

Nutritional risk forms a key priority for many health and social care organisations. There are patients within acute care settings, for example those with advanced dementia, who resist or are indifferent to food, fail to manage a food bolus adequately (oral phase dysphagia) or aspirate when swallowing (pharyngeal phase dysphagia) (Finucane et al, 1999). The challenge arises when the multidisciplinary team – usually involving the medical team, dietician and SLT – deems enteral or parenteral alternative nutrition or hydration (ANH) as unsuitable for these patients because the procedure risks outweigh the benefits; the patient declines ANH or there is poor prognosis/short life expectancy, for example in end of life care.

Clinicians then face the dilemma of how best to manage patients who are unsuitable for ANH but who are at risk of choking on food/fluid and developing aspiration pneumonia. According to Palecek et al (2010), an added complication may be the notion that, for the families involved, forgoing ANH can be wrongly interpreted as ‘do not feed’ and result in a reluctance to agree to this course of action.

It seemed essential, therefore, to establish from the literature the trends in practice on the management of nutrition for this cohort population.

While enteral tube feeding is intended to prevent aspiration pneumonia, forestall malnutrition and its sequelae, and provide comfort, Finucane et al (1999) highlight the absence of data to suggest that ANH improves any of these clinically important outcomes. The existing evidence, based on observational studies, suggests that feeding tubes do not improve survival or reduce the risk of aspiration (Sherman, 2003). Current practice steers towards comfort feeding (referred to in this article as risk feeding) through careful help with eating and drinking (‘hand

A safer approach to risk feeding

Dharinee Hansjee examines the development of a multidisciplinary protocol to assist with risk feeding

feeding’) as the preferred nutritional method, offering a clear goal-oriented alternative to tube feeding (Palecek, 2010).

Retrospective review

As a first step in developing a safer approach to risk feeding, I conducted a review of seven patients on a ward for older people in an acute care hospital who were referred to speech and language therapy during March 2011. Not all had a confirmed history of dementia but all lacked capacity to make their own decisions on nutrition planning. A review of the medical case notes established the number of days from admission to when a nutrition plan was put in place.

A crucial finding was that there was a delay in nutrition planning for five out of the seven patients. A more detailed analysis of the medical notes revealed that following a bedside swallowing assessment by an SLT, the five patients were unsafe



on all consistencies trialled, were at risk of developing aspiration pneumonia and needed a multidisciplinary team decision on the way forward with nutrition. The time taken to make a clinical decision resulted in significant delays, averaging six days before a nutrition plan was implemented, which is clearly unsatisfactory.

Another key finding related to the inconsistencies of the diet regime for these patients. Some were placed on a normal diet and fluids and referred to speech and language therapy when there was reduced oral intake; others were made nil by mouth with intravenous fluids, compromising their safety and comfort.

My findings highlighted the need to introduce a process to better manage nutrition and hydration in this patient group and it seemed integral to develop a system to inform and hasten the decision-making process. This led to the development of a risk feeding protocol.

Reducing risk

The risk feeding protocol is applicable to patients who present with reduced oral intake and/or swallowing difficulties on admission, and who are unlikely to be candidates for alternative feeding. The admitting medical team make a decision to implement the protocol.

The protocol document identifies why a person may be a candidate for risk feeding

“The time taken to make a clinical decision resulted in significant delays”

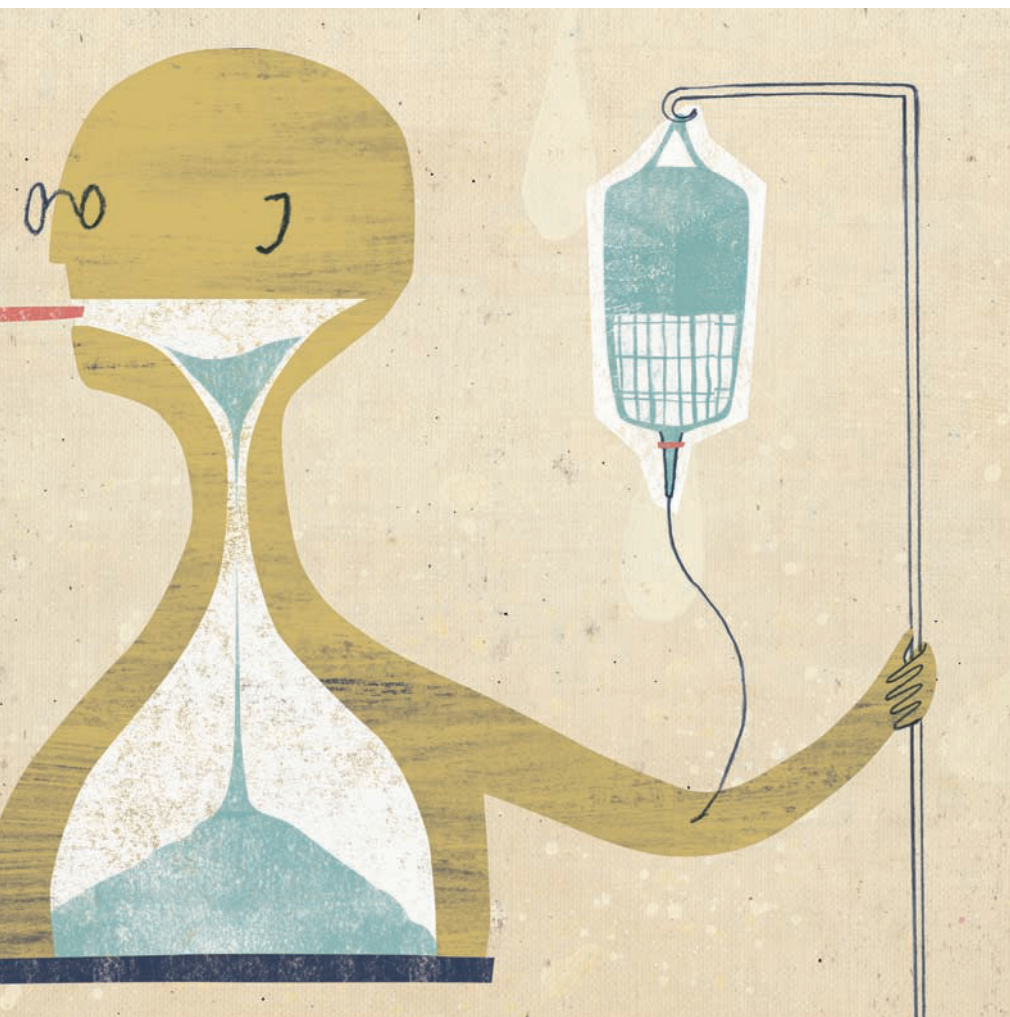


ILLUSTRATION Angela Keoghan

and includes a section for the assessment of the patient's capacity in making a decision regarding their nutritional management.

The signatures of the medical consultant and SLT confirm that multidisciplinary team discussions have taken place and that subsequent information has been shared with the patient/family. The document includes diet recommendations to reduce risk. I hoped that combining these processes within the document might address the gaps in practice disclosed by my review. Figure one illustrates the risk feeding pathway.

I drew up the risk feeding document with practical input from a palliative care consultant and the trust's legal team checked the wording of the section on capacity. I circulated the document to the corporate nutrition steering group for feedback and ratification to facilitate engagement of stakeholders across the trust. I was also involved in co-presentations with gastroenterologists, geriatricians, and dietitians at academic half days across the trust to further support dissemination. The protocol is now implemented trust-wide and audits on its uptake and use will take place over the respective sites in the next six months.

Measuring impact

I conducted a repeat retrospective review where the risk feeding process was applied to establish the impact of the risk feeding

protocol. This looked at six patients from acute medical wards during February 2012, six months after the introduction of the system. It identified a decrease in the number of days taken to put a nutritional plan in place (from six to two days on average). According to Sherman (2003), the reduction of the average wait time for nutritional planning has a significant impact on patient outcomes.

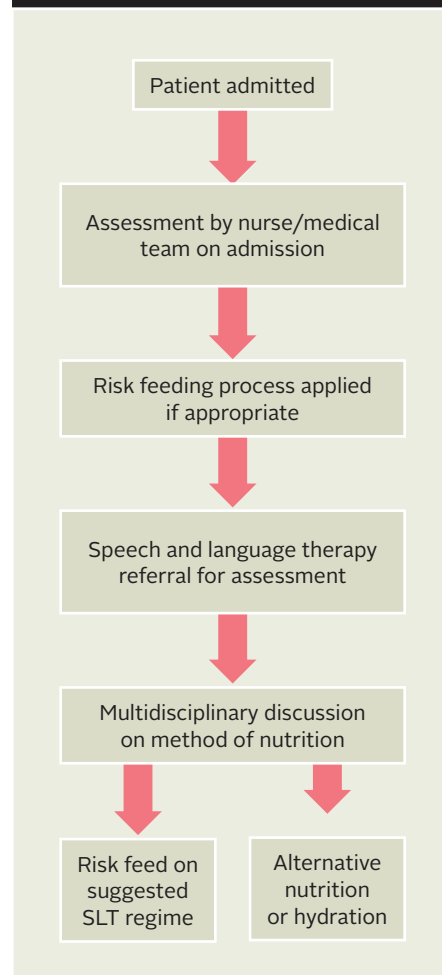
The medical teams reported, via the acute governance meetings, a preference for having a signed document that authorised 'feeding with risk'. The nurses and healthcare assistants - often left feeding patients who overtly choke at times - commented on the value of having signed documentation in place that acknowledges this risk. It seems the risk feeding checklist provides an organised decision, encapsulating patient choice and multidisciplinary clinical input to what appears to be an ethically fraught area.

Ongoing objectives

The following points highlight the ongoing action plan to sustain the change in practice:

- Interactive staff education sessions enable sharing of knowledge and feedback on the clinical and financial benefits of harnessing the new pathway.
- Communication with the community teams ensures the pathway is a core priority. The risk feeding protocol is attached to the discharge summary and

Figure one: The risk feeding pathway



recommendation letters are sent to the families/nursing homes/GPs for patients who are being risk fed.

- Remedial action via review cycles and the subsequent adaptation of the service provided remains essential as a quality and efficiency measure. ■

Dharinee Hansjee, Deputy Manager of Speech and Language Therapy, South London Healthcare NHS Trust. Email: dharinee.hansjee@nhs.net



References & resources

- Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: a review of the evidence. *Journal of the American Medical Association* 1999; 282:14, 1365-1370.
- Palecek EJ, et al. Comfort feeding only: a proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia. *Journal of the American Geriatric Society* 2010; 58:3, 580-584.
- Sherman FT. Nutrition in advanced dementia. Tube feeding or hand feeding until death? Editorial. *Geriatrics* 2003; 58:11, 10.