Multi Agency Guidance
Supporting adults at risk of choking
August 2019
**Summary Paragraph**

This guidance provides the framework for use within Hampshire County Council Adults' Health and Care Department, West Hampshire, Fareham and Gosport, South Eastern, North East Hampshire and Farnham and North Hampshire Clinical Commissioning Groups, Southern Health NHS Foundation Trust, Solent NHS Trust for the identification, assessment and management of adults aged 18 and over presenting with a choking risk in all care groups.

**Keywords**

Choking, Aspiration, Pica, Adults, Carers, SLT (SLT), Training, Practical Support, Adults

**Target Audience**

Adults who present with a choking risk and/or their carers. Staff working in any NHS and Adults' Health and Care, setting. Staff working in the Independent Hospital sector within the Hampshire locality. Staff employed by private domiciliary agencies, Staff employed by Care homes with and without nursing across all care groups.

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**Review Authors**

Lynn Dangerfield, Solent NHS Trust and Jo Laud, Southern Health NHS Foundation Trust, Speech and Language Therapy Departments

**Approved and ratified**

To be signed off by Hampshire County Council Adults' Health and Care, West Hampshire, Fareham and Gosport and South Eastern CCGs, North and North East and Farnham CCGs, Southern Health Foundation Trust and Solent NHS Trust

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**Author**

Choking Task and Finish Group

**Sponsor**

Health sub-group (Hampshire Safeguarding Adults Board)
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Purpose</td>
<td>5</td>
</tr>
<tr>
<td>2.0</td>
<td>Introduction</td>
<td>5-7</td>
</tr>
<tr>
<td>3.0</td>
<td>Contributions</td>
<td>7</td>
</tr>
<tr>
<td>4.0</td>
<td>Who does this guideline apply to</td>
<td>7-8</td>
</tr>
<tr>
<td>5.0</td>
<td>Definitions</td>
<td>8</td>
</tr>
<tr>
<td>6.0</td>
<td>Duties and responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>7.0</td>
<td>Training</td>
<td>9-10</td>
</tr>
<tr>
<td>8.0</td>
<td>Using the Mental Capacity Act 2005 to support decision making and Deprivation of Liberty Safeguards (DOLs)</td>
<td>10-15</td>
</tr>
<tr>
<td>9.0</td>
<td>Managing and reducing the risk of choking</td>
<td>14</td>
</tr>
<tr>
<td>9.1</td>
<td>Screening the risk of choking</td>
<td>14</td>
</tr>
<tr>
<td>9.2</td>
<td>Care planning</td>
<td>15</td>
</tr>
<tr>
<td>9.3</td>
<td>Review of care plan</td>
<td>17-18</td>
</tr>
<tr>
<td>9.4</td>
<td>Managing risk and risk assessments</td>
<td>18</td>
</tr>
<tr>
<td>9.5</td>
<td>Challenging Behaviour that may increase an adult's risk of choking</td>
<td>18-19</td>
</tr>
<tr>
<td>9.6</td>
<td>Staying in Hospital</td>
<td>19</td>
</tr>
<tr>
<td>9.7</td>
<td>Safeguarding</td>
<td>19-20</td>
</tr>
<tr>
<td>9.8</td>
<td>The role of the Speech and Language Therapist (SLT) in relation to the management of an adult presenting with a choking risk</td>
<td>20</td>
</tr>
<tr>
<td>9.9</td>
<td>Referral to SLT will depend upon the organisation as each team will have different routes of referrals</td>
<td>20</td>
</tr>
<tr>
<td>10.0</td>
<td>When to make a referral</td>
<td>21</td>
</tr>
<tr>
<td>10.2</td>
<td>The role of Multi-Disciplinary Team</td>
<td>21</td>
</tr>
<tr>
<td>11.0</td>
<td>Immediate First Aid regarding a choking incident</td>
<td>21</td>
</tr>
<tr>
<td>12.0</td>
<td>What to do following a choking incident</td>
<td>21</td>
</tr>
<tr>
<td>13.0</td>
<td>Medication and risk of choking</td>
<td>22</td>
</tr>
<tr>
<td>14.0</td>
<td>Associated documents</td>
<td>22</td>
</tr>
<tr>
<td>15.0</td>
<td>Guideline review</td>
<td>23</td>
</tr>
<tr>
<td>16.0</td>
<td>Supporting references</td>
<td>23</td>
</tr>
</tbody>
</table>

### Appendices

<table>
<thead>
<tr>
<th>Appendices</th>
<th>Title</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix I</td>
<td>Training Matrix</td>
<td>24-25</td>
</tr>
<tr>
<td>Appendix II</td>
<td>Solent NHS Trust Choking risk assessment tool V.16</td>
<td>26-27</td>
</tr>
<tr>
<td>Appendix III</td>
<td>Referral Form V.3.0 and referral criteria for Hobbs Rehabilitation</td>
<td>28-31</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>Hampshire Care Plan planning guidance (2017)</td>
<td>32-40</td>
</tr>
<tr>
<td>Appendix V</td>
<td>International Descriptors (April 2018/19)</td>
<td>41</td>
</tr>
<tr>
<td>Appendix VI</td>
<td>Multi Adult Safeguarding Hub (MASH) referral details</td>
<td>42</td>
</tr>
<tr>
<td>Appendix VII</td>
<td>Locality map of SLT service across Hampshire</td>
<td>43</td>
</tr>
<tr>
<td>Appendix VIII</td>
<td>Hampshire Hospitals NHS Trust SLT referral form</td>
<td>44-47</td>
</tr>
<tr>
<td>Appendix IX</td>
<td>SLT Adults East SPA/S1 Referral Form</td>
<td>48-50</td>
</tr>
</tbody>
</table>
Version Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Version</th>
<th>Page</th>
<th>Reason for change</th>
</tr>
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<tr>
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Reviewers and Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Version reviewed and date</th>
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<tbody>
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<td></td>
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</tbody>
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Quick reference guide

Please do not wait until an emergency arises before reading this guidance.

For quick reference, this page summarises the actions required by this guidance. This does not negate the need to be aware of and to follow the further detail provided in this guidance.

To provide adults aged 18 and over presenting with a choking risk, and staff working in the NHS, Adults' social care and health and the Independent and Voluntary sector working in Hampshire, including day services, residential settings and domiciliary care, guidance on how to identify, assess and manage an adult who has a choking risk.
1.0 Purpose

1.1 To provide best practice guidance for Adults’ Health and Care, and health care staff, those who commission care and carers in relation to adults who may present with a choking risk, regarding how to identify, assess and manage an adult who presents with a choking risk.

1.2 This guidance does not replace existing national or organisational policies and guidelines regarding the management of an adult with dysphagia and / or a choking risk and should be read in conjunction with those existing policies.

1.3 Each service uses different terminology to describe the adult and therefore for the purposes of this document, the patient, service user, client, person will be referred to as the ‘adult’.

1.4 This guidance builds on the advice and guidance set out in the document Reducing the risk of choking for people with a learning disability: A multi-agency review in Hampshire produced by Hampshire Safeguarding Adults Board Multi Agency Partnership 2012, and, following the development of the Adults' social care and health guidance regarding the management of an adult with a learning disability who presents with a choking risk, this guidance has been broadened to include any adult who is at risk of choking.

1.5 This guidance has been written by multiple organisations within Hampshire and seeks to broaden the earlier guidance so that it is relevant to all adults from all care groups. The multi agencies may include the independent sector, Care homes with and without nursing, home care agencies, the adults themselves and their carers and or families who may be supporting them, including paid carers.

2.0 Introduction

2.1 Choking can be described as the introduction of a foreign object (edible or non-edible) into an adult’s airway which becomes lodged and reduces or completely obstructs the air flow to the lungs. If the airway cannot be cleared, death follows rapidly.

2.2 All providers and staff need to be aware of the catastrophic consequences that can occur if an adult chokes. Recognition and responding appropriately to a choking incident (airway obstruction by a foreign body) is the key to a successful outcome. It is important not to confuse this emergency with coughing, fainting, having a heart attack, seizure or other medical conditions that may cause sudden respiratory distress, cyanosis or a loss of consciousness.

2.3 This guidance has been written to be read in conjunction with existing policies which may be in place within partner organisations to support adults
who may present with a dysphagia and/or choking risk. This guidance offers additional advice and guidance to the adult, family members and staff.

2.4 Referrals should be made to SLTs for general dysphagia assessment, in line with these policies.

2.5 This guidance also supports the newly developed webpage for adults and staff living and working in Hampshire. This webpage provides practical advice and guidance regarding the following areas:-

- Mental Capacity Act 2005
- Supported decision making and Best interest decisions
- Advocacy
- Assessing and recording the risk of choking risk
- Care planning, risk assessment and risk management
- Screening for increased risk of choking
- Training Matrix for all staff across organisation boundaries
- Equipment
- Recipe ideas
- Safe swallowing videos
- Food and fluid texture advice (International Dysphagia Diet Standardisation Initiative – IDDSI)
- Reporting choking episodes/incidents
- What to do following a choking incident
- Going into hospital

2.6 For those adults living in Hampshire who experience a choking risk, the day to day management of ensuring the adult does not suffer significant harm as a result of choking remains challenging for all those involved in their care, such as their carers, including family members, staff members working in the NHS, Hampshire County Council Adults’ Health and Care, and the Independent Sector.

2.7 The close proximity of the structures in the throat through which an adult eats and breathes and the close coordination that is required for both these functions can lead a healthy adult to choke occasionally. Most obstructions in the throat are able to be cleared by an adult coughing.

2.8 Vulnerable adults may have a weak or absent protective cough. For example, those with a neurological weakness, stroke related impairments, rapidly degenerating conditions, for example Motor Neurone Disease (MND) and may present with an increasing risk of choking.

2.9 There are several risk factors that affect an adult’s ability to eat and drink safely and may be related to physical and/or mental health factors, dysphagia, medication, behaviour and compliance. This is not an exhaustive list but includes:
• Where the adult has a reduced capacity to understand their potential risks associated with choking. This could include an adult who is living with dementia, a learning disability or a deteriorating neurological condition affecting their cognitive ability or a deterioration in their functional mental health, for example, bipolar disorder
• Physical and neurological factors affecting an adult's ability to swallow such as chewing, reduced control of food in their mouth and swallowing (pharyngeal clearance), or an adult with a compromised posture – see also 5.2 for signs of dysphagia
• An adult may present with behaviours that increase their risk of choking such as bolting their food or ‘pica’ (eating inappropriate goods and non-food items), a tendency to talk whilst eating, food cramming
• Environmental factors, such as reduced alertness, or increased distractibility
• Consideration should be given to impact of an adult’s prescribed and non-prescribed medication

3.0 Contributions

3.1 The following organisations and staff made valuable contributions to the content of this guidance:

- Solent NHS Trust SLT
- Southern Health NHS Foundation Trust SLT
- Hampshire Adults’ Health and Care
- Fareham and Gosport Clinical Commissioning Group
- South Eastern Hampshire Clinical Commissioning Group
- West Hampshire Clinical Commissioning Group
- North Hampshire Clinical Commissioning Group
- North East Hampshire and Farnham Clinical Commissioning Group
- Hobbs Rehabilitation Specialists
- Hampshire Hospitals NHS Foundation Trust
- University Southampton Hospital NHS Foundation Trust
- Royal College of Speech and Language Therapists (RCSLT) ALD Dysphagia Lead
- Care Quality Commission (CQC)

4.0 Who does this guidance apply to?

4.1 This guidance is directed toward the following groups;

• All adults aged over 18 years who are confirmed as or are suspected of being at heightened risk of choking and their carers which may include privately commissioned carers
• All staff working in an NHS setting within Hampshire currently excluding the acute hospital setting. These staff members should refer to acute hospital guidance to support adults at risk of choking
• All staff working in Hampshire Adults’ Health and Care,
• All staff working in Independent Hospitals in Hampshire
• All staff working in an Independent Provider setting such as a care home with and without nursing, domiciliary providers and the private and voluntary sector

5.0 Definitions

5.1 **Choking** is described as the introduction of a foreign object (edible or non-edible) into an adult’s airway which becomes lodged and reduces or completely obstructs the air flow to the lungs. Choking can also be caused by the adult’s airway being constricted or swollen shut.

5.2 **Dysphagia** describes eating and drinking disorders in children and adults which may occur in the oral, pharyngeal and oesophageal stages of deglutition. Contained in this definition are problems positioning food in the mouth and in oral movements, including sucking, mastication and the process of swallowing. The ‘normal’ swallow needs the respiratory, oral, pharyngeal, laryngeal and oesophageal anatomical structures to function in synchrony, which is dependent upon the motor and sensory nervous system being intact (RCSLT 2018)

5.2.1 Acute signs of dysphagia may include coughing or choking when eating and drinking or immediately after intake, effortful or delayed swallow with increased breathing rate after swallowing, wet vocalisations (gurgly voice) particularly after drinking, and change of skin colour.

5.2.2 More chronic signs of dysphagia may include persistent drooling of saliva, recurrent chest infections, increased anxiety and challenging behavior at drinking and meal times, signs of malnutrition, and/or dehydration, poor skin integrity and hair loss.

5.2.3 **Aspiration** is defined as the inhalation of either oropharyngeal or gastric contents into the lower airways, that is, the act of taking foreign material into the lungs.

5.2.4 **Pica** is defined as an eating disorder typically defined as the persistent ingestion of substances of no or little nutritional value for at least one month at an age for which this behavior is developmentally inappropriate. It may be benign or may have life-threatening consequences.
6.0 Duties and responsibilities

6.1 Staff working in Adults’ Health and Care and in health care is required to ensure they are working within their organisations’ policies with regards to the management of an adult presenting with a choking risk. This guidance will be shared with private providers as appropriate.

6.2 The Care Quality Commission (CQC) inspect and rate residential care homes and nursing homes in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Services are rated with regards to whether they provide safe, effective, caring, and responsive and well led care.

6.3 There are 11 new regulations that set out the fundamental standards of quality and safety. CQC state that “these replace the current 16 regulations (http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards)

6.4 These new regulations are clearer statements of the standards below which care should never fall and apply to all settings. Two of the standards are listed as meeting nutritional and hydration needs (http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-14-meeting-nutritional-hydration-needs),
And safe care and treatment (http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment)

7.0 Training

7.1 All organisations, as listed in section 3.1, will be regularly reviewing the provision of training courses for their employees and for provider organisations in the area of caring for an adult presenting with a choking risk. They do so to ensure that the content is fit for purpose and is aligned with policy and current practice.

7.2 A detailed training matrix is included in appendix I. The training is relevant for the following staff members:-

- Staff members preparing food in the kitchen
- Staff writing risk assessments and care plans
- Staff assessing a choking risk including family members who are supporting an adult who has a choking risk to eat and drink

7.3 The recommended level of training is based on the ‘type’ of care intervention that a staff member or the adult’s support team undertakes in relation to the adult presenting with the choking risk. The level of recommended training is not based on a staff member’s job title within an organisation.

7.4 Private provider services (including Home Care agencies and Independent
Hospitals) regulated by the Care Quality Commission are required to meet a number of essential quality outcomes in order to register to provide services. As part of this arrangement providers must only accept people whose assessed needs can be met safely and in line with the agreed person-centred care plan. This requirement extends to the care of people assessed at risk of choking.

7.5 In order to do this, those providing a commissioned service must ensure that their employees and / or subcontractors who are responsible for meeting an adult’s needs have access to sufficient training as detailed in the training matrix in Appendix I with regards to the following areas:-

- All Hampshire County Council Adults’ Health and Care, providing care to adults who may be at risk of choking will receive training by the Workforce Development team in managing the risk of choking appropriate to their role
- Recognition of choking
- The use of appropriate choking risk screening tools
- Must also understand how and when to make referrals to specialist services, such as, Speech and Language therapy service
- Be able to safely deliver care to any person at risk of choking
- Be able to respond to an episode of choking by administering the correct emergency first aid interventions and then seeking appropriate aftercare
- All Hampshire County Council Adults’ Health and Care and care staff providing care and those responsible for nutritional management, food preparation, including those who support menu development will receive emergency first aid choking response training as part of the Stepping forward, Stepping Back induction programme.

8.0 Using the Mental Capacity Act (2005) to support decision making

8.1 Mental Capacity Act (2005) supports adults to make their own choices. If a decision needs to be made by the adult in relation to their diet, then in line with best practice and legal requirements, the adult has a right to be supported to make their decision. The Mental Capacity Act 2005 and Code of Practice set out the practices to be followed, including the statutory Best Interests checklist (Section 4, MCA 2005). Please use the link below:-


8.1.2 For those adults where there may be diminished mental capacity and where a choking risk exists, eating and drinking will be a complex area to navigate for these adults and associated staff members who are supporting them. The Mental Capacity Act (2005) seeks to ensure that people who lack capacity to make specific decisions for themselves are protected from harm
that may arise from their lack of capacity, by allowing others to make decisions in their ‘best interests’.

8.1.3 There may be circumstances when a staff member or carer may need to assess an adult’s capacity in relation to their choking risk, for example, where an adult likes a particular kind of food which has the potential to raise their risk of choking, and they want to eat that food but the staff member is unsure whether they have the mental capacity to understand the potential dangers that would bring.

8.1.4 Deciding if an assessment of capacity is needed is not always obvious. The staff member should always start by assuming the adult has capacity to make the specific decision (in line with principal 1 in the Mental Capacity Act, 2005). Here are some example questions that you could use to help with the decision:

- Does the staff member or carer have any evidence to make them think that capacity may be impaired?
- Is there evidence of a mental impairment or disorder?
- Does the person admit to any problems in relation to choking risk? If so, does he/she seek appropriate assistance?
- Can the person recognise risky situations and respond accordingly?
- Could the person ask others for help in an emergency?
- Would the person encounter safety or physical health risks because of memory problems?

If the answers to any of these questions leave a staff member with concerns then they should undertake an assessment of capacity in relation to the adult’s decision making in relation to their choking risk.

8.1.5 Staff members or carers must gain the consent of the adult wherever possible, before any screening, assessment or medical investigation is undertaken.

