Safer Care Victoria

Communicating safe eating and drinking

Best practice guidance

To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or email info@safercare.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76069-082-3 (pdf/online/MS word)

Available at www.safercare.vic.gov.au

About this guidance

Patients can be at risk of choking or breathing in food, drink and medicines while they are in hospital. There are a number of reasons this can occur, including the patient having difficulty swallowing (called dysphagia), having unsafe eating and drinking behaviours (such as eating and drinking very quickly, overfilling mouth, talking with mouth full) and adverse effects of medications. Swallowing problems that are not managed well can lead to poorer health outcomes associated with malnutrition and dehydration.

This document guides health services and clinicians on how to best communicate requirements to ensure patients are safe when eating and drinking. This document also helps patients, their family and carers get involved in decisions about the management of their dysphagia and/or unsafe eating and drinking behaviours.

WHO SHOULD USE THIS GUIDE?

Public health services including emergency departments, acute and subacute services and aged care wards, as well as patients, their families and carers.

WHEN SHOULD YOU USE THIS GUIDE?

People commonly have dysphagia due to increasing age or neurological conditions like stroke, multiple sclerosis, Parkinson's disease or dementia. People with reduced consciousness following surgery and after management of certain conditions like head and neck cancer can also be vulnerable. Unsafe eating and drinking behaviours can occur in a range of patients including those with acute brain injuries and mental health conditions.

It is common practice for health services to manage patients with swallowing problems and unsafe eating and drinking behaviours by providing a modified diet and/or prescribing supervision while eating and drinking food, fluids and medicines.

Use this guidance when managing patients who are at an unacceptable risk of choking or inhaling (aspirating) food, drink or medicines if they do not receive supervision when eating or drinking. Most health services have a risk assessment framework to determine if a patient is at high risk.

HOW TO USE THIS DOCUMENT

This guidance is structured around five factors that contribute to the risk of unsafe eating and drinking:

1. Communicating specified higher-level care
2. Involving patients and the people who support them
3. Communicating modified foods and fluids
4. Communicating to reduce patient and environment risks
5. Documenting specified higher-level care

Each section provides tips and advice for health services and staff. We also pose questions to encourage conversations in a health service and to guide patient involvement in their care.

Refer to **Appendix 1** for lived experience of implementing the guidance in a health service.

Use our self-assessment tool at **Appendix 2** to conduct an organisational assessment and prioritise actions.

We have also provided advice on implementing this guidance at **Appendix 3**.

Refer to the SCV change pack at **Appendix 4** for tools health services can use to help guide implementation.

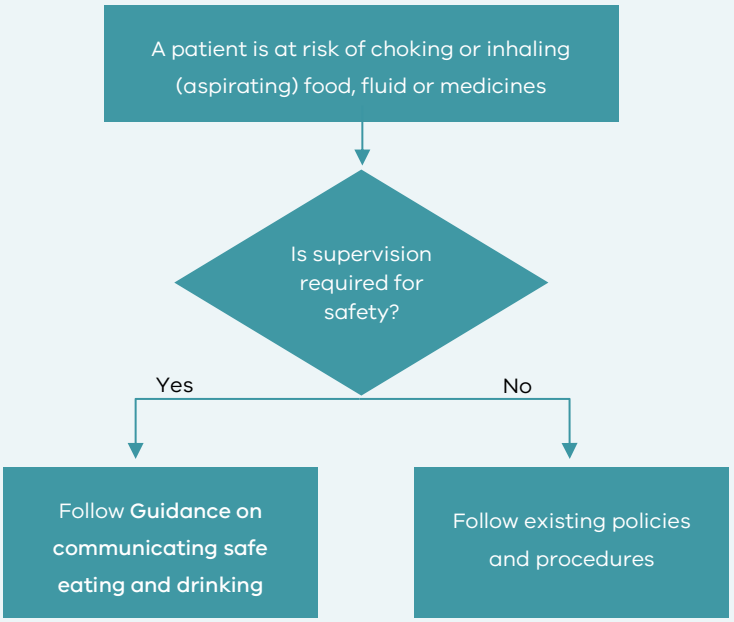
Use this guidance in conjunction with local policies and procedures, as well as Standard 6 of the National Safety and Quality Health Service Standards[2] and SCV **Partnering in healthcare framework.**[3]

This guidance acknowledges there are two different types of patients prescribed supervision:

1. Patients who must be supervised to ensure their safety. These patients are placed at unacceptable risk of choking or inhaling (aspirating) food, drink or medicines if supervision cannot be provided.
2. Patients who require supervision for another purpose. These patients are not placed at unacceptable risk of choking or inhaling (aspirating) food, drink or medicines if supervision cannot be provided.

Use this guidance when supervision is a requirement for patient safety. Existing policies and procedures can be followed when supervision is required for another purpose.

Figure 1: Decision aid for appropriate management pathway



This guidance does not cover:

- oral hygiene
- use of modified food and fluids including thickening agents
- terminology used to describe textures of food or fluids
- food allergies
- dignity of risk in providing treatment
- transportation and storage of food and fluids brought in by visitors for the patient to eat and drink
- management of malnutrition or dehydration
- food safety and meal provision practice.

What is specified higher-level care?

Patients at high risk of choking or aspirating food, drinks or medicines frequently require a specific set of strategies, food and fluid modifications, or environmental adaptations or supports when eating and drinking to ensure their safety. Supports may include supervision, mealtime assistance, verbal prompting and regulating rate of swallowing and size of a mouthful.

The specific set of strategies prescribed to ensure patient safety are referred to in this guidance as 'specified higher-level care'.

Specified higher-level care will vary for each individual. For instance, it may apply to all eating and drinking, or be limited to certain:

- mealtimes, e.g. in the evening when the patient is fatigued
- textures, e.g. when drinking regular consistency fluids, when swallowing medicines
- circumstances, e.g. when family are not present.

Specified higher-level care for an individual can also change over time as symptoms improve, deteriorate or fluctuate.

Please note: Specified care is delivered in addition to the routine care provided to all patients to eat and drink while in hospital.

Why did we develop this guidance?

Every year there are avoidable patient deaths and harm in Victorian health services because patients choke on or aspirate food, drink and medicines.

The coronial case study[1] over page and others like it prompted us to evaluate the systems, processes, terminology, response capability and communication frameworks that Victorian hospitals use, and develop this guidance.

Case study

Larry was 87 years old and lived at home with his wife, Lynne. Although he suffered from chronic lung disease and mild heart failure, he and his wife were able to drive to the local shops and enjoy time with their four children and seven grandchildren.

Due to his worsening shortness of breath and increasing levels of agitation, Larry was admitted to hospital. He was diagnosed with an infective exacerbation of chronic airways disease complicated by delirium. After 11 days in hospital he had a fall sustaining a laceration that required suturing.

Shortly after his fall Larry was sitting in an armchair in his room on the ward eating his meal of 'soft' food. The nursing staff had set him up in his chair and ensured he could reach his meal. A few minutes after the nurse left the room, they returned to find Larry blue and unresponsive.

During resuscitation, food was removed from his mouth. He was transferred to intensive care for ongoing intubation and ventilation. Larry did not recover from the neurological impact of choking and his family made the difficult decision to withdraw treatment. Larry was palliated and died shortly after.

On review

On Larry's first day in hospital he had a speech pathology assessment. He was diagnosed with mild to moderate dysphagia and was kept nil by mouth due to other illnesses. Three days later Larry had a second speech pathology assessment which suggested distant supervision, crushed medication, pureed food and thickened fluids. At his third assessment, he was coughing when eating and close supervision when eating was advised. His medical record was updated to show this.

Larry had his fourth speech pathology assessment nine days into his hospital stay and his record shows he was upgraded to full supervision when eating. The patient, his family, nursing and kitchen staff were all told and a sign was also placed at his bed. On subsequent speech pathology assessments, Larry was still coughing mildly while eating and was started on a soft meal and full supervision.

Coronial findings

During his hospital stay the patient's requirements for safe swallowing changed numerous times. Depending on the assessment of the patient's condition, the patient ate various modified diets – sometimes with distant supervision, close supervision, and on other days full supervision. On the day of death, the patient was found to have breathed in a bolus of food and choked while not supervised. The multidisciplinary team and kitchen staff had discussed the care recommendations. The health service did not have a policy to define different levels of supervision.

This coronial case study shows that circumstances leading to harm are everyday scenarios that could happen anywhere. To ensure patient safety, how we communicate specified higher-level care – what it means and how to provide it – should be clear and commonly understood by all staff as well as the patient, their family and carers. If this doesn't occur, patient deaths can result.

We have developed this guidance to guide and support Victorian public health services to critically evaluate their systems and processes supporting the communication and delivery of specified higher-level care requirements to ensure patient safety. The guide is also designed to help patients, their family and carer be more involved in decisions about the care of their dysphagia and/or management of their unsafe eating and drinking behaviour.

Thank you

We gratefully acknowledge the work completed by Eastern Health that has been incorporated in this document. We also offer our sincere thanks to the consumers and nursing, allied health and food services staff who helped us develop this guidance: Rhiannon Beggs, Christine Bruce, Kerri Easton, Tanya Frost, Heather Gilbertson, Lauren Lynch, Leanne Mills, Claire Nailon, Leonie Pearce, Bernadette Twomey, Deidre White, Kaye Widdicombe and Jane Wilding.

Definitions

Some terms used in this document may have other meanings or definitions in other contexts or in relation to certain clinical professions. For this document, we provide the following definitions:

Eating and drinking: Every occasion when food, fluid or medicines are placed in the mouth followed by oral movements to prepare the food, fluid or medicines for the purposes of swallowing, completion of swallowing processes and ultimately transportation to the stomach for digestion. (American Speech-Language-Hearing Association, 2019).

Routine care: The standard care provided to all patients when preparing for, and during eating and drinking of food, fluid and medicines. Routine care should align with hospital policies and procedures and includes all staff involved in the care such as the multidisciplinary team and food services staff. Additionally, this includes the allocation of a nurse to a patient's care each shift who performs required routine visual observations and interventions and ensures the patient is positioned upright and/or out of bed for eating and drinking.

1. Communicating specified higher-level care

All staff have a responsibility to let the team know if a patient is at risk of choking or aspirating when eating and drinking.

The care team determines the specified higher-level care required for a patient to eat, drink and swallow medicines safely.

'Staff' includes anyone involved in the preparation of food or fluids and delivery of care:

- nursing and medical staff and students
- allied health staff and students, i.e. speech pathology, dietetics, physiotherapy, occupational therapy, pharmacy, and radiology
- support staff, i.e. food services, patient services assistant
- volunteers
- health assistants
- administration staff
- ambulance staff
- aged care staff and aged care assessment team.

This recent coronial below, highlights the importance of identifying when a patient may be at risk of choking or inhaling food or drink.

Case study

Robert was 49 years old and lived in a community care unit following the passing of his parents. He suffered with schizophrenia and enjoyed the regular visits from his sister. Robert admitted himself to hospital and was assessed at medium risk for things like disorganisation and withdrawal/isolation.

Robert had always been a quick eater but during an evening meal he was seen putting large amounts of food into his mouth and not chewing much before taking another mouthful. Robert approached a nurse and explained he thought he was choking. He didn't look distressed and was told it was okay and to return to his meal but to chew and swallow his food and drink some water. A little while later Robert told the nurse again, he felt he might be choking. He didn't appear distressed and was given the same advice.

A short time later Robert was found collapsed in the hallway. He was unable to be resuscitated. It was later discovered a large piece of meat had blocked his larynx.

Robert had undergone several assessments during this hospital stay, but none identified issues with eating or drinking.

This finding highlights a patient's ability to swallow is influenced by many factors, can change during their hospital stay, and the importance of remaining vigilant to the risks of choking and inhalation of food or drink. In this case, recognising the potential gravity of the situation and giving advice to stop the meal may have saved a life.

Before initiating specified higher-level care

Consider who is authorised to make the decision to initiate or change specified higher-level care.

Conduct a professional assessment of a patient's swallow/unsafe eating and drinking behaviour before initiating and changing specified higher-level care.

To determine the level of risk, use the risk assessment framework available in most health services.

Careful deliberation is needed to determine if supervision is a requirement to ensure patient safety or if supervision is required for another purpose. Answering the following questions can help this clinical decision-making process:

- Will the patient be safe if supervision is not provided?
- Why is supervision required?
- What purpose does supervision serve?

Communicating specified higher-level care with the patient, carer and family

Make sure you communicate clearly and avoid jargon.

Modify what you are saying to suit the patient's level of knowledge.

Use Teach Back or similar communication strategies to ensure everyone has the right level of understanding.

Provide verbal and written information about:

- dysphagia and/or the unsafe eating and drinking behaviours
- why specified higher-level care is required, e.g. risk of aspiration, choking
- who can provide the specified higher-level care
- what needs to be done to ensure safe eating and drinking, e.g. sitting upright for meals, avoiding some foods, using adapted cutlery, or specific assistance/supervision
- when specified higher-level care is needed, e.g. when taking medicines, during the evening meal when the patient is fatigued, every time the patient eats or drinks
- what foods and drinks should not be brought in for the patient.

Communicating with other healthcare or support staff

Advise the treating team when a patient presents with signs or symptoms of dysphagia and/or unsafe eating and drinking behaviours and when you have identified them as at risk of unsafe eating and drinking if they do not receive supervision.

Clearly communicate the specified higher-level care for all staff involved. Ensure it is timely and accessible and staff are aware the required specified higher-level care is part of a safety management plan rather than being required for another purpose.

At a minimum, discuss the specified actions to ensure safe eating and drinking during:

- admission
- team meetings
- clinical handover and during patient transfer between wards/units or to another healthcare service
- discharge home to the primary care professional and care giver.

Defining supervision

> "I knew he needed supervision, but I didn't realise that meant I couldn't leave him."

Ensure you have a clear definition of what supervision means in your health service. Patient harm can be the result if we don't have the same understanding of what needs to happen to supervise a patient. You can develop this in collaboration with the multidisciplinary team or use the following suggested definition:

> Supervision is the constant visual observation of the person for the specified time for the specified task.

The supervision required for safety will vary for each individual and throughout an individual's time in a health service.

Communicating every aspect of supervision helps ensure nothing about providing the supervision is misunderstood and patient safety is maintained.

To ensure patient safety, we suggest supervision is communicated by describing the following six elements of supervision:

1. Why is supervision being requested?
2. Who can provide the supervision?
3. When and how often is supervision required?
4. What supervision is needed?
5. How long is the supervision required?
6. What needs to happen if supervision cannot be provided or is unavailable?

The six elements of supervision are not intended to align with other descriptors of supervision. These descriptors such as full, close, distant or direct supervision are open to interpretation. We suggest the term 'supervision' replaces all other terminology. Refer to **Table 1** for further detail on the six elements of supervision.

Table 1: Six elements of supervision

	Description	Example
Why	**Why is supervision being requested?** Outline the clinical rationale to support why the patient needs supervision to safely eat and drink or take medicines that are swallowed.	Patient is impulsive and unable to slow the rate of eating, meaning they are at high risk of choking or inhaling food.
Who	**Who can provide the supervision?** Who is authorised to provide supervision will depend on the type of supervision required, when it is to be provided and the capability of an individual. Consider what training or education is required and if it can be delegated.	Nursing staff regulate swallowing of medicines, family may participate in mealtimes.
When	**When and how often is supervision required?** This may be limited to times of day, or certain circumstances.	At mealtimes, in the evenings when fatigued, when taking oral medicines, all eating and drinking.
What	**What supervision is needed?** What should the supervisor do to ensure patient safety? Consider the type of prompts and assistance required and the signs of unsafe eating and drinking for the supervisor to look out for.	Prompts to slow the rate of eating, check the mouth is empty between mouthfuls, provide adaptive cutlery.
How long?	**How long is the supervision required?**	During meals, at the start of a meal, for 30 minutes after a meal.
What if?	**What needs to happen if supervision cannot be provided or is unavailable?** Describe what escalation process should be activated if supervision cannot occur. This includes anticipated and unexpected scenarios. These planned responses should be determined on a case-by-case basis and ensure safety is maintained. How staff escalate and to whom should be clear.	Food and fluid removed from the patient. Alternative texture of foods and consistency of drinks to be provided.

Discuss with staff how they can meet supervision requirements within existing staffing resources.

We suggest care teams also consider what should happen if the team cannot meet requirements. This may include agreement on an approach to request additional resources, or a step-down approach such as modifying the food and drinks or not providing the food or drink. Changing food and fluid intake should ensure adequate levels of nutrition and hydration are maintained. This may trigger the involvement of care team members in your health service such as dietitians, speech pathologists and medical staff.

Providing supervision should not alter the food safety and meal provision practices in your health service.

Health services

Have clear processes in place, covering:

- how to identify patients who need supervision to ensure they can eat and drink safely
- who can start or change specified higher-level care requirements, and how this is communicated
- who can recommend a patient doesn't eat or drink (e.g. nil oral)
- how to ensure food and fluid access (e.g. nil oral) does not negatively impact on a patient's nutrition and hydration.

Consider how these processes change and what will happen until a professional swallowing assessment is completed.

Please note: Defining roles, responsibilities and accountabilities should be decided by the health service in collaboration with care teams. We acknowledge there is no one-size-fits-all approach and a local team approach is required.

Questions to ask

- Does your health service have a clear definition of supervision? And a standard risk assessment to identify high-risk patients?
- Who is authorised in your health service to initiate or change specified higher-level care? What about outside of usual working hours?
- How can you access timely and clear information about specified higher-level care requirements? E.g. staff huddles, care plan, journey boards, signage, ID board, coloured alerts.
- What processes/tools support you to communicate specified higher-level care requirements when a patient changes room or ward/unit? Is transferred to another health service? Is discharged home? E.g. transfer checklist, transfer form, handover processes.
- How does your health service ensure a patient's requirements for safe eating and drinking can be met and carried out? When requirements cannot be met how is an agreed plan put in place?
- What education/training is available to you to support safe eating and drinking? What strategies are used by staff to help patients, their family/carer understand? E.g. 'Teach Back'.
- What information is provided to patients and their family/carer? Is it clear? Provided in relevant languages? E.g. information sheets, bedside signage, discussions with individuals and families.
- How does the health service avoid unnecessary periods of not eating or drinking? E.g. what type of foods/fluids are available in emergency departments, wards or units including after hours?
- If the patient's food or fluid intake is consistently prevented or is poor, what process is in place for a review of the patient by relevant health professionals?

2. Involving patients and the people who support them

"It was only when Bob was discharged back to the nursing home that anyone bothered to communicate with Bob's children about the meaning and reason for the 'thickened water' sign." – Consumer, Expert Advisory Committee.

Involve patients and their family/carer in decisions about safe eating and drinking. This can help improve how effective your safe eating and drinking strategies are. This will also help you personalise the patient's care and consider their:

- personal values
- cultural or religious beliefs
- food preferences.

Encourage the family/carer to be active participants in safe eating and drinking. Do not assume they are available or willing, so always ask for their agreement.

Do not assume knowledge. Be proactive by communicating to all family members/carers who may be involved in safe eating and drinking.

Consider the information, training and monitoring they will require to participate.

Discuss with the patient, family or carer:

- if the patient has an existing meal plan
- what they can do to help, the specified period of help and how help should be given
- how to identify when a patient is not swallowing safely
- when and how to seek help from staff
- what help they should **not** give, e.g. regulating intake of medicines
- the location and availability of up-to-date information
- additional information such as:
  - temperature of food or fluid
  - amount of food or fluid for each mouthful
  - correct size and texture of food and thickness of fluids
  - swallowing strategies to be used, e.g. double swallow, clearing the mouth after a swallow
  - the accepted terms to describe modified food and fluids and their meaning, e.g. thickened fluid.

Consider the social context of each family including beliefs, language and the nature of relationships.

Health services

Make it clear who can authorise family or carer participation in specified higher-level care and who is responsible for monitoring and evaluating the safe eating and drinking in the presence of the family/carer.

Questions to ask

- What processes are in place to cover shared decision making about safe eating and drinking?
- How does your health service know that patients, their family/carer feel empowered to participate in decisions about safe eating and drinking and feel able to help with care?
- What training and written/verbal information does your health service give to family/carers to support their involvement in safe eating and drinking?
- Who in your health service is responsible for authorising, overseeing and evaluating the involvement of family and carers in safe eating and drinking?
- What processes and safeguards are in place to ensure the help provided by family/carers supports safe eating and drinking?
- Who is responsible for teaching the patient, family or carers how to modify the consistency of food or drink on discharge from the health service?

More information

For more information on how to improve shared decision making and consumer involvement, please refer to the:

- Partnering in healthcare framework
- Partnering with consumers standard
- NHS Education for Scotland, Making dysphagia advice easier to swallow

3. Communicating modified foods and fluids and medicines

Recommendations to modify food and drink or fluid should be made after a professional swallowing assessment.

We suggest a medication review if a recommendation is made to crush medicines.

To avoid misunderstandings, we suggest care teams agree on accepted terms and common definitions such as the International Dysphagia Diet Standardisation Initiative (IDDSI) guide[4] – or a similar terminology guide – to be used by all staff to communicate the texture of modified foods and fluids in your health service.

Have clear processes in place covering:

- how staff communicate changes to a modified diet outside of usual working hours
- how to ensure a patient is given the correct meal texture and fluid consistency. This includes how staff communicate a patient's requirement for a modified diet when they move to a different bed, ward/unit, healthcare service or supported accommodation.
- how to ensure patients, their family and carers, have the right level of understanding about the texture of foods and consistency of fluids required for their safety.

Questions to ask

- Does your health service use standardised terminology for the textures and consistency of food and drinks?
- How are changes to the texture and consistency of food or drinks communicated to food services staff? What about when a decision is made outside usual working hours? Or when a patient moves bed, or transfers to another ward/unit or healthcare service?
- How does your health service ensure the right meal is given to the right patient?
- How are patients, their family and carer involved in decisions about the required consistency of foods and drinks for their safety and have the right level of understanding about their modified diet?
- Who ensures that food and drink containers and packaging can be opened by the patient or that assistance to open packaging is provided, to ensure the person is able to maintain hydration and nutritional intake?

4. Communicating to reduce patient and environment risks

Individual patient and environmental factors can contribute to the risk of unsafe eating and drinking and the effectiveness of specified higher-level care to ensure patient safety.

Consider modifying the environment. This can include:

- changing the location of eating and drinking, e.g. a quieter mealtime to reduce noise distraction, shared room or dining room with effective role models of safe eating and drinking
- increasing time to eat and drink
- timing of meals, e.g. avoiding times when a patient is fatigued or drowsy – after anaesthesia or after some types of medicines
- use of aids to help with eating and drinking including adaptive cutlery, cups or mugs and use of a straw.

Consider measures to address patient factors. This can include:

- positioning a patient upright as much as possible and sitting out of bed if appropriate
- patient dental hygiene and use of dentures
- vision and hearing, e.g. placing food and drink within a visual field, using glasses and/or hearing aid
- level of patient understanding and ability to follow instructions.

Questions to ask

- Are eating and drinking aids available to patients in your health service? E.g. adaptive cutlery.
- How is the requirement for a modified environment for patient safety communicated?

5. Documenting specified higher-level care

To ensure documents are clear and consistent, use Standard Terminology from the IDDSI guide or similar standardised terminology for the texture of food and drinks and accepted terms for supervision.

If supervision is required to ensure patient safety, we suggest documents clearly describe the six elements of supervision.

Clearly document the specifics of specified higher-level care requirements including:

- clinical handover – nursing staff, allied health, medical staff
- bedside signage
- entries in the medical file
- multidisciplinary team meetings
- information provided to patients, their family or carers
- information provided to staff involved in food and drink provision.

Make sure documentation is timely and can be accessed by other staff and relevant information is visible to the patient, their family and carers.

At the time of discharge from the health service, documentation about the patient's dysphagia risk and/or unsafe eating and drinking behaviours and specified higher-level care must be provided to the person, family, carer and/or staff at the patient's usual residence.

Questions to ask

- How does your health service ensure the documentation of specified higher-level care requirements and modified food and/or drinks is accessible and timely to all staff? E.g. alert system, handover processes.
- How does your health service ensure the agreed standardised terminology is used?
- How does your health service document the standardised safety management plan? E.g. specified higher-level care, contingency plan, agreed level of family and carer involvement.
- How does the health service ensure that on discharge, the relevant documentation about a person's risk of choking or breathing in food or drink is provided to the person, family, carers, or supported accommodation, to ensure the appropriate level of care is maintained?

Appendix 1

THE EASTERN HEALTH EXPERIENCE

In July 2018 in response to a coroner's recommendation, the Eastern Health speech pathology department reviewed the language used and processes followed when supervision was recommended by speech pathologists for patients when eating or drinking.

As soon as we started it became apparent that what we thought was a simple, easily understood, everyday practice was far more complex and variable than we had ever anticipated.

We thought we were communicating effectively but we were not.

We thought our rationale was clear – but it was not.

We thought we were speaking the same language – but we were not.

We thought patient risk was understood – but it was not.

Yet we knew what we were doing was common, accepted practice throughout Australia.

We were shocked that such a common practice, implemented every day in healthcare services across Australia had so many potential failure points. And so, in collaboration with our senior nursing colleagues, we set about completely unpacking our professional assumptions and processes and redesigning it from the ground up.

Our mantra? 'Assume nothing. Question everything.'

Our most important learning? We were dealing with two completely different groups of patients:

1. Patients who always required supervision to ensure safe oral intake. Patients placed at unacceptable risk when that supervision was not provided or not available.
2. Patients for whom supervision served another purpose and who were not at risk when it was not provided or not available.

Our most important outcome? We designed a completely different process for the cohort of patients who **required supervision to ensure safe oral intake.**

By redesigning our process to ensure we were communicating clearly about safety and risk, all care providers now understand when supervision is **required** as part of a safety management plan rather than when supervision is **requested** for another purpose.

Speech pathologists must carefully deliberate any request for patient supervision during oral intake. Why is it required? Will the patient be safe if it is not provided? What purpose does supervision serve? What should the supervisor do to ensure patient safety? Is supervision available? Who should provide supervision? Following this clinical problem-solving process, if supervision is a genuine requirement to ensure safety a **different pathway** of communication, negotiation, documentation and handover is followed.

What we have found is the cohort of patients who genuinely **require supervision to ensure safe oral intake** is relatively small. Consequently, we have been able to provide the necessary supervision without additional nursing resource. Elevating the conversation to a safety conversation rather than a care conversation has been an important factor in ensuring all those involved understand the gravity of not providing the required care and accept the responsibility to deliver it according to specifications.

We are now genuinely communicating for safety and working as a healthcare team to ensure this is provided to the cohort of patients for whom oral intake is an unacceptable risk without supervision.

Additional information

Our definition (as in our clinical practice guidelines):

Supervision: When recommended by a speech pathologist as being required by a patient to support oral intake, 'supervision' is the constant visual observation of the patient by the supervisor for a specified and defined period. The specified period will vary between individuals and throughout their admission. It may be limited to some circumstances only such as when drinking regular fluids; when family is not present; during the evening meal; or it may apply to all oral intake of food and fluids. These individual requirements must be specified for each person by a speech pathologist. 'Supervision' is the sole accepted term to be used, and replaces previous terminology such as 'full supervision' or 'close supervision'.

Our process when supervision is required (as in our clinical practice guidelines)

Whenever supervision is recommended, the speech pathologist must undertake the following steps:

- Verbal discussion with the registered nurse in charge of shift specifying that supervision is required:
  - What is the specified period when supervision is required?
  - What specific prompting or assistance is required?
  - Who is authorised to provide supervision? E.g. registered nurse, enrolled nurse, personal care assistant, nursing attendant, health assistant in nursing, (trained) family member, other.
  - Specification and agreement of the step-down strategies to be activated in the absence of supervision being available. E.g. Food/fluid be removed from the patient, alternative texture foods to be provided if supervision is not available.
- Confirmation must be obtained from the registered nurse in charge of shift that the specific supervision requirements can be met within existing staffing resources. In circumstances where the supervision requirements cannot be guaranteed within existing staff resources, authorisation is required for additional resources according to the standard authorisation protocols.
- Confirmation must be obtained that the supervision requirements will be communicated by nursing staff at every shift handover.
- Documentation of the above discussions and agreements to be made in the medical record by the speech pathologist.
- When supervision is unable to be provided with a resultant impact on the patient's nutritional status and/or hydration status, the speech pathologist will notify the dietitian for urgent assessment of alternate nutrition support and/or medical staff to notify of the requirement for hydration support.

Appendix 2

SAFE EATING AND DRINKING SELF-ASSESSMENT TOOL

This self-assessment tool lists the actions to consider when applying our guidance in your organisation. Use this tool to reflect on your strengths and challenges and to help guide your organisation's focus for improvement.

How to use this tool

1. Review the five key focus areas of the guidance
2. Identify current strengths and challenges against each action item of this tool
3. Identify areas in need of improvement
4. Identify the top priorities that you will choose to focus on

Action items

1. Communicating specified higher-level care

Your health service has clear processes in place covering:

- how to correctly identify patients who require supervision to ensure their safety, e.g. risk assessment framework and standardised risk assessments
- how to consistently deliver appropriate management plans for patients who require supervision to ensure safety, e.g. standardised communication for specified higher-level care, clear definition of supervision, contingency plans, escalation of care, initiating/changing specified higher-level care
- how timely information is accessed by staff, patients and their family, e.g. staff huddles/handover, care plan, journey boards, signage, ID board, coloured alerts, discussions and information sheets for the patient and their family
- how staff competency is determined and what staff education and training provided.

Refer to the NSQHS Communicating for Safety Standard[2] and Comprehensive Care Standard[2] when completing this section.

Current strengths	Current challenges	Opportunities for improvement
Additional notes about this action item		

2. Involving patients and the people who support them

Your health service has clear processes in place covering:

- how to use strategies like 'Teach Back' or similar communication strategies to ensure everyone has the right level of understanding
- how the patient and their family can be active participants, e.g. information and education resources, training, authorisation and who is responsible for monitoring participation.

Refer to NSQHS Partnering with Consumers Standard[2] and the SCV **Partnering in healthcare framework**[3]

Current strengths	Current challenges	Opportunities for improvement
Additional notes about this action item		

3. Communicating modified foods and fluids

Your health service has clear processes in place covering how a patient receives the right meal, e.g. standard terminology, foods and fluids available including emergency/short stay, communication templates and tools for bed moves/transfers and decisions made outside of usual working hours.

Refer to NSQHS Communicating for Safety Standard[2] and the International Dysphagia Diet Standardisation Initiative[4] (IDDSI) or a similar terminology guide when completing this section

Current strengths	Current challenges	Opportunities for improvement
Additional notes about this action item		

4. Communicating to reduce patient and environment risks

Your health service has clear processes in place covering how standardised management plans address all patient and environmental factors that may contribute to risk, e.g. timing and location of meals, sensory aids, patient positioning, adaptive utensils/aids.

Refer to NSQHS Communicating for Safety Standard[2] and Comprehensive Care Standard[2] when completing this section.

Current strengths	Current challenges	Opportunities for improvement

Additional notes about this action item

5. Documenting specified higher-level care

Your health service has clear processes in place covering:

- how to document an alert system for high-risk patients to the wider multidisciplinary team
- how to document a standardised management plan
- what standardised terminology to use
- how information about specified higher level care is accessible to the patient and carers
- How information on specified care is provided to the person, family, carers, or supported accommodation, to ensure the appropriate level of care is maintained following discharge.

Refer to the NSQHS Communicating for Safety Standard[2] and the International Dysphagia Diet Standardisation Initiative[4] (IDDSI) or a similar terminology guide when completing this section.

Current strengths	Current challenges	Opportunities for improvement

Additional notes about this action item

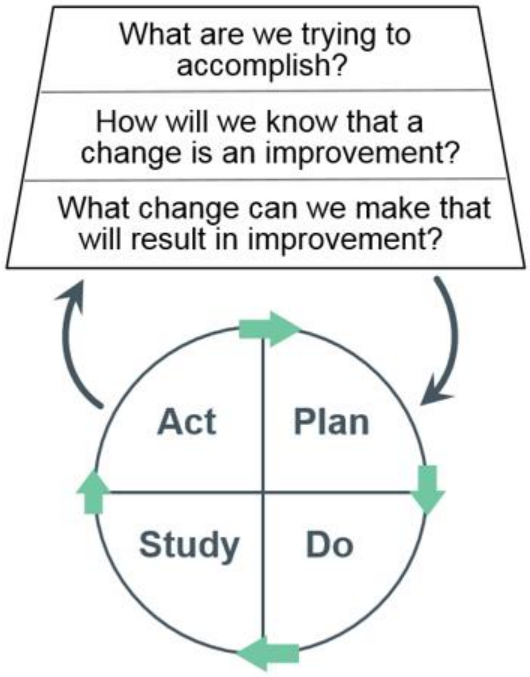
Appendix 3

IMPLEMENTING THIS GUIDE

To implement the guidance, health services should use an improvement methodology to help work out if changes made have led to an improvement. Most health services will already have a preferred improvement methodology.

We use the Model for improvement (created by Associates for Process Improvement) to help us deliver results-based outcomes. This model asks three questions to guide improvement and tests a change in the workplace – by planning it, trying it, observing the results, and acting on what is learned.

Figure 2: Model for improvement



After testing a change on a small scale, learning from each test, and refining the change through several Plan-Do-Study-Act cycles, your team may implement the change on a broader scale – for example, from starting with tests on several patients to expanding the pilot to an entire unit.

An exploration process was undertaken by the Safer Care Victoria expert working group to provide health services with some preliminary ideas when discussing the requirement for patient safety when eating and drinking.

Two main influencers were identified as key to ensuring patients at high risk of choking or aspirating can eat and drink safely in Victorian hospitals:

- appropriate assessment of risk
- adherence to recommendations.

