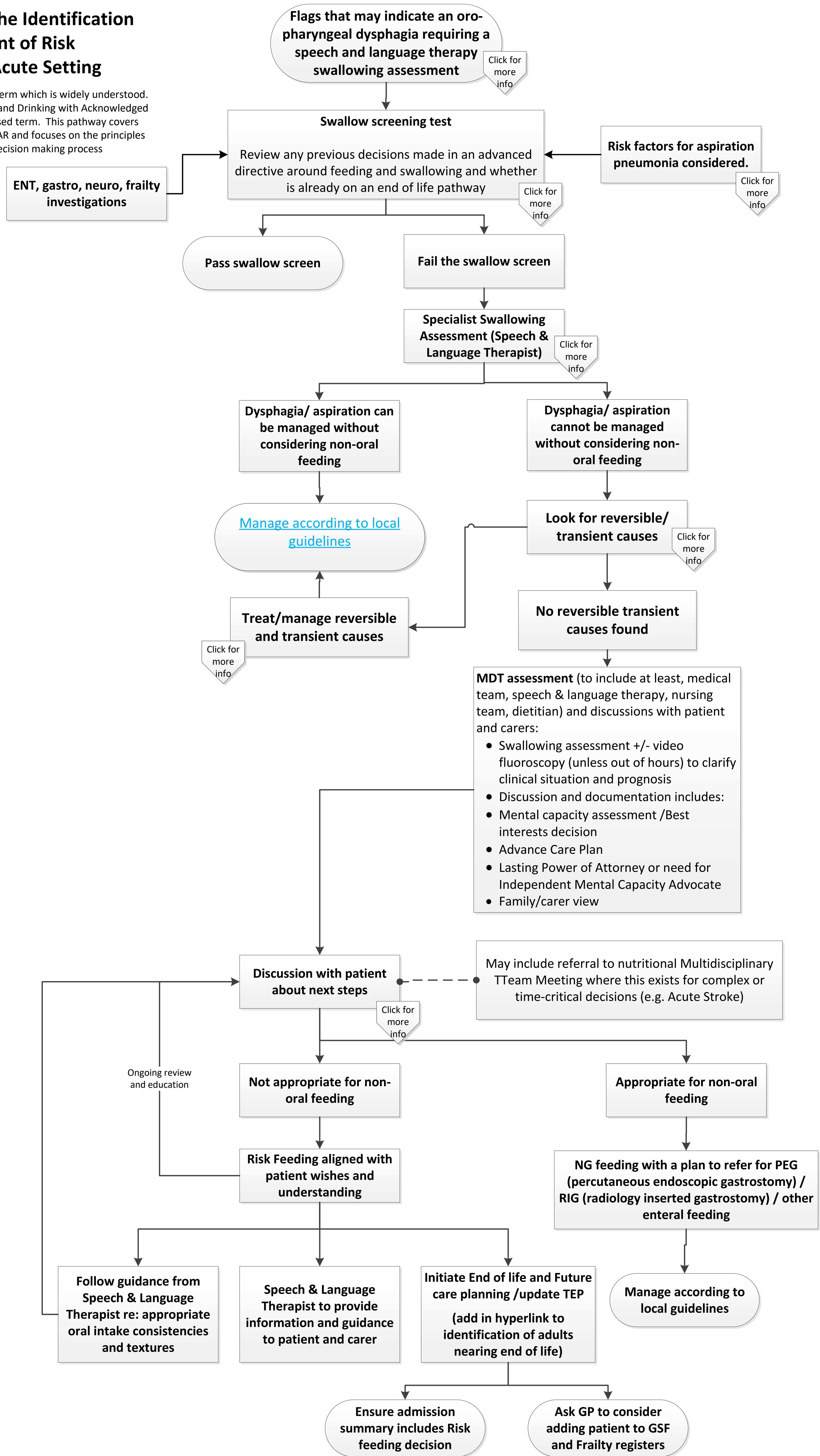
A Pathway for the Identification and Management of Risk Feeding in the Acute Setting

'Risk feeding' is a general term which is widely understood. However, the term Eating and Drinking with Acknowledged Risk (EDAR) is the endorsed term. This pathway covers both Risk Feeding and EDAR and focuses on the principles of an effective decision making process



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Flags that may indicate an oro-pharyngeal dysphagia requiring a speech and language therapy swallowing assessment

Please check with community teams/GP/care home if patient normally takes modified consistency liquids and foods

Patient/carer/Health Care Assistant/family member may report

- Difficulty swallowing
- Coughing when eating and drinking
- Pooling of fluid and food in the mouth
- Dribbling of liquids
- Shortness of breath when swallowing

- Please remember when observing swallowing to:
  - Make sure the patient is sitting upright if possible
  - That they are alert
  - That they have correct method of feeding for that patient e.g. spouted beaker if previously used or tea cup if previously used
  - Check adequacy of oral care provision

- Previous decisions made in an advanced directive around feeding and swallowing

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Highest predictors for Aspiration Pneumonia (Langmore 1998)

- Dependence for feeding
- Dependence for oral care
- Poor oral care provision
- Tube feeding
- Multiple medical diagnosis
- Previously documented swallowing difficulties
- Number of medications prescribed

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Swallow screening test

Patients with the following presenting symptoms or high risk groups should be screened by an appropriately qualified clinician for swallowing issues