8.1.6 Supporting adults to make their own decisions

8.1.7 Assessing Mental Capacity – Key steps

- Who is the right person to assess capacity? Usually the person who is most directly involved with the adult in relation to the decision such as a senior care worker who knows the adult, or main carer if the adult is living at home, but the assessment may also need the input of other relevant professionals (e.g. SLTs). Where the risks are higher or the situation is more complex it may be appropriate to invite a social worker or nurse who is involved to undertake the capacity assessment
- Be clear on the specific decision that the staff member or carer is assessing against (e.g. is the adult able to make informed decisions about eating the high risk foods and fully understands the risks?)
• Make every effort to help the adult make the decision in question. Help the person to gain a general understanding of what the decision is (including the risks) and why they need to make it.

• Ask questions designed to uncover the degree of insight the person has in relation to his/her self-care limitations. The staff member or carer should begin by asking the person if they are aware of any concerns about risks associated with their diet raised by others who know them well (e.g. friends or family).

• The staff member or carer should ask the person specific questions to test their ‘understanding and appreciation’ of the choices available. Choices may include different food options that would generate more or less risk. It may be necessary to probe to assess: how far the person is able to weigh up the advantages and disadvantages of one option over another; whether or not the person can anticipate the consequences, both in terms of likelihood and severity. Explore fully the person’s appreciation of the foreseeable consequences.

• Are the person’s stated reasons for his/her choice relevant to the decisions in hand? Look for evidence of reasoned choice. Examine the chain of reasoning for logical consistency. This is especially important where the person seems to be making an irrational or illogical decision that may have an adverse impact on his or her personal care, physical safety or well-being. A review of previous actions, prior wishes or history of choice under similar circumstances may provide information that either justifies or challenges the present choice or preference being expressed.

• Decisions about mental capacity are made by the assessor on the ‘balance of probability’. In borderline cases or where there is doubt, the assessor must be able to show that it is more likely than not that the answer to these questions is no (Code of Practice 4.48 Mental Capacity Act 2005.)

8.1.8 Best Practice - Recognising that the adult’s wish for a quality of life is a legitimate factor

• How is this important when considering whether an adult has capacity or undertaking a capacity assessment? To practitioners and family members the reduction of risk is usually of critical importance, whereas the adult may feel that their quality of life is more important than reducing their risk of choking. An adult taking this view is not necessarily lacking capacity, and may not be making an ‘unwise decision’. It may be a reasonable decision depending on their circumstances, priorities, history and preferences.
• How is this important following an assessment of capacity (where the adult lacks capacity) and you are undertaking a best interest decision? Justice Mumby (Court of Protection, 2007) said “all life involves risk … we must avoid the temptation always to put the physical health and safety of the elderly and vulnerable before everything else …. Safety can sometimes be bought at too high a price …. We should be willing to tolerate manageable or acceptable risks to achieve the vital good of the vulnerable person’s happiness”. (Please also refer to section 8.3 below)

8.2 It is essential that all assessments of mental capacity are clearly documented, and there is also clarity about which specific decision the assessment of capacity is being made against. The clear rationale behind the decision must be set out showing the factors that have been considered.

8.3 Use of the Best Interests process when the adult is unable make a key decision or give informed consent.

8.3.1 If an adult is assessed as being unable to make an informed decision about their own care, a best interest meeting must be held in line with the Mental Capacity Act, 2005. This must include the adult wherever possible or possibly an advocate who can express views about the adult’s wishes, feelings and values. Family members and / or friends should also be invited to share their views and professionals who are able to contribute to the decision making process on behalf of the adult in their best interests. This provides an opportunity to consider all possible options of care and through discussion reach a decision as to what the course of action will be in the “best interest” of the adult concerned, taking into account the adult's known wishes, feelings and values. The ‘decision maker’ is usually the person or agency with the lead clinical or funding responsibility in relation to the specific decision that is being considered, or the doctor if it is a treatment decision.

8.3.2 In circumstances where care workers or family members disagree with any decision reached regarding the adult’s care, it is up to the decision maker (usually, the commissioning body) to weigh up the views of the different parties and make a best interest decision when developing the care plan.

8.3.3 In the event of a significant dispute regarding the best interest’s decision made, every effort should be made to resolve it through discussion, negotiation or mediation. In the event of irresolvable disputes about best interests, an application may need to be made to the Court of Protection for a decision about the adult’s welfare best interests.

8.3.4 It may be necessary to restrict access to certain environments, foods or objects for some adults who lack capacity in relation to decisions about their food choices due to a risk of choking. In all instances this must be taken as a
best interest decision and the process set out in section 4 of the Mental Capacity Act, 2005 should be followed.

8.3.5 Should the staff member or carer require further support and or advice regarding the operational application of the Mental Capacity Act (2005), please refer to a senior member of your team.

8.4 Deprivation of Liberty Safeguards (DOLs)

8.4.1 In relation to monitoring an adult who has a high risk of choking it is possible that an enhanced level of supervision may generate consideration of whether a referral for a DOLs or a Community DOL authorisation is indicated. In most cases this will be unlikely, but in a small number of cases where additional restrictions of are placed upon independent movement in the accommodation or levels of supervision are increase; these will need to be considered alongside existing best interest restrictions to determine whether the combined effect deprives the individual of their liberty. Regard will be had to whether the purpose for which a measure is needed can be effectively achieved in a way that is less restrictive to the adult's rights and freedoms.

9.0 Managing and reducing the risk of choking

9.1 Screening the risk of choking

9.1.2. Whilst it is not possible to prevent all episodes of choking, reducing the risk of choking and improving the safety of adults who present with a risk of choking is critical.

9.1.3. There is an expectation that all organisations will ensure that:-

- Their employees or subcontractors who meet an adult’s care needs are fully aware that choking risks can result in fatal choking incidents and that the choking can affect anybody however certain factors may increase the likelihood of a choking incident occurring
- Their employees or subcontractors have an adequate understanding of the varied and range of medical and behavioural conditions and circumstances which can place a person at risk of choking
- They will provide an appropriate screening tool for employees or subcontractors to use when they are concerned that a person may be at risk of choking. It is recommended that staff working with adults with a learning disability complete the Solent NHS Trust Choking Screening tool (V.16) in appendix II
- Their employees or subcontractors know when and how to escalate concerns to a specialist service – for example, SLT.

9.1.4 Choking risk and subsequent choking can occur as a result of the following;
• Progressive neurological conditions for example, Parkinson’s disease, Motor Neurone disease
• Cerebrovascular disease / stroke
• Dementia
• Learning difficulty
• Structural changes, for example, pharyngeal pouch
• Head and neck surgery, for example cancer of the tongue
• Behavioural difficulties / effects of institutionalisation
• Mental health concerns
• Poor oral health / dentition
• Compromised posture
• Effects of medication (see section 17.0)

9.1.5 It is recommended therefore that staff working with an adult with a learning disability (ALD) are required to use the Solent NHS Trust Choking Screen (V.16, see appendix II) as part of the assessment process to determine if professional advice is required from a SLT, if there are concerns relating to questions 1-6, then pre-referral liaison will help staff identify if a referral to the SLT is appropriate.

9.1.6 All other referrals to SLT following a concern about a choking concern, should be made to the relevant SLT service, see Appendix V111 for details.

9.1.7 The Quality Standard, Care of people at risk of choking, has been developed for Hampshire County Council staff working in Hampshire County Council Care residential and nursing homes to guide them in the practical steps required to aid them reduce the risks of choking among the people they deliver care to.

9.2. Care planning

9.2.1 The development of an adult’s care plan must, wherever possible, include the views and wishes of the adult. The principles and requirements of the Mental Capacity Act (2005) must be considered and implemented when developing an adult care plan.

9.2.2 Providers must have robust processes to ensure that an appropriate eating and drinking care plan is in place for any adult who is at risk of choking. This must be undertaken regardless of the adult’s capacity to understand. If the adult is making an unwise decision to eat high risk foods or drink, the provider should ensure that the service user understands the risks they are taking and have a documented mental capacity assessment to support their decision.

9.2.3 Providers must ensure there is a process in place to prompt regular reviews by the care provider and for the choking risk to be re-assessed as the needs of the adults change. For example, if there is a medication or
physiological change or deterioration in an adult’s clinical condition that may impact on their ability to swallow safely.

9.2.4 The provider must monitor that staff are fully competent to recognise and assess a choking risk and to deliver ‘safe and effective’ care to those adults who are at risk of choking, in line with the adult’s agreed care plans and risk assessments.

9.2.5 Different professionals or care givers will often have their own care plans for the people they are supporting. For example, a self-directed support plan, a speech and language therapy care plan, and caregivers may have their own adult care plans.

9.2.6 If an adult presents with an increased choking risk this must be considered and reflected consistently throughout the care planning process by those involved in specialist advice giving, or day to day care provision. A consistent approach across all care givers is very important for keeping the adult safe and reducing the risk of choking and/or aspirating. It is recommended that the care plan follows the adult to any care setting to ensure a consistent and safe approach to managing the adult’s choking risk.

9.2.7 Each adult for whom a service is provided must have an adult first aid treatment plan so that those who are wheelchair users or cared for in bed are treated with first aid appropriate to their needs and staff must be aware of this plan and understand how to execute it if required.

9.2.8 In day services, such a plan would only be developed for those people who are both wheelchair users and also identified as at risk of choking.

9.2.9 Where a risk of choking is identified, the plan must include what the concern is and what interactions and interventions are required to minimise the risk.

9.2.10 Refer to Appendix IV for guidance on how to complete a care plan. In essence it would be recommended that consideration is given to the following when writing an adult’s care plan regarding management of the risk of choking:

- Detail how to support the adult to eat, drink and take medication safely and minimise the risk of choking
- Detail if the risk of choking increases as a result of their challenging behaviour, fluctuating medical and or cognitive status
- Record in the adult’s records if an incident of choking occurs
- Document if there is a change in the adult’s risk of choking
- It is important that the risk plan considers the risk of choking presented by both edible and non-edible items, if appropriate
- Clearly document all health care that is relevant for the person, such as an annual health or dental check and when and where the care should be
sought. It must inform the care givers of what they must do to support the person in their care to visit the GP, dentist etc

- Document any medication or treatments prescribed to them. Some medications can have an impact on a person’s swallowing functioning and it is important that any changes are considered before a medication change. Any identified risks following a change in medication must be clearly documented within the person’s care plan.
- The care plan should be reviewed if there are any changes in the medication prescription.
- Clearly document any signs and symptoms of swallowing difficulties or dysphagia that may be relevant to an adult’s health care and condition, and that can assist care givers in identifying an emerging risk of, or change in risk of choking.
- Document the likely prognosis and or anticipated deterioration for the adult deemed to be at increased risk of choking so that care givers will not make false assumptions which might place the adult at risk.
- Provide detailed contingency plans should emergency intervention be required.
- Detail the first aid care/intervention that is required to the adult should choking occur. This must take into account any adults who use a wheelchair or those who are cared for in a bed.
- Include information about the adult’s mental capacity to be able to understand their risk of choking and their ability to understand and agree to the protective actions which may be put in place to reduce that risk.
- Any recommendations recorded from the SLT review must NOT be altered.

9.2.11 Further information regarding good care planning can be found on the Hampshire PACT website. Written and produced by Hampshire County Adults’ Health and Care and South Eastern Hampshire and Fareham and Gosport, West Hampshire CCGs.

9.3 Review of Care plan

9.3.1 Whilst regular reviews are necessary in line with each organisation’s policy and guidance, it is recommended all care plans are reviewed based on clinical need. Staff must remain vigilant and responsive to the adult’s needs at every intervention during all oral intakes, including meals, drinks, snacks and medications.

9.3.2 An adult’s care plan and any decisions outlined in it must be reviewed and monitored regularly for any changes. Assessments and decisions must be actively revisited following any change or deterioration in the person’s health or behaviour.

9.3.3 In Hampshire, the key statutory commissioners of care and support for adults (Hampshire County Council Adults’ Health and Care, West Hampshire,
Fareham and Gosport and South Eastern CCGs, North Hampshire and North East Hampshire and Farnham CCGs) have all agreed that when the provision of support moves from one provider to another, best practice must be demonstrated by the new provider by them not automatically re-write the care/support plan relating to choking risk onto paperwork of the new provider. This is because there have been instances of care plans relating to choking being transferred to new paperwork incorrectly, which has led to increased choking risks for the adult. Instead the key statutory commissioners of care will develop a standard format for care/support plans relating to choking which will be best practice for all providers to use.

9.4 Managing risk and risk assessments

9.4.1 Any staff member, including support staff has a responsibility to ‘screen’ for the risk of choking where it is thought that an adult may be at risk. All staff involved in the adult’s care must:-

- Be informed of the care plan and any changes to it in relation to the adult's management plan for choking risk, eating, drinking and taking medication
- Be involved in the care planning process for adults at risk of choking
- Be aware of the consequences of staff not following an agreed management of an adult’s choking risk, eating and drinking plans
- Complete a choking screening every time concerns are raised or a risk of choking is suspected regarding current oral intake and be completed every six months after initial completion/initial Speech and Language therapy recommendations are made
- Understand what staff are required to do if the choking screening tool indicates there is a risk of choking or an increased risk of choking for an adult
- Be able to recognise and know how to prepare/present food and fluids to the person, in keeping with their eating and drinking recommendations. Please see appendix V for information in relation to the International Dysphagia Diet Standardisation Initiative (IDDSI)
- Follow instructions in the care plan for giving medications; including the correct positioning of the adult and ensuring medications are prescribed and dispensed in the appropriate format
- Where an adult experiences a choking episode or a near miss choking episode, this must always be recorded on an incident form
- The incident must also be fully recorded in the daily notes for that adult (where relevant) and consideration should be given to whether a referral or re-referral to an appropriate professional is required such as their General Practitioner or SLT

9.5 Challenging Behaviour that may increase an adult's risk of choking

9.5.1 Some adults may exhibit challenging behaviours for example, e.g.
putting non-food items into their mouth, swallowing non-food items or deliberately trying to choke themselves through self-harm. If this occurs, staff should immediately seek a multi-disciplinary assessment to agree an action plan to mitigate the risk.

9.6 Staying in Hospital

9.6.1 When an adult has a stay in hospital

9.6.2 When an adult is staying in hospital for any reason, their eating and drinking needs must be communicated verbally or through a document such as their hospital passport. It is of paramount importance that this information goes with the person to hospital to detail the adult’s most up to date eating and drinking recommendations.

9.6.3 When an adult is known to the Speech and Language therapy service and they are aware of their hospital admission, best practice would be for the community services and acute services for Speech and Language therapy to liaise regarding any changes to the eating and drinking recommendations during the hospital admission and following discharge.

9.6.4 Processes are in place for Solent East SLT to liaise with Portsmouth Hospital SLT service if an adult is admitted to hospital. When an adult is acutely unwell, the adult’s eating and drinking skills often will require assessing again within the hospital setting.

9.6.5 This potential review of an adult’s eating and drinking skills does not negate the importance of clear communication and handover between the hospital, provider, family carers and any other professionals who may be involved such as Adults’ social care and health or Community Nursing.

9.6.6 Hospitals should also consider whether there are any training needs identified for the provider staff and / or family carers following the discharge of the adult back to their care in the community setting.

9.6.7 Following discharge from hospital there is a responsibility on hospital teams to ensure that that any changes to the management of an adult with a choking risk, including changes to the adult’s care plans and risk assessments are appropriately amended in the community setting and the appropriate teams are informed of such amendments. This responsibility is within their duty to arrange a safe discharge.

9.7 Safeguarding

9.7.1 The Care Act 2014 (Section 42) confirms the three part test which is used by the Local Authority to decide whether or not a safeguarding concern meets the criteria for a safeguarding enquiry to be opened. The criteria are:
• The adult has care and support needs (whether or not these are being met by the Local Authority)
• The adult is experiencing or at risk of experiencing abuse or neglect and
• The adult as a result of their care and support needs is unable to protect themselves from abuse or neglect

9.7.2 It is expected that any choking incident that may have resulted in significant harm due to lapses in care to the adult and/or the lack of care is suspected to have resulted in a choking incident that consideration is given to reporting this incident to the multi-agency safeguarding hub (MASH). Please refer to appendix (VI) for details of how to make a referral to MASH.

9.8 The role of the SLT in relation to the management of an adult presenting with a choking risk

9.8.1 A referral is received by the relevant SLT or Multi-disciplinary team (MDT) service and, depending on local policy, an acknowledgement letter is sent to the referrer, adult and GP. The referral is triaged and prioritised in line with local policies and standards. This referral may be deemed inappropriate and the referrer is informed, it may be passed to SLT or to another profession within the MDT.

9.8.2 If the referral is agreed as appropriate for SLT due to a dysphagia need:
• A swallowing assessment will be completed, either in an outpatient or home/day service setting
• Recommendations will be provided for the safest swallow regime and these will be discussed and agreed with the adult and / or significant care givers
• Written information to support the recommendations will be provided. This includes a safest swallow care plan/mealtime mat and IDDSI documents for modified food and fluids - see Appendix V.
• A report/letter will be sent to the referrer, adult, GP and other relevant agencies
• A SLT review may be carried out, this decision is made on case by case basis
• The adult will be discharged when no further SLT intervention is indicated

9.9 Referral to SLT will depend upon the organisation as each team will have different routes of referrals.

9.9.1 The SLT service across Hampshire is mapped in appendix VIII. This map details the contact details for the SLT service that is responsible for receiving SLT referrals. Should a staff member or carer experience a problem
with referring an adult to the SLT service, please refer to your General Practitioner or the local Clinical Commissioning Group for advice.

10.0 When to make a referral

10.1 Referrals to SLT should be made on completion of the Solent choking screen that highlights concerns (see appendix II) and / or if signs of dysphagia are noted (see 5.2.1).

10.2 The role of the multi-disciplinary team

10.3 A referral may be more suited to other members of the multi-disciplinary team depending on the risk factors that have been identified. Examples include:

- Consideration of the function of the behaviour if someone is eating very fast, deliberately blocking airway (liaison with Psychology)
- Consideration of sensory needs if cramming food, regurgitation of food or moving about whilst eating (liaison with Occupational Therapy)
- Consideration of unmanaged Pica (may be multi-disciplinary)
- Consideration of excessive wheezing (liaison with Physiotherapy)
- Consideration of difficulty taking medication and side effects of medication (liaison with Pharmacy and/or Psychiatry)

11.0 Immediate first aid for a choking incident

11.1 If an adult isn’t breathing normally during or after a choking incident, call 999 to seek emergency medical assessment.

