## Health Standard No.: 16-2 Issue Date: March 2007

Subject: Safe Eating and Drinking Guidelines for Individuals Effective Date: April 1, 2012

with Swallowing Difficulties (Dysphagia)**Revised:** December 1, 2016

(Replaces Medical Advisory #07-1) **Approved:**/s/Jordan A. Scheff

**Section:** Health Standards Acting Commissioner/SLT

**Introduction**

The goal of the safe eating and drinking health standard is to assist an individual to eat with the highest degree of dignity and independence, and enjoy the least restrictive diet while maintaining health and safety. Safe eating and drinking guidelines may include positioning techniques, food and liquidconsistency changes, and use of adaptive equipment which may be components of an individualized program. Interventions may include increased direct support staff observation or assistance, individualized programs to address behaviors and eating techniques which would reduce individual risk.

1. **Purpose**

The intent of this Health Standard is to provide licensed clinicians and supervisory or professional staff who are qualified trainers in safe eating and drinking and swallowing risks and Speech Language Pathologists (SLT) and Occupational Therapists (OT) with best practice guidelines to support and guide direct support staff in the identification and management of eating, drinking and swallowing risks so as to maintain the greatest degree of independence, dignity, respect and health for the individuals served by the department.

1. **Applicability**

This health standard applies to all individuals for whom the department bears direct or oversight responsibility for their health and safety. This standard is to be applied to the planning and coordination of care for individuals and provides guidance to direct support staff for individuals receiving residential funding or in residential placements and individuals receiving employment opportunities and day services.

1. **Definitions**

“Adaptive Equipment” means devices, which are provided or modified to meet the individual's abilities to eat independently and safely (e.g. cups that adjust fluid flow, modified spoons, etc.)

“Aspiration” means entry of food, liquid, or other materials into the individual’s airway that may occur before, during or after a swallow and which may be silent or may occur with observed signs (Refer to: Health Standard No. 16-2 Attachment C Sample protocol: Aspiration Precautions)

“Bedside Swallow Evaluation” means a clinical evaluation of swallowing skills to identify the presence of eating or drinking problems (dysphagia), or changes in swallowing function. A Bedside Swallow Evaluation is completed by a Speech Language Pathologist (SLP) or Occupational Therapist (OT) with expertise in swallowing disorders. (Refer to: Health Standard No. 16-2 Attachment B Bedside Swallow Evaluation)

“Dysphagia” means a swallowing disorder in which there isdifficulty swallowing or moving food or liquid safely from the mouth to the stomach

“Fiber optic endoscopic evaluation of swallowing (FEES)” means the procedure designed to assess swallowing function through the use of vocal tract visualization and imaging to examine the pharyngeal and laryngeal structures.

“Modified Barium Swallow (MBS)” means a radiological procedure designed to examine the details of the oral and pharyngeal physiology during a swallow.

“Pica” means a diagnosed condition of a persistent eating of non-nutritive items or non-food materials.

“Reflux” means a return or backward flow of substance from the stomach into the esophagus. Reflux precautions are commonly prescribed for individuals with gastroesophageal reflux disease (GERD). (Refer to: Health Standard No. 16-2 Attachment D Sample protocol: Reflux Precautions)

1. **Implementation**
2. **Training staff to understand swallowing disorders and recognize swallowing risks**
3. Licensed clinicians are permitted to become qualified trainers in safe eating and drinking and swallowing risks if they have attended and successfully completed a DDS train-the-trainer session.
4. Supervisory or professional staff with at least three years of experience working with persons with intellectual disability, are permitted to become qualified trainers in safe eating and drinking and swallowing risks if they have attended and successfully completed a DDS train-the-trainer session
5. Speech Language Pathologists (SLPs) and Occupational Therapists (OTs) are exempt from having to participate in a DDS train-the-trainer course to be a qualified trainer in safe eating and drinking and swallowing risks.
6. All qualified trainers in safe eating and drinking and swallowing risks shall utilize the DDS training curriculum to provide instruction to direct support staff and other employees.
7. Non-licensed trainers in safe eating and drinking and swallowing risks who have not taught for a period of three years shall repeat the DDS train-the-trainer curriculum before they are allowed to provide instruction to employees.
8. Training in safe eating and drinking and swallowing risks shall be provided by a qualified trainer to all new direct support staff. Other staff, who support or assist individuals with a swallowing disorder (i.e., licensed nurses, supervisory staff, case managers), also, may require training. Training in safe eating and drinking and swallowing risks shall be repeated at a minimum every two years.
9. Qualified provider agencies shall designate a qualified trainer or licensed clinical consultant who shall provide training in safe eating and drinking and swallowing risks to direct care staff and other employees.
10. Training in safe eating and drinking and swallowing risks shall address the following areas:
11. The definition and explanation of basic swallowing process, swallowing risks factors and potential complications;
12. Observable signs of swallowing difficulties, reporting and documentation responsibilities; and

1. Food and liquid consistency modifications.
2. **Identification and follow-up of individuals with swallowing risks**

Individuals may display signs and symptoms of a swallowing disorder independent of whether or not he or she has a diagnosis. There are several formal and informal processes that identify swallowing risks or the need for further evaluation. These include:

1. Observations by direct care staff
2. Frequently the direct care staff is the first to notice a change in the individual’s ability to eat or swallow safely, or other risk factors for dysphagia. When a change is observed, the direct care staff should take the appropriate action based on the type of dysphagia risk observed, the instructions in the individual’s support plan and as stated in the qualified agency’s dysphagia policy. Actions may include, but are not limited to, the following:
3. Performing abdominal thrusts in an instance of choking.
4. Calling 911 for choking incidents.
5. Notifying the registered nurse (RN) or the nurse-on-call, immediately for incidents called into 911, or as soon as possible for other observations of dysphagia risk.
6. Increasing observation of the individual especially while eating, drinking or taking medication.
7. Cutting food into smaller pieces until a safe eating assessment for the individual can be completed by a clinician.
8. Notifying promptly other appropriate agency personnel (i.e., supervisor, SLP, OT) as established in the qualified provider’s policy.
9. Following the identified qualified provider’s documentation reporting process (Refer to Attachment A, example of Swallowing Episode Report Form).
10. Connecticut Level of Need (LON) Assessment and Screening Tool
    * + 1. This assessment and screening tool documents the presence of diagnosed medical conditions and prescribed treatments as well as certain behaviors that may place an individual at increased risk for choking or other swallowing concerns.
        2. When conditions or behaviors that increase an individual’s risk of dysphagia are noted during the LON assessment and screening process, the need for assessment and further evaluation shall be documented by the individual’s case manager or a qualified intellectual disabilities professional (QIDP) for individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
11. Nursing or Community Health Care Provider Assessment
12. A comprehensive nursing assessment, using the Community Health and Safety Assessment, may identify health concerns or other health-related issues that place an individual at increased swallowing risk. The individual’s assessment shall evaluate the effect of prescribed medication on the individual’s ability to swallow, as many medications may cause dysphagia, including, but not limited to:
    * + 1. Antipsychotic or neuroleptic medications.
        2. Anticholinergics.

* + - 1. Medications that cause dry mouth (xerostomia) such as antiepileptic medications, anti-anxiety medications, narcotics and muscle relaxants.
      2. Medications that depress the central nervous system (CNS depressants).
      3. Medications that can cause esophageal injury, including but not limited to aspirin, NSAIDs, osteoporosis medications, iron containing products, bronchodilators, potassium supplements, vitamin C and certain acid-containing antibiotics.
      4. Local anesthetics used for dental work.

1. Identified dysphagia risks that pose an immediate threat to the individual shall be addressed through immediate actions, which may include:
2. Notifying an appropriate clinician or health care provider (Speech Language Pathologist (SLP), Occupational Therapist (OT), psychologist or behaviorist, primary care provider (PCP), psychiatrist, or dentist).
3. Temporarily modifying food and liquid consistency until a licensed practitioner’s order is obtained.
4. Initiating temporary positioning requirements for an individual when he or she is eating, drinking or taking medication for a period following the identification of risks of dysphagia.
5. Requesting closer supervision of the individual during specific times.
6. An individual’s identified dysphagia risks shall be reported to his or her primary care provider (PCP) for determination of need for new licensed practitioner’s orders or further evaluation.
7. Information on an individual’s health concerns and health related issues that may increase swallowing risk including reflux, aspiration, or choking, etc., and information on individual-specific food and liquid consistency modifications should be communicated to appropriate qualified providers, including employment opportunity and day services providers.
8. If an individual experiences a change in condition, a reassessment shall be conducted by a nurse or community health care provider.
9. **Evaluation and Follow-up**
   1. An individual’s identified dysphagia risks shall be addressed by his or her planning and support team (PST) in the individual planning process. The individual’s PST shall ensure the reports and recommendations are provided to the registered nurse or to the community health care provider, if there is no RN involvement, and to the employment opportunity or day services provider. If further evaluations to determine the extent of the individual’s dysphagia-risk are needed, these evaluations may include:
      * 1. Clinical assessment and evaluation of the individual’s swallowing by a Speech Language Pathologist (SLP) or Occupational Therapist (OT). At a minimum, the SLP’s or OT’s report should document the areas addressed in the sample assessment. (Refer to Attachment B, Bedside Swallow Evaluation)
        2. Modified Barium Swallow (MBS) or Fiber Optic Endoscopic Evaluation of Swallowing (FEES)
10. In order to maximize either an MBS or FEES test performance, it is recommended that a direct care staff, familiar with the individual, accompany him or her to the test and bring the individual’s supporting documentation.
11. The licensed practitioner should consider requesting a Barium Pill Study as part of the MBS.
12. Medical, Dental and Other Health Evaluations
13. A dental, an OT or an SLP evaluation may be required for an individual who does not have teeth (edentulous), has few teeth, or has other oral concerns to determine to what extent the individual’s missing teeth or other oral concerns impact the individual’s ability to chew and swallow solid foods.
14. A gastroenterologist’s evaluation may be necessary for the individual for any of the following: (1) swallowing abilities that are significantly impaired; (2) alternative feeding techniques used or recommended for non-oral feeding (i.e., nasogastric tube, g-tube, etc.); or (3) if gastroesophageal reflux (GERD) is suspected.
15. Dietary consultation may be necessary to ensure appropriate caloric and nutrient intake when the individual’s treatment plan includes (1) enteral feeding, or (2) eliminating certain foods from the individual’s diet due to food and liquid consistency issues.
16. Pharmacist consultation may be required to help determine if there is a correlation between an individual’s prescribed medication and his or her difficulty in swallowing.
17. Neurological evaluations may be required if the individual’s swallowing issue is suspected to be due to (1) the individual’s anticonvulsant use, or (2) some other neurological condition.
18. A behavioral, psychological, or psychiatric evaluation may be required for an individual who has high risk behaviors such as acquiring food inappropriately, gorging of food, or pica, etc. If indicated by this evaluation, a plan shall be developed to promote safe eating and drinking and reduce swallowing risks for the individual.
19. Periodic nursing assessment and clinical re-evaluation may help identify the emergence of new safe eating or drinking risk factors or additional concerns for the individual, especially when an individual has been observed with significant dysphagia risk factors, or if the individual has had significant changes in his or her medical or behavioral condition.
20. Dysphagia or swallowing risks related to the ingestion of food or non-food items (pica) may be increased due to factors in the individual’s living environment. Environmental risk prevention strategies to be implemented by staff may include, but are not limited to:
21. A review of the layout of the individual’s residence and day or employment setting. Staff should consider proximity or access to foods for individuals with pica or swallowing issues.  Staff also should consider the proximity of an individual’s bedroom to the kitchen, refrigerator or freezer, food storage, and dining area. Staff should make modifications where possible.
22. Routine environmental surveillance sweeps of areas where the individual spends time to check for ingestible items, food or non-food items, including, but not limited to, gloves, medical supplies, strings, dirt, office supplies, and cleaning supplies.
23. Motor vehicle surveillance sweeps to remove food or non-food items prior to each time an individual enters the vehicle.
24. Consideration of the type of supports the individual may need in the environment of a planned outing to minimize dysphagia or swallowing risks for the individual.
25. Education of all staff to be vigilant for dysphagia or swallowing risks.
26. **Recommendations**
27. The individual’s planning and support team shall be responsible for reviewing all evaluations, recommendations, and prescribed treatments concerning the individual’s dysphagia or swallowing risks and shall incorporate them, as appropriate, into his or her individual plan. The individual’s PST is required to take into consideration the individual’s personal choices and preferences when integrating the safe eating and drinking and swallowing risks. These recommendations are required to be based upon the individual’s personal preferences. Changes to the individual’s plan concerning dysphagia or swallowing risks and any recommendations shall be communicated to all staff who support the individual.
28. Written individual-specific instructions and training on safe eating and drinking and swallowing risks shall be provided to direct care staff, the individual, and the individual’s family or guardian to ensure understanding of the individual’s support needs, such as:
29. Prescribed food and liquid consistencies
30. Eating and positioning plans
31. Aspiration precautions
32. Reflux precautions
33. Consideration of pleasure foods when a G-Tube is in place in order to support an individual’s quality of life.
34. Analysis to determine whether an individual is an appropriate candidate for a G-tube.
35. Behavioral plans and supervision requirements including staff training on the actions to be taken and supervision that has been identified to keep the individual safe.
36. **Qualified Provider Responsibilities**

Qualified providers shall develop and implement policies, procedures, and guidelines for safe eating and drinking and swallowing risks that are consistent across all agency settings and that:

1. Identify the notification process to be used for reporting observations, incidents, and concerns related to safe eating and drinking and swallowing risks. (Refer to: Health Standard No. 16-2 Attachment C Sample protocol: Aspiration Precautions and Health Standard No. 16-2 Attachment D Sample protocol: Reflux Precautions)
2. Identify food consistency definitions that are the same as the DDS-defined consistencies:
3. **Whole Food** No modifications; an individual may still require direct support staff assistance to cut food before being served, but the size of food pieces is not specified as no swallowing risk has been identified.
4. **Cut-up Food** Pieces of food not to exceed ½” x ½” x ½”.
5. **Chopped Food** Pieces of food cut by hand to pea size pieces not to exceed ¼” x ¼” x ¼”.
6. **Ground Food** Foods ground in a machine to small curd cottage cheese consistency.
7. **Pureed Food** Foods prepared to a smooth consistency that resembles pudding. (Refer to: Health Standard No. 16-2 Attachment D Sample protocol: Reflux Precautions and Health Standard No. 16-2 Attachment E Guidelines for Consistency Modifications of Food and Liquids)
8. Identify definitions for the prescribed liquid consistencies that agree with the DDS-defined liquid consistencies:
9. **Thin consistency** means any liquid and is considered non-restrictive for an individual’s intake. Thin liquid consistency requires no thickening agent. An individual prescribed thin liquids also may have gelatin, ice cream, sherbet, sorbet, Italian ice, etc.
10. **Nectar consistency** means apricot or tomato juice consistency; some liquids will require a thickening agent to be added to reach nectar consistency.
11. **Honey consistency** means liquids can still be poured, but are very slow. Some liquids will require a thickening agent to be added to reach honey consistency.
12. **Pudding consistency** means liquids are “spoonable,” but when a spoon is placed upright in the liquid, it will not stay upright. (Refer to: Health Standard No. 16-2 Attachment E Guidelines for Consistency Modifications of Food and Liquids)
13. Include the requirement that a licensed practitioner’s order document any exceptions to an individual’s food or liquid consistency requirements.
14. Ensure appropriate equipment for the modification of food and a thickening agent to modify liquid consistencies is available at the sites where it is needed. The maintenance and upkeep of this equipment shall be performed and documented.
15. Implement a process for mealtime observations by supervisory and clinical staff to monitor the preparation of prescribed modifications of food and liquid consistencies. These observations and their frequency shall be documented according to a standardized process. (Refer to: Health Standard No. 16-2 Attachment F Meal Observation Documentation Form and Health Standard No. 16-2 Attachment G Meal Observation Documentation Form)
16. Ensure that there is communication regarding food and liquid consistency requirements for an individual and how these consistencies are achieved with all persons involved with the individual.
17. Ensure that when there is a change to an individual’s prescribed food or liquid consistency that this information is reflected in the individual’s (1) Level of Need (LON) Assessment and (2) individual plan (IP); and (3) entered into the appropriate screen in CAMRIS.
18. **References**

DDS Procedure I.D.PR.013 [Risk Management Individual Safety Screening](http://www.ct.gov/dds/lib/dds/dds_manual/id_quality/risk_mgmt/pr_013_risk_management_individual_safety_screening.pdf)

Balzer, KM, PharmD, **“Drug-Induced Dysphagia,”** International Journal of MS Care, page 6, Volume 2 Issue 1, March 2000.

Carl, Lynette L. And Johnson, Peter R., **Drugs and Dysphagia, How Medications Can Affect Eating and Swallowing**, PRO-ED, