagia Practitioner

- A therapist who specialises in the field of dysphagia.
- A therapist who is a clinical lead for dysphagia within a service.
- A therapist who runs specialist or tertiary clinics.

The nature of the dysphagia caseload in Heritage House School requires regular access to a Level D Consultant Dysphagia Practitioner, and at least one Level C Specialist Dysphagia Practitioner for the day-to-day management of the dysphagia caseload. A Level B Foundation Dysphagia Practitioner may be considered in lieu of developing competencies in becoming a

Level B Foundation Dysphagia Practitioner if a Level D Consultant Dysphagia Practitioner is in place for weekly supervision and caseload management.

5. Liaison

Dysphagia practitioners will take on the following liaison roles:

- Verifying medical and parental consent for referrals prior to assessment.
- Liaison with the Children and Young People (CYP) Speech and Language Therapy Service prior to children entering full time education, to ensure all equipment and training can be put in place prior to a child starting to attend a primary school.
- Feedback to referring agents (General Practitioner (GP), Consultants, Dietician, Occupational Therapist) to promote multi-disciplinary relationships.
- Attending MDT meetings where feeding and swallowing difficulties are being discussed for individual children, at the discretion of the therapist.
- In addition to providing feedback to referring agencies, clinicians should have knowledge of onward referral systems for specialist investigations, such as Video Fluoroscopic Swallow Studies (VFSS), etc.

6. Prioritisation

- Prioritise the caseload in terms of:
 - **New referrals:** it is important to gather as much information as possible to determine priority in terms of safety, nutrition, and review.
 - **Safety:** any issues regarding safety of swallow (suspected aspiration, signs of aspiration, chronic chest infections, etc.).
 - **Nutrition:** any concerns regarding dietary intake (amount, variety, etc.) or weight (sudden weight loss, slow weight gain, etc.).
 - **Review:** reviewing guidelines already put in place
- Individuals who are at extremely high risk of choking / inhalation of food or inadequate nutritional intake should be seen within **2 working days** of receipt of a referral. (CQ3)
- Individuals who are at risk of choking / inhalation of food or inadequate oral intake in the context of ongoing long-term conditions should be seen for assessment within **10 working days**. (CQ3)
- During longer periods, where speech and language therapists may not be able to meet these referral times, the caseload should be placed in the care of a professional that can honour the safe practice criteria for dysphagia referral.

6. Assessment Process

- **Verify referral:** if referral is not made by medical practitioner, contact the GP / paediatrician / other specialist to confirm that there is no medical reason not to get involved.

- **Notify:** Confirm receipt of referral to parents and request background information: see feeding questionnaire and food diary.
- **Liaise:** Liaison with teaching staff and informal observations.
- **Oral Motor Assessment:** Assess the lips, tongue, teeth, cheeks, and jaw. Describe in terms of symmetry, muscle tone, and movement.
- **Assess:** Assess the oral reflexes and sensory issues.
- **Formal Assessment:** Things to include in observations / assessment:
 - a. Positioning,
 - b. Self-feeding / fed by assistant,
 - c. Sensory difficulties (hearing impairment, visual impairment, dyspraxia),
 - d. Diet (consistency, etc.),
 - e. Cutlery / crockery in liaison with Occupational Therapist (OT),
 - f. Phases of the swallow:
 - Oral – preparatory phase (before it gets to mouth).
 - Oral phase (chewing skills, bolus formation, bolus manipulation, and oral transit).
 - Pharyngeal phase (timing of swallow, laryngeal elevation, upper airway sounds, suspect aspiration/ no aspiration detected).

7. Therapy and Advice

- Following an assessment, direct intervention (direct therapy for oral motor skills or reducing oral sensitivity) or advice may be offered on:

Positioning

- This should be discussed and assessed jointly with the physiotherapist/occupational therapist.

Texture modification (IDDSI descriptors)

Food:

- Stage 7 – Normal / Easy to chew
- Stage 6 – Soft and bite sized
- Stage 5 – Minced and moist
- Stage 4 – Pureed
- Transitional – Bite and dissolve

Liquids:

- Stage 4 – Extremely thick
- Stage 3 – Moderately thick
- Stage 2 – Mildly thick

- Stage 1 – Slightly thick
- Stage 0 – Thin

Training on Feeding Skills

- All members of teaching and teaching support staff taking responsibility for eating and drinking difficulties should receive training on individual pupils' feeding needs.

Feeding Equipment

- Feeding equipment (e.g., special spoons, specialist cups, chewy tubes, etc.), may be recommended and liaison will take place with the relevant agencies (OT and Physiotherapy).

Oral Motor Intervention

- Therapy programmes targeting specific oral motor skills may be provided to staff and parents. Where needed, individual therapy may also be offered.

8. Documentation

Case notes

- Case notes should be written up in accordance with **departmental policy** following all assessments and reviews, stating what the outcome was and what the proposed change in management should be.

Reports

- Detailed reports should be written following initial assessments and where specific advice has been requested.
- Reports should be circulated to all relevant parties (e.g., school, parents, GP, consultants, etc.).

Feeding plans

- Feeding plans are documents that should always be with the relevant child.
- The purpose of these documents is to outline specific needs and highlight equipment required, as well as specific information that staff may need during mealtimes.

9. Review

- Reviews of feeding skills should take place at regular intervals to be determined by the Level D Consultant Dysphagia Practitioner, either monthly, 3-monthly, 6-monthly, or annually.
- Interim reviews may be arranged as needed and does not affect the regular review schedule
- This policy will be reviewed annually by the Level D Consultant Dysphagia Practitioner