11.2 If the adult stops breathing following a choking incident, this is a potentially a reversible event and cardiac pulmonary respiratory resuscitation (CPR) should be commenced immediately regardless of a valid ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) in place.

12.0 What to do following a choking incident

12.1 Ensure that following a choking incident or near miss, a clinical review of the adult is arranged.

12.2 Following a choking incident or near miss it is essential that the incident is clearly documented in the adult’s records; that care plans are reflective of the need and that risk assessments have been reviewed and updated if necessary (see appendix IV for care planning advice).

12.3 Report any choking incident using own organisation’s incident reporting system. This will ensure that any learning identified can be shared with others.
13.0 Medication and risk of choking

13.1 Certain medications irrespective of formulation can produce side effects which can subsequently impact on swallowing and increases the risk of choking. Certain anti-psychotic medication (used to treat psychiatric disorders), anti-sickness medication (used to treat nausea) and anti-histamines and decongestants (used to treat cold like symptoms) can cause a dry mouth which then interferes with the swallowing process. A doctor and or pharmacist can advise. Remember that an adult assessed as presenting with a choking risk may require closer supervision and monitoring when taking medication.

13.2 In keeping with best practice, it is recommended that any known allergies and or risks of choking should be clearly printed on the front of the person’s medication chart to allow for risks to be mitigated appropriately.

13.3 Administration of any prescribed and non-prescribed medication would need to be risk assessed in the same way that administration of food and fluids would need to be risk assessed appropriately. Advice should be sought from the prescribing physician and or pharmacist in terms of weighing up the benefits and risks of medication for an adult considered to be at risk of choking.

13.4 The type, frequency and formula for medication all form part of the risk assessment. There is an array of different formulations of medicines. These can include tablets and capsules, dispersible/effervescent tablets which are designed to dissolve in water. Liquid medication, topical formulations such as creams, ointments, lotions and injections which need to be administered by specially trained carers and members of staff.

14.0 Associated documents

- CQC Regulation 12: Safe Care and treatment
- CQC Regulation 14: Meeting nutritional and hydration needs
- CQC Regulation 9: Person Centred Care
- National Patient Safety Agency
- Southern Health Dysphagia (Swallowing Disorder) Policy Version 2
- Solent Health Choking risk assessment tool – Its no Choking matter!
- PACT Training
- Mental Capacity Act 2005
- How people with Learning disabilities die
- Reducing the risk of choking for people with a learning disability A Multi-agency review in Hampshire
- Choking Guidance – risk assessment and management South Staffordshire and Shropshire Healthcare NHS Foundation Trust
15.0 Guideline review

15.1 The expectation is this guidance will be reviewed every three years by the health sub group of Hampshire Adults Safeguarding Board and Speech and Language Therapy teams working in Southern Health Foundation Trust and Solent NHS Trust.

16.0 Supporting references


http://www.gov.scot/Publications/2008/02/01151101/0

N.B. This guide relates to Scottish incapacity law, however their legislation follows the same principles as British mental capacity legislation.
Appendices

Appendix I

Choking Workforce Development Strategy

Minimum recommended level (please see next page)

It is for each organisation to review the learning outcomes and the activities staff undertakes recorded within this document to identify the level of training staff in their organisation require matched to the responsibilities they hold.

Recommendation that all Family members/ Carers/ Friends and Volunteers should as a minimum, have the knowledge of each persons Choking / Dysphagia (link to descriptor) support plan and the skills to meet the identified outcome of that plan
<table>
<thead>
<tr>
<th>Level of Training</th>
<th>Course Title (working title's)</th>
<th>Basic Emergency First Aid</th>
<th>Awareness of Risk of Choking</th>
<th>Food Preparation and Nutrition</th>
<th>Enhanced Awareness</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Identify people who are choking.</td>
<td>Face to Face Training</td>
<td>E-learning</td>
<td>Face to face training</td>
<td>Face to face training</td>
<td>On Line resources</td>
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<tr>
<td></td>
<td>Take immediate appropriate action on the incident.</td>
<td></td>
<td></td>
<td>On line resources</td>
<td>On line resources</td>
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<tr>
<td></td>
<td>Take immediate appropriate action on the incident for people in wheel chairs / beds and who have restricted mobility</td>
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<td></td>
<td>Take appropriate action after the incident with regard to Medical check.</td>
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<td></td>
<td>Training to include use of simulation models to practice back slaps and abdominal thrusts.</td>
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<tr>
<td>Outcomes</td>
<td>Understand the different definitions of food textures and preparation</td>
<td>Helpstopchoking.hscni.net</td>
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<tr>
<td></td>
<td>Support menu development for food textures.</td>
<td>Online resource page including links to</td>
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<td></td>
<td>Appropriate use of Thickening Agents.</td>
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<td></td>
<td>Presentation of meals</td>
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<td></td>
<td>Food Nutritional value</td>
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<td></td>
<td>Links to</td>
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<td></td>
<td>NH – Dysphagia in the Social Care and Health Care Sector</td>
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<td></td>
<td>Public Health Document: Make reasonable adjustments to Dysphagia services for people with a Learning Disability</td>
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<td></td>
<td>NES Preparing Food to correct Textures</td>
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<td></td>
<td>Video clips of Food Preparation</td>
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<td></td>
<td>Individual knowledge of each person’s choking support plan and the skills to meet the identified outcome of the plan</td>
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<tr>
<td>Outcomes</td>
<td>Understand the difference between choking risks (including dysphagia)</td>
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<td></td>
<td>Provide safe, holistic, good quality care which reduces the risks of choking and aspiration incidents occurring and understand what is a normal and abnormal swallow</td>
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<td></td>
<td>Understand the importance of adequate nutrition and hydration and the adverse effects of not receiving these</td>
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<td></td>
<td>Identify factors that increase the risk of choking and the importance of health checks</td>
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<td></td>
<td>Understand how to contribute to the process of risk assessment and care planning around choking and where to gain support with individual management plans</td>
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<td></td>
<td>Understand proactive strategies that can reduce the risk of choking</td>
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<td></td>
<td>Consider an individual’s capacity to consent and the role of mental capacity Act/ DOLS and advocacy</td>
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<td></td>
<td>Supporting risk assessment and management plans course to have an experiential focus and practical application of skills to support individuals</td>
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<td></td>
<td>People attending should hold prior knowledge and skills in Support / Care Planning principles, Positive risk assessment, Mental capacity Act and Safeguarding</td>
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<td></td>
<td>Know how to identify factors/ signs and / symptoms that highlight potential increased risk of choking for individuals</td>
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<td></td>
<td>Knowledge to signpost to specialist practitioners to manage the individuals risk of choking</td>
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<td></td>
<td>Hold the Skills and knowledge to complete, interpret and take appropriate action; a levels of negative health assessment – Dysphagia</td>
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<td></td>
<td>Add Specialist linked to other risk factors e.g. behaviour, health conditions</td>
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</tbody>
</table>

| Target Audience  | All staff who are required to respond and provide emergency aid to choking incidents | All Staff who assist individuals to eat who are identified at an increased risk of choking | All non S&L staff who are involved in assessing and reviewing an individual’s plan of care for choking | All Staff who assist individuals who are identified at an increased risk of choking | All staff involved in food preparation for people who are identified at an increased risk of choking | All staff who lead on the monitoring and identification of individuals who are at the risk of choking and Complete risk assessments to minimise the risk of choking | All non S&L staff who are involved in assessing and reviewing an individual’s plan of care for choking. | Specialist practitioners e.g. GPs, Social Workers, SLTs Identify role function (tbc) |
Appendix II Solent NHS Trust Choking Screening Tool - for use with adults with a learning disability only

Client Name: .......................................................... Date of Birth: .........................
NHS Number: .........................................................
Medical diagnosis: .......................................................... Recent changes to health: ..........................................................

<table>
<thead>
<tr>
<th>Questions screening the possibility of dysphagia</th>
<th>COLUMN A</th>
<th>COLUMN B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the person frequently or continually cough before, during or after eating and/or drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Does the person have Speech and Language Therapy (SLT) eating and drinking guidelines?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are these guidelines being followed? Give reasons for not following guidelines</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Has there been a choking (partial or complete obstruction affecting respiratory function) incident in the last 12 months?</td>
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</tbody>
</table>
| If ‘Yes’: Number of occasions ……………………………………………………………………………………....
| What was being eaten? ………………………………………………………………………………………………
| 4. Has the person had pneumonia or recurrent chest infections in the last 12 months?                              | Yes      | No       |
| If ‘Yes’: Number of occasions ………………………………………………………………………………………
| Known respiratory conditions……………………………………………………………………………………
| 5. Has there been a significant change in the last 12 months in any of the following: (Please provide details for any ‘Yes’ responses) |
| a) Unexpected weight loss…………………………………………………………………………………………
| b) Fluid intake…………………………………………………………………………………………………………
| c) Time taken to complete meal/drink …….Due to problem using cutlery? yes/no                                  | Yes      | No       |
| d) Self-feeding skills……………………………………………………………………………………………….
| e) Mealtime Environment……………………………………………………………………………………………
| 6. Oral skills:                                                                                                   | No       | Yes      |
| a) Are they able to chew a normal diet? If ‘No’, give details…......................................................................
| b) Is their food and/or drink currently modified? If ‘Yes’, how and why...                                       | Yes      | No       |
| 7. Does the person have any other behaviour’s that increase their risk of choking?                              | Yes      | No       |
| If ‘Yes’, please provide details e.g. fast pace/food cramming/self-harming at mealtimes (not seen at other times)/ pushing fingers/ utensils into mouth/ storing food in cheeks?
| .............................................................................................................................................
| .............................................................................................................................................
| What strategies are in place to manage this behaviour? (Prompts / smaller cutlery etc.)
| .............................................................................................................................................
| Questions that relate to possible choking risks in addition to/ not related to dysphagia                         | COLUMN A | COLUMN B |
| 8. Oral Health: Does the person have good oral hygiene/healthy teeth? If ‘No’, please provide details…………………...| No       | Yes      |
| 9. Does the person have a diagnosis of Pica (a persistent craving & compulsive eating of non-food substances)? | Yes | No |
| 10. Is the person currently experiencing any of the following side effects from their medication: relaxed muscle tone; drowsiness; dryness of the mouth; increased saliva? | Yes | No |

**ACTION:** If you have circled answers in column A, an updated care plan, adopting a common sense approach, may be required to manage the risk of choking.

If you have circled an answer in Column A, questions one to seven refer to SLT, via relevant ALD MDT.

☐ Referral made (date): ……………………………………………………………..PLEASE ENCLOSE THIS COMPLETED SCREEN WITH REFERRAL

If you have circled an answer in Column A, questions eight to ten liaise with appropriate health professional / GP

☐ Dentist    ☐ GP    ☐ Behaviour specialist    ☐

other…………………………………………………

Information provided by: (print name) _____________________________
Relation to referred person: _________________________________
Date completed: ___________________________
### Appendix III Referral Form V.3.0 and referral criteria for Hobbs Rehabilitation

**ADULT SPEECH AND LANGUAGE THERAPY REFERRAL FORM**

Please complete all sections and email to:  
whccg.hobbsrehabilitation@nhs.net

*(To ensure patient confidentiality please only use this email if you are emailing from a secure nhs.net account)*

Speech & Language Therapy  
Hobbs Rehabilitation  
Bridgets Farm Lane Offices  
Bridgets Lane  
Martyr Worthy  
Winchester  
SO21 1AR

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### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DOB:</th>
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<table>
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<tr>
<th>NHS NUMBER:</th>
<th>ADDRESS:</th>
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<tr>
<th>POSTCODE:</th>
<th>TELEPHONE No:</th>
<th>MOBILE No:</th>
</tr>
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<tr>
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<table>
<thead>
<tr>
<th>NOK:</th>
<th>NOK CONTACT No:</th>
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</thead>
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<table>
<thead>
<tr>
<th>GP Name:</th>
<th>GP Surgery:</th>
<th>TEL No:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Who should be contacted to arrange the appointment?  
- Patient ☐  
- NOK ☐  
- Other *(please state)*

### REFERRAL INFORMATION

Reason for referral:

- Communication assessment ☐  
- Swallowing assessment ☐

Relevant medical diagnosis/difficulties:

<table>
<thead>
<tr>
<th>Currently eating:</th>
<th>Currently drinking:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Normal Diet</td>
<td>□ Soft Diet (texture E)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>□ Pre-mashed Diet (texture D)</td>
<td>□ Puree Diet (texture C)</td>
</tr>
<tr>
<td>□ NBM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

Description of problem *(give as much detail as possible)*:

Previous Medical History:

Medication:

Known Allergies:

**Which of these apply to your patient?**

- □ Recent chest infection
- □ Recurrent chest infections
- □ Choking episode(s) (=occlusion of airway)
- □ Weight loss
- □ Recurrent UTIs
- □ Catheter in situ
- □ PEG/PEJ/RIG/RIJ in situ
- □ Wheelchair bound
- □ Bed bound
- □ Hoist transfer

**Level of harm because of swallowing and /or communication difficulty:**

- Low □
- Medium □
- High □
Can the patient attend outpatients? Yes ☐ No ☐

REFERRER DETAILS:
Name: 
Designation: 
Contact telephone number: 
Contact address: 
Date of referral: 
Signature: 

Please use this chart for our referral criteria before you refer:

<table>
<thead>
<tr>
<th>☑️</th>
<th>☒️</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We accept:</strong></td>
<td><strong>We don’t accept:</strong></td>
</tr>
<tr>
<td>Over 18 years of age</td>
<td>Under 18 years of age</td>
</tr>
<tr>
<td>Swallowing difficulty as a result of an acquired neurological condition (e.g. Stroke, Parkinson’s, Dementia)</td>
<td>Swallowing difficulty as a result of gastro / respiratory / oncology condition</td>
</tr>
<tr>
<td>Communication (speech / language / voice) difficulty as a result of an acquired neurological condition (e.g. Stroke, Parkinson’s)</td>
<td>Patients with voice difficulties NOT as a result of a neurological condition</td>
</tr>
<tr>
<td>Patients over 65 years old with a progressive neurological condition (not MND)</td>
<td>Patients with dysfluency / stammer NOT as a result of a neurological condition</td>
</tr>
<tr>
<td>Patients under 65 years old with a progressive neurological condition who can attend outpatients (and are likely to be able to for the next year)</td>
<td>Patients with MND, regardless of age (please refer all MND patients to CNRT via <a href="mailto:SNHS.AdultCommunitySALT@nhs.net">SNHS.AdultCommunitySALT@nhs.net</a>)</td>
</tr>
<tr>
<td>Patients under 65 years old with a progressive neurological condition who require a home visit (or will likely be unable to attend outpatients within the next year)</td>
<td>(please refer these patients to CNRT via</td>
</tr>
<tr>
<td><a href="mailto:SNHS.AdultCommunitySALT@nhs.net">SNHS.AdultCommunitySALT@nhs.net</a></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Patients with learning difficulties (unless also experiencing an acquired neurological condition)</td>
<td></td>
</tr>
<tr>
<td>Patients with mental health difficulties (unless also experiencing an acquired neurological condition)</td>
<td></td>
</tr>
<tr>
<td>Adults with a congenital / developmental condition (unless also experiencing an acquired neurological condition)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV

Hampshire Care Planning Guidance

July 2017

in partnership with PACT
This guidance has been developed to support health and social care staff who are involved in the care planning process.

Care planning is at the heart of the health and social care therapeutic process and should be developed in partnership with the service user, and wherever possible his or her carer. It is recognised that there may be considerable variation between care plans as there is no single correct way to write one, but there are important common points to cover regardless of the client group.

This document provides some guidance for what to include and how to structure a care plan that is helpful for both staff and service users.

**Key principles of care planning:**

- Involving service users and carers in care planning – people significant to the person
- Building on strengths as well as focusing on needs
- Making the care plan central to a person’s care
- Ensuring the care plan is holistic – covering health and social care needs
- Sets out clear goals and support interventions
- Describes in an easy, accessible way the support needed to be provided

**What does care planning involve?**

- Gathering and sharing stories – views of all concerned including the resident, their family/carers and professionals
- A systematic review of the areas of need, what people can do for themselves, outcomes people want to achieve as well as areas of need.
- Needs to promote independence/empowerment where possible, thinking about re-enablement model
- Exploring and discussing information – to work out what is most important
- Goal setting – what do we want to achieve?
- Action planning – What are we going to do? Who is responsible? When will it be reviewed?
- Risk Management – how do we make care as safe as possible
- Mental Capacity Act (MCA, 2005) principles
A care plan is:

- A record of needs, actions and responsibilities, outcomes important to the person, so that it tells you about the person – their likes and dislikes and how they wish to be supported
- A tool for managing risk
- A plan which can be used and understood by service users, families, carers and professionals
- Something which people who use the service feel they own
- Based on a thorough assessment of need
- A multi-professional, multi-agency endeavour
- Co-ordinated by the most appropriate person, e.g. a key worker
- Shared with those that are part of it
- The written record of a plan of action, negotiated with the person to meet their physical/mental health and social care needs
- A legal document the author is professionally accountable for the care they have planned

A care plan is not:

- A bureaucratic exercise
- A wish list but is a plan of agreed elements of care
- A risk assessment

Risk Assessments:

Risk assessments are NOT a care plan – a risk assessment is a tool to help you identify the need for a specific care plan. Risk assessments should always be accompanied by a plan of action based on the information you have learnt as a result of conducting the risk assessment. Sometimes a risk assessment can be used to identify and evidence that there is no risk, in this instance there needs to be no specific plan. However please remember risks need to be re-assessed and the plan maybe when you will do this.

How to write a care plan:

A care plan should be written with the person or significant other/advocate who knows the preferences of the person the plan is for. A sense of ownership by all those concerned is vital in making the plan translate into reality which can be promoted by:

- Using people’s own words and phrases and involving them in the writing of the plan
- Recognising that care plans exist for the benefit of the person
Using the person’s lasting power of attorney (LPOA) for health and welfare (if applicable)

**In practice, it may be useful to write:**

- the care plan as ‘I need’, to encourage the service user to think about what he/she needs
- statements of action that are instructional and able to be followed in your absence
- interventions that relate directly to the needs and goals

**To make text more inviting to read, use:**

- Short sentences – in general no more than 15-20 words long
- Present and active tenses, where possible, for example, ‘your appointment is on…’ not ‘your appointment has been made for…’
- Bulleted or numbered points to divide up complicated information
- Small blocks of text. Do not use long paragraphs – divide them up using headings and new paragraphs
- White space makes the information easier to read
- Large bold font emphasizes text. Avoid UPPER CASE letters, italics, and underlining as they make the text more difficult to read. WRITING IN CAPITALS READS AS IF YOU’RE SHOUTING.
- The font size should be between 12 point (minimum) and 14 point. However, if you are providing information for elderly people, or those with sight difficulties, you should always use at least 14 point.
- Typed information should usually be in Ariel font
- Handwritten plans should be in simple text (not joined up writing) to avoid misinterpretation
- Avoid abbreviations unless stating at the beginning of the document what the abbreviations refer to
- Consider the use of pictures and images to meet the communication needs of the person

Most care plans follow a similar format based on a simple process. The four stages of the process are:

**Assess, Plan, Implement and Evaluate:**

**Assess:** The assessment process involves gathering information and completing various assessment tools, for example the Water low Pressure Ulcer risk tool and is an on-going and dynamic process. The overall aim of assessment is to initiate a therapeutic relationship with the resident and develop an understanding of problems and needs, which will enable the team
to move to the next stage (planning). The assessment will also include what they can do for themselves or what they want to try and achieve.

A clinical assessment should have physical, psychological, emotional, spiritual, social and cultural dimensions. Risk assessments are formulated and implemented from the assessment process and form an integral part of the care plan.

The written assessment and identification of client needs must include identifying areas such as (not an exhaustive list):

- Allergies
- Medication
- Infection risks
- Pressure ulcer & skin integrity risks
- Nutritional risks
- Resident handling needs
- Falls risk

**Plan:** Residents may be admitted to the home with a range of problems, and it will be necessary to prioritise these. The goals of the care should be agreed by the multi-disciplinary team based on the patient’s perspective, resources available and management of identified risk. The process of setting goals can be therapeutic, particularly if they are the result of a collaborative process between staff and residents and as they can help to clarify complex problems and indicate a commitment to change.

**What is a goal?** Goals convey what it is that is to be achieved and the desired outcome for the health gain for the client – i.e. a patient centred outcome.

Goals can be seen as challenging for staff, either because they seem unrealistic, or that supporting them is outside of their role. However, it is an important part of care planning to identify ways in which the team may support that goal.

For example an individual may want to go to the toilet unaided this may be unrealistic but it could be agreed or a compromise reached that they are left in privacy for part of the time. Understanding the rationale behind the goal may be because they don’t want to bother anyone, understanding this may be that the compromise be they are offered assistance at certain key points in the day so they don’t need to ask for assistance.
Goals must be SMART:
Specific
Measurable
Attainable
Realistic
Time Bound

For all clients, a care plan should include:

- **Aims** – why are we doing this?
- **Outcomes** – What are we planning to achieve?
- **Actions** – How are we going to do it?
- **Responsibilities** – Who will do it?
- **Environment** – where and when will it take place?
- **Time** – when will it be done by?
- **Personalisation** – any needs/preferences relating to race/culture, economic disadvantage, gender, age, religion/spirituality disability or sexuality?
- **How was the person involved in care planning?**
- **Was capacity and consent considered?**
- **Safeguarding** – risks, capacity, vulnerability, crisis and contingency arrangements?
- **Previous history** – any unmet needs?
- **Date of next planned review**

**Implement:** The assessment has provided a focus for planning and implementation of care that is effective (best possible outcome for residents) and evidence-based. The multi-disciplinary care team will determine the immediate priorities and recognise when clinical intervention and what referrals to other health and social care professions is required.

**Evaluate:** Effective evaluation of care requires the staff member to critically analyse the service user’s health status to determine whether the service users’ condition is stable, has deteriorated or improved.

Involving the service user, their family or advocates will facilitate the decision making. The frequency of the evaluation will depend upon the individuals care; however regularly evaluation review dates need to be included in the care plan:
• Clinical care e.g. nursing, therapy should be evaluated using measurable outcomes on a regular basis and interventions adjusted accordingly
• Progress towards achieving outcomes should be recorded in a concise and precise manner
• Personalise, use service users own words if appropriate
• State what care you have given, planned or any variation. Comment e.g. “pressure area care given skin slightly red on sacrum”
• Amend the care plan if circumstances have changed
• Discontinue care plans if the goal(s) have been reached Evaluation must take place as per local guidelines and must focus on all elements of the care plan, i.e. the assessment; goals, interventions and the achievement of goals must be reviewed

Evaluation involves considering if it is appropriate to continue with the current plan of care or try something different, and it will need to involve an element of on-going assessment (and, at times, re-assessment).

The evaluation must demonstrate patient involvement and, if this is not possible, a rationale and a plan for engaging the patient must be given. Amend the care plan if circumstances have changed, and discontinue it if the goals have been reached or the interventions need to change significantly.

Discontinued care plans must be clearly marked as discontinued by crossing through with a single line and ‘discontinued’ written across with the date. The date of discontinuation must also be entered on the care plan index.

Document your evaluation and actions taken on the evaluation form.

Record Keeping - Record keeping is a fundamental aspect of clinical care and clinical records must be:
• Factual, consistent and accurate
• Be written as soon as possible after the event
• Be written and recorded clearly and in such a manner that the text cannot be erased
• Have any alterations or additions clearly dated, timed and signed in such a way that the original entry can still be read clearly
• Be accurately timed and signed with a signature printed alongside the first entry
• Be readable when photocopied - Be written when possible with the service user involvement
Please refer to your professional body (NMC for Registered Nurses) or work place policy for standards of record keeping. Remember – ‘If it is not recorded, it did not happen’

**CQC Fundamental Standards**

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC’s main aim is to ensure that the care provided by hospitals, services provided in the community, dentists, GP’s and care homes meet with regulatory requirements based on fundamental standards.

The CQC have regulations associated with the provision of safe, quality care. To regulate a service the CQC inspect and monitor in accordance with five key lines of enquiry, these lines of enquiry serve as prompts for CQC inspectors.

Key Lines of Enquiry (KLOE’s) are:

**Safe:** you are protected from abuse and avoidable harm.

**Effective:** your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

**Caring:** staff involve and treat you with compassion, kindness, dignity and respect.

**Responsive:** services are organised so that they meet your needs.

**Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

**Question:** How can you ensure that care plans demonstrate compliance with the fundamental standards?

- Ensure you involve the service user in their care plan – it’s all about them – personalise it to ensure that care is centred around their preferences
- Service users should understand, agree and consent to their care and treatment plan. They should have enough information to make informed choices
- If capacity is an issue, involve family, carers, relatives in the care plan
- Risk assessments balancing safety and effectiveness should inform the care and treatment plan
• When a patient's clinical/ social/ psychological/ risk factors change presentation changes – or when a risk assessment is completed – update the care plan
• Where communication is an issue – ensure that the care plan has outlined the most effective method of communication – this may be the use of communication passports, the use of translators, to ensure that service users understanding and personal preferences are being adequately addressed
• Care plans should consider their immediate and long term needs for needs, preferences and diversity
• Ensure that the care plans are reviewed regularly
• Make sure that service users know who to speak to about their plan of care and how to contact them.

References & acknowledgements:

The Care Quality Commission Essential Standards of quality and safety; http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Derbyshire Healthcare NHS Foundation Trust (2012) Writing Good Care Plans, a good practice guide


NMC (2009) Standards of record keeping for nurses and midwives

http://www.skillsforhealth.org.uk/
# Appendix V International Descriptors

<table>
<thead>
<tr>
<th>International Descriptors</th>
<th>PDF Document</th>
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<td>IDDSI level 0</td>
<td>![IDDSI Level 0.pdf](IDDSI Level 0.pdf)</td>
</tr>
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<td>![IDDSI Level 1.pdf](IDDSI Level 1.pdf)</td>
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<td>![IDDSI Level 7.pdf](IDDSI Level 7.pdf)</td>
</tr>
<tr>
<td>IDDSI Transitional Foods</td>
<td>![IDDSI Transitional foods.pdf](IDDSI Transitional foods.pdf)</td>
</tr>
</tbody>
</table>
Appendix VI

MASH Referral Details

To contact the multi-agency safeguarding hub (MASH) for adults to discuss a concern in relation to safeguarding please use the following contact details:

Via email:
adult.services@hants.gov.uk

Via telephone:
0300 555 1386
### Appendix VII: Locality Map for SLT service across Hampshire

#### Southern Health Foundation Trust
Receives referrals for adults who are presenting with a choking risk from the following areas:

- West Hampshire CCG
- North Hampshire CCG
- North East Hampshire and Farnham CCG
- In-patient wards for Older Peoples Mental Health
- Lymington Hospital (all care groups)

#### Solent NHS Trust
Receives referrals for adults who are presenting with a choking risk from the following areas:

- Portsmouth CCG
- Fareham and Gosport CCG
- South East Hants CCG
- Southampton City CCG
- West Hampshire CCG for patients under 65 years old with a progressive neurological condition who require a home visit or patients with MND regardless of age
- In patients at Gosport War Memorial Hospital (excluding OPMH wards), Petersfield Community Hospital
- SHFT LD teams based in Fareham and Gosport and South East Hants

**Referral details**
Portsmouth City, F&G and SHE GP patients – refer via SPA 0300 300 2011
Southampton City / Hants GPs refer via SNHS.AdultCommunitySALT@nh.s.net

#### Hobbs Rehabilitation
Receives referrals for adults who are presenting with a choking risk from the following areas:

- West Hampshire CCG individuals who present with a swallowing and communication problem of an acquired neurological origin only
Appendix VIII  Hampshire Hospitals NHS Trust Referral Form to SLT
Adult Speech and Language Therapy Referral Form

Please use this referral form to refer people with swallowing, communication or voice difficulties for outpatient or community services. Please refer to our referral criteria for full details on who to refer to our service.

In order to triage and prioritise the referral appropriately, please complete as much of the following as possible. **Incomplete referrals may not be accepted.**

| Name: |  |
| NHS Number: |  |
| DOB: |  |
| Address: |  |
| Telephone number: |  |
| GP practice |  |

| Has the patient consented to referral? | Yes ☐ No ☐ Best interest ☐ |
| Is there any reason to doubt that this person has the capacity to make decisions regarding the areas covered in this referral? | Yes ☐ No ☐ Don’t Know ☐ |
| Has the patient previously been seen by SLT? | Yes ☐ No ☐ Don’t Know ☐ |
| If yes, when? |  |

<table>
<thead>
<tr>
<th>Reason for referral?</th>
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</thead>
<tbody>
<tr>
<td>• Swallowing ☐</td>
</tr>
<tr>
<td>• Communication ☐</td>
</tr>
<tr>
<td>• Voice ☐ People must have been seen by ENT prior to referral for voice therapy</td>
</tr>
</tbody>
</table>

| Brief history and duration of present condition |  |
| Past medical history |  |
Please complete the questions linked to the reason/s for referral you have ticked above

### Swallowing

Does this person have any of the following predictors of aspiration pneumonia?

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent for oral care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent for feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding tube in situ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High number of medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed bound/ poor mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple medical diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decaying teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of reflux</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What FOOD are they currently having?

<table>
<thead>
<tr>
<th>Diet</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft and bite sized diet</td>
<td></td>
<td></td>
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<tr>
<td>Minced and Moist diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puréed diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil by mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative feeding (PEG)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What DRINKS are they currently having?

- Thin
- Thickener Level: 1, 2, 3, 4
- Nil by mouth
- Alternative feeding (i.e. PEG)

Do they have difficulty swallowing medication?

Yes | No

If yes, please refer to swallowing medications pathway before completing referral

Do they have difficulty when eating?

Yes | No

If YES, daily, weekly, monthly

Is the person having difficulty when drinking?

Yes | No
If YES, daily ☐ weekly ☐ monthly ☐

<table>
<thead>
<tr>
<th>Have they choked (airway obstructed)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

If yes please state:
- What happened?
- What food they were eating?
- What help did they need?

<table>
<thead>
<tr>
<th>Have they had any chest infections in the last 3 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

If yes, how many?

**Communication and Voice**

<table>
<thead>
<tr>
<th>Can they call for help if required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can they express their needs and wishes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are these difficulties impacting on their ability to work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are these difficulties impacting on their mental health and wellbeing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

**Voice**

<table>
<thead>
<tr>
<th>Date seen by ENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report attached Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

**Additional information**

<table>
<thead>
<tr>
<th>Social circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone/ independently ☐</td>
</tr>
<tr>
<td>Lives with family ☐</td>
</tr>
<tr>
<td>Nursing home ☐</td>
</tr>
<tr>
<td>Residential home ☐</td>
</tr>
<tr>
<td>Supported living ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can they attend an outpatient appointment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there a package of care or community services in place?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Are there any risks or hazards to visitors for community visits?</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>If yes, please give details</td>
</tr>
</tbody>
</table>

**Referrer details**

<table>
<thead>
<tr>
<th>Name and designation</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tel No:</th>
<th>nhs.net email address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOK Name/ contact details:</th>
<th>Date of referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please send completed forms to:

**Winchester/ Andover and surrounding areas (WHCCG)**

- If you have access to nhs.net please send by email to  [hh-ft.RHCH-adultspeechtherapy@nhs.net](mailto:hh-ft.RHCH-adultspeechtherapy@nhs.net)
- Fax no. 01962 824 916
- Via post to: Speech and Language Therapy, Therapy Services, Nightingale Wing, Royal Hampshire County Hospital, Romsey Road, Winchester, SO22 5DG
- Contact via telephone on: 01962 824 928

**Basingstoke/ Alton/ Bordon (NHCCG/ SEHCCG)**

- If you have access to nhs.net please send by email to  [hh-ft.BNHH-adultspeechtherapy@nhs.net](mailto:hh-ft.BNHH-adultspeechtherapy@nhs.net)
- Via post to: Speech and Language Therapy, F Floor, Basingstoke and North Hampshire Hospital, Aldermaston Road, Basingstoke, RG24 9NA
- Contact via telephone on: 01256 313 596
Appendix IX: SLT Adults East SPA/S1 Referral Form April 2019
Speech and Language Client Referral Form (Community East)

Please register on System 1 to SLT Adults SPA caseload and SPA waiting list.
Please confirm client details on system 1 are correct.
All questions should be asked. Referrals are only accepted if mandatory (grey) fields are completed.

<table>
<thead>
<tr>
<th>NHS Number:</th>
<th>____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>____________</td>
</tr>
<tr>
<td>DOB:</td>
<td>____________</td>
</tr>
<tr>
<td>Client Address (confirmed or updated):</td>
<td>____________</td>
</tr>
<tr>
<td>Client Telephone (confirmed or updated):</td>
<td>____________</td>
</tr>
<tr>
<td>Referrers Name:</td>
<td>____________</td>
</tr>
<tr>
<td>Referrers Address:</td>
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</tr>
<tr>
<td>Referrers Tel No:</td>
<td></td>
</tr>
<tr>
<td>Referrers secure email address:</td>
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</tr>
<tr>
<td>Referrers Relationship to client:</td>
<td></td>
</tr>
<tr>
<td>Client’s current location:</td>
<td></td>
</tr>
<tr>
<td>Access code/keysafe number:</td>
<td></td>
</tr>
<tr>
<td>CALL HANDLER:</td>
<td></td>
</tr>
<tr>
<td>DATE:</td>
<td>____________</td>
</tr>
</tbody>
</table>

Please note incomplete referrals will not be accepted by SLT.
In order for SLT to be able to triage the referral and give a priority rating to each referral, the information the referrer is being asked for is needed.

Has the patient consented to referral?
Yes ☐ No ☐
If the answer is no, a reason is required
1. Reason for referral?
☐ Communication Difficulty (Explain)
☐ Swallowing Difficulty (see questions below)

2. Brief history and duration of the difficulty

3. Please describe the client’s relevant medical history. (This is important information for SLT to assist with triage and priority rating)

4. Swallowing Status:-
This information is needed for all swallow referrals to ensure accurate triage. Give the food and drink options below if necessary

What FOOD are they currently taking?
☐ Normal Diet
☐ IDDSI Level 7 Easy to Chew
☐ IDDSI Level 6 Soft and Bitesized (Previously known as Texture E fork mashable diet)
IDDSI Level 5 Minced and Moist  *(Previously known as Texture D pre-mashed diet)*  
IDDSI Level 4 Pureed  
IDDSI Level 3 Liquidised  
Nil By Mouth  
Alternative Feeding (PEG)

What **DRINKS** are they currently taking?  
- Thin  
- IDDSI Level 1 Naturally thick  
- IDDSI Level 2 *(Previously known as Stage 1 syrup consistency)*  
- IDDSI Level 3 *(Previously known as Stage 2 – custard consistency)*  
- IDDSI Level 4 *(Previously known as Stage 3 pudding consistency)*

5. Do they have difficulty swallowing medication?  
- Yes  
- No

6. Is the person coughing when eating?  
- Yes -  
- Occasionally  
- Frequently  
- No

Is the person coughing when drinking?  
- Yes -  
- Occasionally  
- Frequently  
- No

7. Has this person choked (airway fully obstructed)  
- Yes –  
  What happened?  
  What food were they eating?  
  What help did they need?  
- No

8. Has the patient had any chest infections in the last 3 months?  
   How many?  

9. Does client live alone?  
- Yes  
- No

10. Can this person attend an outpatient appointment?  
- Yes  
- No

11. Does the patient have a package of care or any community service in place?  
- Yes
12. Risks or hazards to visitors? (explain)

13. Family / Next of Kin Details
This question is important as the person being referred may not be able to answer the phone or respond to a letter due to their difficulties

This referral will be acknowledged by SLT within 2wks. This will be by letter.

If Using SystmOne: Please send this form via electronic referral selecting the following task recipient 1 SaLT eReferral

This letter has been generated from SystmOne.