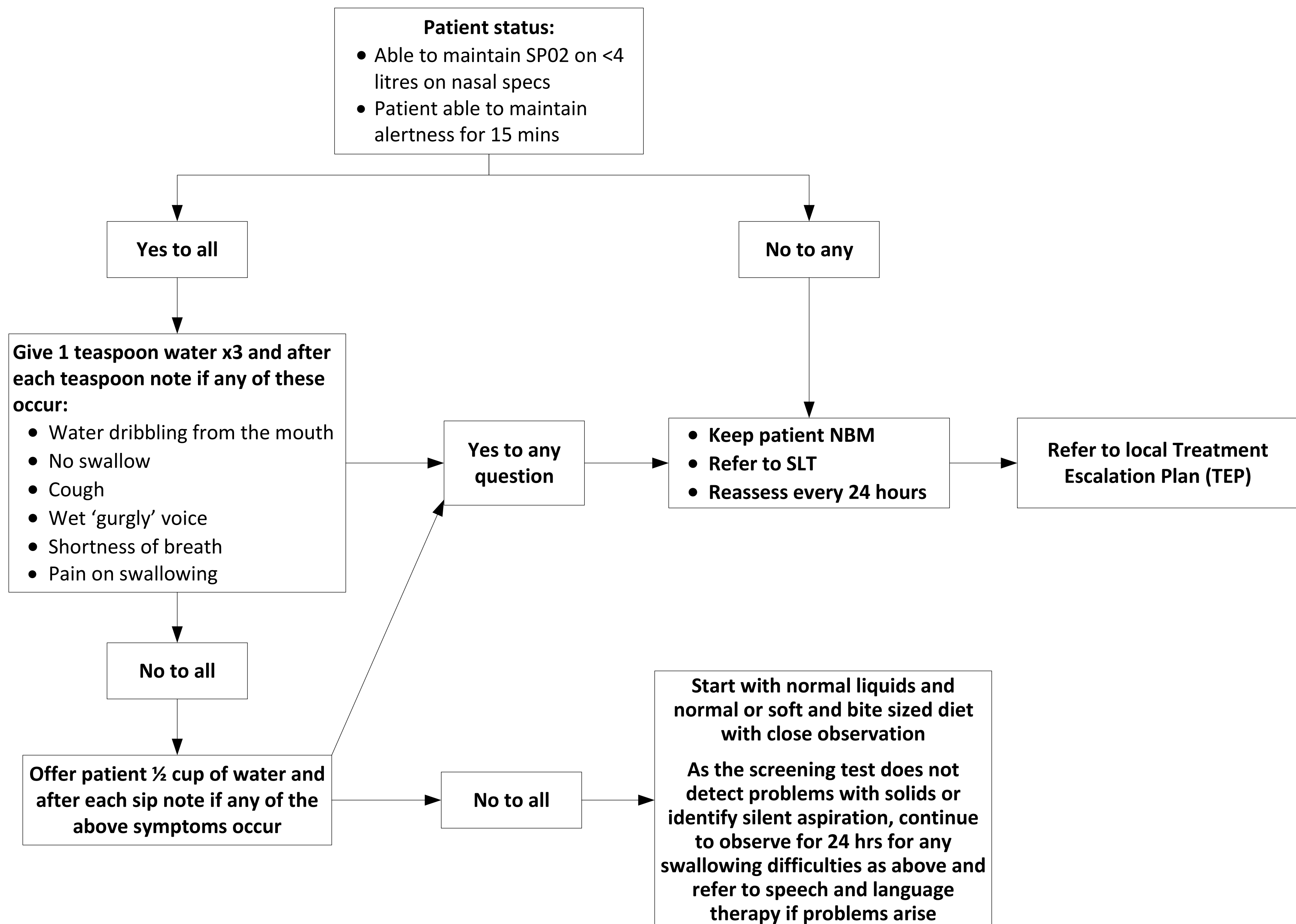
Presenting symptoms

- Diagnosis of aspiration pneumonia
- Recurrent chest infections
- Coughing and /or choking during or after food and/or drink
- Frequent throat clearing
- Wet/gurgly voice quality after eating
- Food feels like it sticks in throat
- Family/carer/patient reports difficulty swallowing

High risk groups

- Stroke patients – swallow screening should be completed within 4 hours of admission
- Patients with advanced neurological conditions
- People with severe learning disability
- People with severe frailty as per Rockwood score (level 7 and above)
- Patients with head and neck cancer
- Patients in a deteriorating phase of end of life care (GSF amber-red)

To carry out a swallowing screen please do:



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Specialist Swallowing Assessment (Speech & Language Therapist)

RCSLT National Guidance states that acute patients should be assessed within 2 working days

Ensure hydration is maintained within assessment period as per acute guidance.

Liaise with pharmacy re: meeting patients medication needs whilst Nil By Mouth during assessment period and post assessment.

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Look for reversible/transient causes

- Medication – particularly medications that give a dry mouth and medications that are time dependent e.g. Parkinson's medication and psychiatric medications - article relating to medications causing dry mouth to add to the 'Look for reversible/transient causes' info box (please copy and paste link) http://wsdha.com/clientuploads/pdfs/Public%20Info/Seniors/DryMouthMedications.pdf
  - Information about anti-psychotic drugs which can cause dysphagia: http://www.entsurgeonessex.co.uk/throat/medications-that-cause-swallowing-problems/
- Infection including thrush in oro-pharynx or in GI tract
- Functional neurological disorders/globus
- Delirium
- Low physiological reserve i.e. frailty secondary to UTI

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Treat/manage reversible and transient causes

- Review medication using the STOPP-START medication review tool
- Treat any infection
- Manage delirium
- Psychiatric or functional review

Manage nutrition and hydration support

- MDT discussion lead by the patient’s wishes (shared decision making) and consider NG tube unless contraindicated
- Regular swallowing assessment by speech and language therapist
- If after two weeks patient unable to feed safely orally, decision needs to be made about long-term feeding plan i.e. either continue with NG feeding to see if further improvement or consider non-oral feeding e.g. PEG or consider risk feeding

Decision with patients consent

If capacity has been established but patient chooses to eat and drink against the clinical advice given this needs to be documented, communicated and plans adjusted accordingly.