The group also brainstormed and identified secondary factors:

- Skilled workforce undertaking risk assessments
- Risk profile for high-risk patients identified correctly
- Consistent management plans once high-risk patients are identified – includes contingencies
- Clear communication and documentation
- Consistent terminology
- A workforce and carers skilled at providing specified care
- A workplace culture of swallowing safety.

These factors will vary for each health service. We encourage health services to explore the contributing and influencing factors relevant to them when applying the guidance.

Appendix 4

SAFE EATING AND DRINKING CHANGE PACK

Choking on and inhaling food, drink and medicines are risks of unsafe eating and drinking that have led to patient deaths in Victorian health services. In response, we established an expert working group, chaired by Chief Allied Health Officer Donna Markham, to review these events and to critically evaluate the systems and processes used in Victorian hospitals. The review identified variation and inconsistencies in many of the systems and practices.

This guidance aims to help everyone – including doctors, nurses and allied health staff, staff involved in food and drink provision and visiting family and friends – understand when a patient is on a modified diet and needs supervision as a safety requirement. We consider these patients to be high risk.

In response to feedback, we have also developed this change package. It aims to support health services and clinicians to safely and confidently manage patients for whom supervision while eating or drinking is necessary for their safety.

Definition of supervision

- There is no universally accepted definition of supervision. We encourage health services to develop a definition in collaboration with their clinicians, if they do not have one already.
- Here we define supervision as the constant visual observation of the person for the specified time for the specified task.
- This definition is not intended to align with current terms for supervision such as distant, close or full supervision.

HOW TO USE THIS CHANGE PACKAGE

This change package contains tools designed to help health services develop and implement local policy and procedures for managing patients with swallowing difficulties and/or unsafe eating and drinking behaviours, who are at risk of choking or breathing in food, drinks or medicines if they are not supervised.

The package includes:

Fact sheet for staff

This details key information from the guidelines for staff. This suggested content can be quickly adapted for your use.

Fact sheet for patients and families

This contains information for the patient and their family or carer for management of dysphagia while in hospital. This suggested content can be quickly adapted for your use.

More information

If you have any questions or feedback about this package, please contact info@safercare.vic.gov.au

COMMUNICATING SAFE EATING AND DRINKING FOR PATIENTS WITH SWALLOWING DIFFICULTIES WHO NEED SUPERVISION TO BE SAFE

Staff fact sheet

This information sheet aims to give you the confidence to manage patients with swallowing difficulties (dysphagia) who need to be supervised to ensure they are safe when eating or drinking.

BACKGROUND

Every year in Victoria, hospital patients are harmed or die after choking on or inhaling food, drink or medicines.

Patients most at risk have dysphagia or difficulty swallowing. Health services commonly manage these patients with strategies such as a modified diet, changes to the environment and supervision. We refer to the set of strategies to ensure patient safety as 'specified higher-level care'.

When supervision is required to ensure patient safety rather than for another purpose, we suggest following a different approach to communication, negotiation and documentation.

In addition to this information sheet, you can refer to the **Guideline on communicating safe eating and drinking** for more information.

IDENTIFYING THE LEVEL OF RISK FOR MY PATIENT

Most health services will already have a risk assessment framework to help you determine if your patient is at high risk of choking or inhaling food, drink or medicines.

After a professional swallowing assessment, carefully deliberate and decide if supervision is part of a safety management plan or for another purpose.

Answering these questions can help you decide:

- Will the patient be safe if supervision is not provided?
- Why is supervision required?
- What purpose does supervision serve?

SUPERVISION

We suggest having a definition of supervision, clearly and commonly understood by the care team. If you don't already have one, you can collaborate with your care team to develop one, or use what we've provided here:

> Supervision is the constant visual observation of the person for the specified time for the specified task.

The specifications of supervision will vary for each patient. So we developed the six elements of supervision to clearly describe every aspect of supervision.

We suggest you communicate the six elements of supervision whenever it's recommended as a requirement for patient safety.

The six elements of supervision

1. Why is supervision required?
2. Who can provide supervision?
3. When and how often is supervision required?
4. What supervision is needed?
5. How long is supervision required?
6. What if supervision cannot be provided?

Please note: The term supervision and the six elements do not align with descriptors like close, distant or full supervision.

COMMUNICATING FOR SAFETY

Whenever specified higher-level care is required to ensure patient safety, we suggest:

- staff requesting the supervision carefully consider the request and can clearly communicate why supervision is a safety requirement for the patient
- discussions and documentation always describe the six elements of supervision to avoid misinterpretation
- care teams negotiate how they will provide supervision and confirm it can be done
- someone is responsible for telling staff about every element of supervision at every change of shift, care team meeting and patient transfer to another bed, ward, home or facility
- communication with the patient, family and carers ensures the correct level of understanding about the specified higher-level care. This includes why specified higher-level care is important to them, what needs to occur to ensure patient safety and the things they should do or avoid, as well as how they can be involved in the specified higher-level care
- providing clear information about a person's dysphagia on discharge, to ensure an appropriate level of care is maintained
- using clear and consistent terminology for describing the texture of food and consistency of fluids.

MORE INFORMATION

- Partnering in healthcare framework
- Partnering with consumers standard
- NHS Education for Scotland, Making dysphagia advice easier to swallow

INFORMATION FOR PATIENTS WITH SWALLOWING DIFFICULTIES AND/OR UNSAFE EATING OR DRINKING BEHAVIOURS AND NEED SOMEONE TO HELP THEM EAT AND DRINK SAFELY

Patient fact sheet

You have been given this fact sheet because you have difficulty swallowing (called 'dysphagia') and/or you have unsafe eating and drinking behaviours placing you at risk of choking or breathing in food, drink or medicines. To eat and drink safely you need someone to help you. This information helps you to know how to be safe when eating and drinking while you are in hospital and when you go home.

