

# **Dysphagia Assessment and Management in Adults Policy**

**V7.0**

**October 2019**

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# 1. Introduction

1.1. Oropharyngeal dysphagia describes difficulties with eating and drinking. The intake of adequate food and drink is essential for life. Difficulty with swallowing normally not only has potentially life threatening consequences, but also can lead to an impaired quality of life. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences.

1.2. The prevalence of dysphagia varies with the aetiology and age of the individual.

For some populations it is difficult to ascertain the prevalence rate because of the way dysphagia is reported, often forming part of other health conditions for which the patient is being treated. Dysphagia can be a transient, persistent or deteriorating symptom according to the underlying pathology.

Each year in England approximately 110,000 people have a stroke, up to 78% of these patients have dysphagia immediately post stroke, of those with initial dysphagia following stroke 76% will remain with moderate to severe dysphagia and 15% profound (Mann et al. 1999). 200/100,000 UK population have dysphagia due to Parkinson's disease (Hartelius and Svensson 1994). More than 90% of those with motor neurone disease will develop dysphagia. 27% of those with COPD (McKinstry et al 2009) will experience dysphagia. 68% of those with dementia in homes for the aged have dysphagia (Steele 1997). 5.27% of all adults with a learning disability were referred for advice regarding dysphagia (Chadwick et al 2003). Between 50 and 75% of nursing home residents (O'Loughlin & Shanley 1998) and 10% of acutely hospitalised elderly (Lugger 1994) experience dysphagia.

Dysphagia is now recognised as a symptom of concern in many other conditions such as COPD (McKinstry et al 2009), head and neck cancer (McCabe et al 2009), thermal Burn injury (Ward et al 2001) and acquired brain injury (Ward et al 2007). A study of those having cervical discectomy and fusion indicated an incidence of dysphagia of 48% pre-operatively; and 67% post-operatively in those with a previously normal swallow study (Frempong-Boadu et al, 2002)

1.3. There are cost implications associated with dysphagia. Length of stay in hospital is longer for those stroke patients with dysphagia compared with patients without dysphagia and patients with dysphagia were twice as likely to be discharged to a nursing home than those without. (Odderson et al 1995)

1.4. Economic impact research showed that every £1 invested in low intensity speech and language therapy for adult stroke survivors with swallowing problems generates £2.30 in healthcare savings through avoided cases of chest infections (Marsh K, et al. 2010)

1.5. Speech and language therapists have a unique HCPC registered role in identifying and managing oropharyngeal dysphagia associated with a broad range of developmental, neurological and head and neck disorders. The key role of the speech and language therapist in the assessment, differential diagnosis and management of dysphagia has been recognised in national and international guidelines of practice.

1.6. The involvement of speech and language therapists in the assessment and management of those with dysphagia is associated with better outcomes and

advocated within national guidelines e.g. Scottish Intercollegiate Guidelines Network (SIGN 119 and 90), Royal College of Physicians 2008.

1.7. This version supersedes any previous versions of this document.

### **1.8. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team [rch-tr.infogov@nhs.net](mailto:rch-tr.infogov@nhs.net)

## **2. Purpose of this Policy/Procedure**

2.1. This policy is to ensure that clients of the Trust who have dysphagia (swallowing difficulties) receive the highest possible level of assessment, care and support to achieve maximum independence and as near normal experience as possible in the eating/drinking process, while keeping risks, e.g. choking, to a minimum.

2.2. This policy aims to describe the roles of different members of the multi-professional team in recognising, assessment and supporting dysphagia.

2.3. The policy primarily describes dysphagia management of inpatients. Outpatients and specialist patient groups are described separately.

## **3. Scope**

It is recognised that the assessment and treatment of dysphagia benefits from a multidisciplinary approach to ensure that all aspects of client care are identified and addressed. The Royal College of Speech and Language Therapists supports the principle that Speech & Language Therapists are ideally equipped to take a central role within the multi-disciplinary team in the assessment and remediation of swallowing disorders. (Royal College of Speech and Language Therapists, 1996).

## **4. Definitions / Glossary**

- The term dysphagia describes swallowing disorders, which may occur in the oral, pharyngeal or oesophageal stage.
- SLT – Speech and Language Therapist
- RCSLT – Royal College of Speech and Language Therapists
- Videofluoroscopy – a video x-ray of the swallow using contrast to assess the oral,

pharyngeal and oesophageal stages of the swallow

- IDDSI – International Dysphagia Diet Standardisation Initiative. A new set of Dysphagia diet descriptors to describe food and fluid textures, adopted throughout the UK by April 2019.
- FEES – Fibreoptic Endoscopic Evaluation of Swallowing – performed using a naso-endoscope in order to visualize the larynx whilst swallowing

## **5. Ownership and Responsibilities**

5.1. This policy is written and reviewed by the SLT Professional Lead and SLT Dysphagia Lead. The policy is further reviewed and ratified by the Nutrition Steering Group and Therapies Integration CQAG.

### **5.2. Role of the Trust Board**

- The Trust board should recognise the seriousness and importance of dysphagia and its effect on patient outcomes and are responsible for ensuring that the Trust complies with local and national Standards.
- The Trust board should ensure that staff have appropriate and adequate training to deal with matters related to dysphagia.
- The Trust board should ensure that staff have access to resources to enable them to assess nutritional requirements and to deliver individualised care to meet these.

### **5.3. Role of the Managers**

Divisional managers, department managers, matrons and charge nurses are responsible for:

- Ensuring that resources are available for health care workers to provide appropriate nutrition and hydration to all patients
- Ensuring that training is provided/accessed so that registered and non-registered health care workers are aware of their responsibilities in relation to patients with dysphagia and are able to carry these out.
- Demonstrating compliance with CQC outcome 5 by conducting relevant audit / patient survey / review.
- Ensuring that all clinical staff are aware of this policy and monitor compliance with the standards set out within.

### **5.4. Role of the Nutritional Steering Group**

The Nutrition Steering Group is responsible for:

- Agreeing and ensuring adequate food provision, including textures within RCHT.
- Co-ordinating and monitoring appropriate education and training programmes for all staff involved in nutrition provision.
- Developing and improving communications around dysphagia and nutrition/hydration.

### **5.5. Role of Individual Staff**

All staff directly or indirectly involved in the care of patients with dysphagia are responsible for:

- Following Trust policy and protocols relating to the care of patients with oro-pharyngeal dysphagia.
- Documenting all information concerning oro-pharyngeal dysphagia in accordance with Trust policies and protocols
- Compliance with food hygiene regulations when involved with food service
- Conforming with their relevant professional standards and guidelines relating to dysphagia
- Maintaining their own awareness of dysphagia
- Referral to SLT for specialist assessment when a patient at risk of dysphagia is identified.

### **5.6. Role of Speech and Language Therapists**

Speech and Language Therapists are responsible for:

- SLTs working with individuals with dysphagia should meet the dysphagia competencies set out by the RCSLT.
- Newly qualified SLTs should develop their own dysphagia competence through training and the completion of the Interdisciplinary Dysphagia Competency Framework (or equivalent) when first qualified.
- The skill level of the speech and language therapist working with people with dysphagia must be commensurate with the job requirements. Postgraduate training and clinical expertise are required for specialist posts. All Speech and Language Therapists are responsible for maintaining their competence and onward development through training, clinical supervision, shadowing and attendance at Clinical Excellence Networks.
- The overall aims of the speech and language therapist working with an individual with dysphagia include:
  - detailed assessment and re-assessment of oropharyngeal dysphagia as required leading to diagnosis which may assist with the differential medical diagnosis
  - ensuring safety (reducing or preventing aspiration) with regards to swallowing function
  - balancing these factors with patient choice and quality of life
  - taking account of the individual's preferences and beliefs
  - optimisation of nutrition and hydration
- Provision of information and education to the patient, their family and other members of the multi-disciplinary team around their individual needs
- Provision of information and education to the multi-disciplinary team promoting general dysphagia awareness
- Referral to the appropriate specialist therapists for instrumental dysphagia assessments (videofluoroscopy or FEES) can be made, provided there is agreement for the assessment with the medical team (and a medical referral is made for VF), in order to facilitate diagnosis, help identify strategies to improve the swallow efficiency and to provide a benchmark for outcomes.

- The stroke SLT team and Stroke SLT clinical lead hold responsibility for:
  - Agreeing and reviewing the Stroke Swallow Screen and its associated training package for non-SLTs
  - Ensuring availability of education and training around dysphagia to members of the stroke MDT

### **5.7. Role of Speech and Language Therapy Assistants**

Speech and Language Therapy Assistants are responsible for:

- Carrying out swallow rehabilitation exercises as directed by a Speech and Language Therapist
- Reviewing patients on their current recommendations under the guidance of a Speech and Language Therapist
- Developing competence to Assistant level under the Interdisciplinary Dysphagia Competency Framework (or equivalent) with the support of a Speech and Language Therapist.