- Staff will discuss with you (and your family or carer) what foods, drinks and medicines are safe to swallow and what help you need.
- Please discuss your existing meal plan (if you have one) with a member of staff.
- Immediately tell a staff member if you feel out of breath, need to cough, have a gurgly voice or you feel you might choke during/after eating or drinking.

WHAT IS DYSPHAGIA?

Dysphagia occurs when you have difficulty swallowing. This may be because:

- you have a chronic or other health condition that affects swallowing, e.g. stroke, dementia, multiple sclerosis, Parkinson's disease, head or neck cancer
- you are very tired and unwell
- you are over 80 years of age.

With dysphagia, you may notice:

- you cough or clear your throat during/after meals
- your voice becomes gurgly after swallowing
- changes in your breathing during/after meals
- difficulty managing some foods or choking
- frequent chest infections or aspiration pneumonia.

HOW TO EAT AND DRINK SAFELY

If you have dysphagia or unsafe eating and drinking behaviour, staff may recommend you change what you eat and drink and how you take medicines that are swallowed.

You have been given this sheet because you also need someone with you – or supervision – in order not to choke or breathe in food, drink or medicines. This will mean someone watches you when you eat and drink to ensure your safety.

The type of supervision you require will be unique to you. It's important to understand the supervision you need. Staff will explain:

- why you need supervision
- who can give supervision
- when you need supervision
- what type of supervision you need
- how long you need the supervision
- what will happen if someone is not available to give you supervision.

WHILE YOU ARE IN HOSPITAL

When you arrive at hospital, tell staff if you already have a meal eating plan. Staff will:

- assess your ability to eat and drink.
- confirm you know what snacks, meals and drinks are safe for you
- explain the type of supervision you need
- update you with any changes on what you can eat and drink and the supervision you require.

A pharmacist may also review the medicines you swallow to ensure you can safely take your tablets.

If you receive a snack, meal or drink that doesn't look safe for you, ask staff to check.

Staff will check that you and your family/carer have the correct level of understanding about the help you need and what foods, drinks and medicines you can safely swallow.

Staff will provide your GP and staff at your supported accommodation with information on how to manage your dysphagia and/or unsafe eating and drinking behaviours.

MORE INFORMATION

NHS Education for Scotland, Making dysphagia advice easier to swallow

What I need to know to eat and drink safely

The foods I can safely eat are:

.....

.....

.....

The type of drinks I can safely swallow are:

.....

.....

.....

I can safely swallow my medicines when:

.....

.....

.....

The type of supervision I require to be safe is:

.....

.....

.....

Other things I should know:

.....

.....

.....

References

1. Coroner finding 2018, Coroners Court of Victoria www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=costello
2. The National Safety and Quality Health Service Standards https://www.nationalstandards.safetyandquality.gov.au/standards
3. Safer Care Victoria's Partnering in healthcare framework: bettersafercare.vic.gov.au/resources/tools/partnering-in-healthcare
4. International Dysphagia Diet Standardisation Initiative (IDDSI) guide: https://iddsi.org/

USEFUL RESOURCES

Partnering with consumers standard www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard

Standardised care resources www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes#SCPs

Dietitians Association of Australia and Speech Pathology Association of Australia Limited. (2007). Texture-modified foods and thickened fluids as used for individuals with dysphagia: Australian standardised labels and definitions. Nutrition & dietetics, 64, S53-S76.

New South Wales Government Nutrition policy: www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_041.pdf

National Safety and Quality Health Service Standards – User Guide for Acute and Community Health Service Organisations that Provide Care for Children: www.safetyandquality.gov.au/wp-content/uploads/2018/05/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Acute-and-Community-Health-Service-Organisations-the-Provide-Care-for-Children.pdf

References for definitions

The following documents and resources were reviewed and considered by the expert working group when forming the key term definitions for 'routine care', 'specified higher-level care' and 'eating and drinking'.

- American Speech-Language-Hearing Association, (2019). ASHA Glossary: Oral Intake. Retrieved from: www.asha.org/Glossary/Oral-Intake/
- Australian Government Department of Health, (2016). Aged Care Funding Instrument (ACFI) User Guide. Retrieved from: agedcare.health.gov.au/sites/default/files/documedents/02_2018/final_acfi_user_guide_2017.pdf
- Department of Human Services, (2006). Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities. Retrieved from: www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit
- Lippincott Williams & Wilkins, publisher, & Ovid Technologies, Inc. (2015). Lippincott nursing procedures. (Seventh ed.) Retrieved from: monash.hosted.exlibrisgroup.com/primo-explore/fulldisplay?docid=catau21294618370001751&context=L&vid=MONUI&lang=en_US&search_scope=au_everything&adaptor=Local%20Search%20Engine&tab=default_tab&query=any,contains,Lippincott%20Williams%20&%20Wilkins,%20publisher,%20&%20Ovid%20Technologies,%20Inc.%20(2015).%20Lippincott%20nursing%20procedures.%20(Seventh%20ed.)%20Page%20374.&sortby=rank&offset=0
- NHS Tayside, (2016). Nursing and Midwifery patient observation and engagement policy. Retrieved from: www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=DOCS_016381&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1
- NSW Government, South Eastern Sydney Local District Health (2017). Standardised mobility terminology for use across SESLHD. Retrieved from: www.seslhd.health.nsw.gov.au/sites/default/files/migration/Policies_Procedures_Guidelines/PHP/Falls_Prevention/docs/SESLHDGL047Standardisedterminologytodescribepatienttransfersand.pdf
- The Australian College of Critical Care Nurses Ltd., (2003). ACCCN ICU Staffing Position Statement (2003) on Intensive Care Nursing Staffing. Retrieved from: www.acccn.com.au/documents/item/20
- The Royal Children's Hospital, (2015). High dependency and special nursing care. Retrieved from: www.rch.org.au/rchcpg/hospital_clinical_guideline_index/High_dependency_and_special_nursing_care/

Safer Care
Victoria