### **5.8. Role of other non-SLT staff holding additional dysphagia competence**

#### 5.8.1. Stroke

- Stroke nurses, Emergency Department nursing staff and Assistant Practitioners in stroke can receive training to develop competence to deliver the stroke swallow screen which enables them to identify whether a patient is experiencing dysphagia immediately following their stroke. If a dysphagia is identified, the stroke nurse is responsible for referring on to Speech and Language Therapy for specialist assessment. The training is found via the CITS training portal at <http://elearning.cornwall.nhs.uk>
- These staff members are responsible for their own maintenance of competencies and should seek further training/supervision as required.

#### 5.8.2. Nurses general wards

- A swallow screen for use with non-stroke patients by nurses and associated training is under development

#### 5.8.3. General Support Workers

- Generic support workers are expected to complete training and maintain competencies to be able to complete swallow screens for patients in ED/AMU. Competencies are stored in [S:\TR13\AHP Therapies Resources\Acute Early Intervention Team\GSW\Competencies\GSW SLT Competencies.docx](#)

#### 5.8.4. Re-ablement workers

- Carrying out swallow rehabilitation exercises as directed by a Speech and Language Therapist
- Supporting people with dysphagia at meal times

## **6. Standards and Practice**

### **6.1. Referrals**

The referral process to Speech and Language Therapy varies slightly by clinical area:

#### **6.1.1. General wards**

Electronic referrals are taken via Maxims from any member of the MDT, referrals should be documented in medical notes. Referrals are checked at least daily Monday-Friday

#### **6.1.2. Stroke**

Referrals are taken verbal from any member of the MDT. SLTs attend the twice daily ward round on Phoenix to receive referrals. The ward has dedicated SLT cover Sunday-Friday

#### **6.1.3. Neurology patients**

Referrals are taken from any member of the MDT via Maxims or verbally on the ward and by attendance of SLT at Tintagel ward round when able.

#### **6.1.4. AMU**

Referrals are taken from any member of the MDT via Maxims or verbally on the ward and by attendance of SLT at AMU ward round when able

#### **6.1.5. West Cornwall Hospital**

Referrals are received via Maxims from any member of the MDT and should be documented in medical notes.

#### **6.1.6. Marie Therese House**

Referrals are taken from any member of the MDT verbally and by attendance of SLT at MDT meetings.

### **6.2. Waiting Times and Prioritisation**

6.2.1. Referrals are triaged according to the information contained within them for urgency and risk. The general ward teams aim to see urgent new cases within 48 hours during the working week with the SLT service being funded on week days only. In stroke, national guidelines recommend that all new dysphagia cases are seen within 72 hours.

6.2.2. Marie Therese House receives SLT cover one day per week and West Cornwall hospital one half day per week. Dedicated Neurology SLT cover for Tintagel is 2 days per week. Waiting times will vary accordingly.

### **6.3. Screening**

6.3.1. Swallow screening for patients who have experienced a stroke is carried out by some members of staff (see roles and responsibilities). The purpose of a screen is to identify patients who are showing signs of dysphagia. Following a screen, a patient can be moved to a more modified texture to reduce immediate risk. Any patient with signs of dysphagia

following a swallow screen should be referred to Speech and Language Therapy for a full assessment.

6.3.2. Swallow screening is currently only undertaken by Specialist Stroke nurses and nurses within the Stroke unit. A screen and training which is suitable for other client groups is currently under development.

## **6.4. Assessment**

### **6.4.1. Bedside**

A bedside assessment will be completed for the majority of new referrals. This involves the SLT gathering a case history, understanding the patient's baseline eating and drinking status and observing the patient with a selection of food and/or drink textures. Cervical auscultation and palpation may be used to assess the strength and timing of the swallow.

### **6.4.2. Specialist**

Videofluoroscopy (VFSA) – SLTs involved in VFSA clinic must have completed either the RCHT VFSA competencies or another recognised competency programme, be compliant with the RCHT Ionising Radiation Safety Policy and have a relevant entry in their job description before being involved in such assessments. For a VFSA referral to be acted upon both a referral from an SLT (to provide the appropriate information for the assessing therapists) and a medical referral (to prescribe a dose of radiation) are required, in line with the RCHT VFSA guidelines.

FEES - SLTs involved in FEES assessments must have completed either the RCHT FEES competencies or another recognised competency programme and have a relevant entry in their job description before being involved in such assessments. For a FEES assessment to be completed, agreement with the medical team is required and it is recommended that a doctor is within easy access for the duration of the assessment, in line with the Fibreoptic Endoscopic Evaluation of Swallowing (FEES) RCHT SLT – PROTOCOL. *Use of FEES remains under development.*

Patients with a tracheostomy - SLTs assessing tracheostomised patients must have completed either the RCH tracheostomy competencies or another recognised competency programme and have a relevant entry in their job description before treating this patient group independently. A professional appropriately trained in suctioning via a tracheostomy should be present.

Ventilated patients - Patients requiring mechanical ventilation should not be assessed other than by staff trained in this area. A professional appropriately trained in suctioning; preferably Physiotherapist or Nurse must be present.

## **6.5. Dysphagia Management**

Dysphagia management plans are written onto SLT Swallow Advice Sheets. These sheets are displayed above the patient's bed. This information is also communicated through the medical notes and to ward hosts who record this on their handover sheets.

### **6.5.1. Food textures**

All care settings should provide the required textures as outlined by the International Dysphagia Diet Standardisation Initiative (IDDSI) as endorsed by the BDA and RCSLT. Information on these descriptors can be found at <https://iddsi.org/resources/>

### **6.5.2. Equipment (including self-feeding)**

Specialist cutlery, cups or plates may be recommended for certain patients. Where possible, all patients should be encouraged to feed themselves to promote independence and reduce risk of aspiration.

### **6.5.3. Positioning**

Where appropriate, patients should be seated in a chair for meals with feet placed on the ground. Where necessary, patient specific guidance on positioning will be provided.

### **6.5.4. Mouth care**

All patients should be supported to complete/receive mouth care twice daily to increase oral health and comfort and decrease the risk of aspiration of bacteria laden saliva. Patients who are nil by mouth should be supported to complete/receive mouth care every two hours.

### **6.5.5. Swallow rehabilitation**

Where there is potential to improve swallow function, patients will be given exercises to increase muscle strength and range. Food/fluid textures, temperature and amounts are also used to support swallow rehab. These may be overseen by Assistants, Nursing Staff, SLTs or family members following training.

## **6.6. Review and Discharge**

### **6.6.1. Reviews**

Reviews will be determined and prioritised by clinical need

### **6.6.2. Discharge paperwork process for general ward patients**

6.6.2.1. If no change from baseline, no discharge letter written. Hospital discharge summary only.

6.6.2.2. If change from baseline but no onward referral needed (including if transferred to community hospital):

- GP - Letter informing of change in baseline (and prescription repeat request if necessary), handing over duty of care.
- Patient res/home – Copy of GP letter with Swallowing advice sheet.
- If in community hospital, letter goes to patient with community hospital ward as address

6.6.2.3. If onward referral to community SLT

- GP - letter with transfer report enclosed (requesting prescription repeat if necessary and awareness of duty of care/waiting times)

- Community SLT– transfer report (GP letter enclosed)
- Patient/Care home – GP letter and recommendation sheet enclosed (and telephone handover to residential/nursing homes)

6.6.2.4. If going to community hospital with SLT follow up:

- Transfer report
- Telephone handover to ward

### **6.6.3 Discharge process for Stroke patients**

6.6.2.5. No SLT transfer information is provided for Stroke patients transferred to other stroke wards as full and detailed SLT info is provided in the medical notes

6.6.2.6. SLT complete the relevant section of an Early Supported Discharge referral form for patients discharged with the Early Supported Discharge Team

### **6.7. Specialist/Outpatient Client groups**

6.7.1. Patients with head and neck cancer – Should be under the care of the Head and Neck cancer specialist SLTs

6.7.2. Patients receiving Palliative Care for Non Head and Neck Oncology - Should be under the care of the Palliative Specialist SLT

6.7.3. AMU role – The AMU SLT is primarily based within the Acute Medical Unit at RCHT but may conduct a home visit to follow up assessments and recommendations when a one-off visit is required. This increases continuity of care and reduces the need for a new episode of care and associated waiting times with the Community SLT team.

6.7.4. Videofluoroscopy for patients residing in the community – to be conducted following the receipt of a medical referral and an SLT referral detailing the patients' current recommendations and aims of the assessment. The SLT making the referral should be offered the opportunity to attend the patient's appointment.

## **7. Dissemination and Implementation**

This document will be made available on the Royal Cornwall Hospital Trust intranet. It will also be ratified and disseminated through the Nutrition Steering Group and Therapies CQAG.

## 8. Monitoring compliance and effectiveness

Element to be monitored	<ol style="list-style-type: none"> <li>1. SLT dysphagia competencies</li> <li>2. Appropriate use of Stroke swallow screen documentation</li> <li>3. Appropriate use of Mild Cognitive Impairment Swallow Screen</li> </ol>
Lead	<ol style="list-style-type: none"> <li>1. SLT supervisors, team leads &amp; manager</li> <li>2. Stroke Clinical lead for SLT</li> <li>3. SLT dysphagia lead</li> </ol>
Tool	<ol style="list-style-type: none"> <li>1. SLT supervision framework (Appendix 3)</li> <li>2. Audit – yet to be devised</li> <li>3. Audit – yet to be devised</li> </ol>
Frequency	<ol style="list-style-type: none"> <li>1. Monitored as required by the individual and level of competency</li> <li>2. Annually</li> <li>3. Annually</li> </ol>
Reporting arrangements	<ol style="list-style-type: none"> <li>1. SLT management</li> <li>2. Business &amp; Governance meeting/ SLT clinical lead stroke</li> <li>3. SLT dysphagia lead</li> </ol>
Acting on recommendations and Lead(s)	<ol style="list-style-type: none"> <li>1. SLT Professional lead</li> <li>2. Stroke Clinical lead for SLT</li> <li>3. SLT dysphagia lead</li> </ol>
Change in practice and lessons to be shared	<ol style="list-style-type: none"> <li>1. SLT CPD</li> </ol>

## 9. Updating and Review

This policy will be reviewed every three years.

## 10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ['Equality, Inclusion & Human Rights Policy'](#) or the [Equality and Diversity website](#).

### 10.2. *Equality Impact Assessment*

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

## Appendix 1. Governance Information

<b>Document Title</b>	Dysphagia Assessment and Management in Adults Policy V7.0		
<b>Date Issued/Approved:</b>	July 2019		
<b>Date Valid From:</b>	October 2019		
<b>Date Valid To:</b>	October 2022		
<b>Directorate / Department responsible (author/owner):</b>	Jennifer Lloyd Professional Lead for Speech & Language Therapy		
<b>Contact details:</b>	01872 253115		
<b>Brief summary of contents</b>	This policy aims to ensure that all adult patients with oropharyngeal dysphagia receive appropriate care. It provides guidance on responsibilities of staff in relation to the care of adult patients with oro-pharyngeal dysphagia.		
<b>Suggested Keywords:</b>	Dysphagia, IDDSI, Swallowing, Speech and Language Therapy, SLT, SALT		
<b>Target Audience</b>	RCHT ✓	CFT	KCCG
<b>Executive Director responsible for Policy:</b>	Kim O'Keefe, Director of Nursing, Midwifery & AHPs		
<b>Date revised:</b>	July 2019		
<b>This document replaces (exact title of previous version):</b>	Management of Oro-pharyngeal Dysphagia in Adults Policy V6.0		
<b>Approval route (names of committees)/consultation:</b>	Clinical Consultation June/July 2019 Therapies Clinical Governance Forum Aug 2019 Therapies CQAG Sept 2019		
<b>Care Group General Manager confirming approval processes</b>	Robin Jones – Clinical Support Care Group		
<b>Name and Post Title of additional signatories</b>	Not required		
<b>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</b>	{Original Copy Signed}		
	Name: Kevin Wright Clinical Support Care Group		
<b>Signature of Executive Director giving approval</b>	{Original Copy Signed}		
<b>Publication Location (refer to Policy on Policies – Approvals and Ratification):</b>	Internet & Intranet	✓	Intranet Only
<b>Document Library Folder/Sub</b>	Clinical/Speech and Language Therapy		

<b>Folder</b>	
<b>Links to key external standards</b>	None
<b>Related Documents:</b>	<p>RCHT Policy for the Speech and Language Therapy Management of Adult Patients presenting with Head and Neck Cancer</p> <p>RCHT VFSA competencies framework (2011) Dysphagia Policy Page 28 of 30</p> <p>RCHT FEES competencies and protocol (2012)</p> <p>RCHT Ionising Radiation Safety Policy</p> <p>RCH SLTs working with tracheostomy competencies Framework (2009)</p>
<b>Training Need Identified?</b>	<ul style="list-style-type: none"> <li>• On-going training needs for staff working towards/maintaining VFSA and tracheostomy competencies.</li> <li>• Training in the use of FEES.</li> <li>• Development of non-stroke swallow training for nursing staff.</li> </ul>

### Version Control Table

<b>Date</b>	<b>Version No</b>	<b>Summary of Changes</b>	<b>Changes Made by (Name and Job Title)</b>
November 1997	V1.0	Initial issue	Margaret Ray, Head of Adult Speech and Language Therapy
May 2008	V2.0	Review and update	Margaret Ray, Head of Adult Speech and Language Therapy
May 2008	V3.0	Review and update	Margaret Ray, Head of Adult Speech and Language Therapy
August 2009	V4.0	Review and update	Margaret Ray, Head of Adult Speech and Language Therapy
January 2010	V5.0	Review and update	Margaret Ray, Head of Adult Speech and Language Therapy

July 2014	V6.0	Review and update on current RCHT document template	Julie Wright, Highly Specialist Adult Speech and Language Therapist (Dysphagia Specialist)
July 2019	V7.0	<ul style="list-style-type: none"> <li>• Review and update of references</li> <li>• Update of diet textures to reflect new International Guidance (IDDSI)</li> <li>• Review and update on current RCHT document template</li> </ul>	Julie Wright, Highly Specialist Adult Speech and Language Therapist (Dysphagia Specialist) / Jennifer Lloyd, Professional Lead - SLT

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

#### **Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

## Appendix 2. Initial Equality Impact Assessment Form

<b>Name of the strategy / policy /proposal / service function to be assessed</b>						
Dysphagia Assessment and Management in Adults Policy V7.0						
<b>Directorate and service area:</b> Speech and Language Therapy			<b>New or existing document:</b> Existing			
<b>Name of individual completing assessment:</b> Jennifer Lloyd			<b>Telephone:</b> 07979 800514			
1. <i>Policy Aim*</i>  <i>Who is the strategy / policy / proposal / service function aimed at?</i>		Staff involved in the care of patients with dysphagia.				
2. <i>Policy Objectives*</i>		Describe the role and responsibilities of staff working with patients with dysphagia Describe the referral routes and pathways for patients with dysphagia				
3. <i>Policy – intended Outcomes*</i>		Increase patient safety through clarified roles and responsibilities for patient care around dysphagia				
4. <i>*How will you measure the outcome?</i>		Incident monitoring, audit				
5. <i>Who is intended to benefit from the policy?</i>		Patients with dysphagia				
6a Who did you consult with		Workforce	Patients	Local groups	External organisations	Other
		X				
b). Please identify the groups who have been consulted about this procedure.		<b>Please record specific names of groups</b> Clinical Consultation July 2019 Therapies CG forum Consultation Aug 2019 Therapies CQAG Sept 2019 Care Group Approval Oct 2019				
What was the outcome of the consultation?		Agreed				

### 7. The Impact

Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence			
<b>Age</b>		X					
<b>Sex</b> (male, female, trans-gender / gender reassignment)		X					
<b>Race / Ethnic communities /groups</b>		X					
<b>Disability -</b> Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		X					
<b>Religion / other beliefs</b>		X					
<b>Marriage and Civil partnership</b>		X					
<b>Pregnancy and maternity</b>		X					
<b>Sexual Orientation,</b> Bisexual, Gay, heterosexual, Lesbian		X					
<p><b>You will need to continue to a full Equality Impact Assessment if the following have been highlighted:</b></p> <ul style="list-style-type: none"> <li>You have ticked "Yes" in any column above and</li> <li>No consultation or evidence of there being consultation- this <u>excludes</u> any <i>policies</i> which have been identified as not requiring consultation. <b>or</b></li> <li>Major this relates to service redesign or development</li> </ul>							
8. Please indicate if a full equality analysis is recommended.				Yes		No	X
9. If you are <b>not</b> recommending a Full Impact assessment please explain why.							
This policy applies to all patients with dysphagia, regardless of any other personal characteristics.							
Date of completion and submission	July 2019		Members approving screening assessment	Policy Review Group (PRG) <b>APPROVED</b>			

**This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.**

A summary of the results will be published on the Trust's web site.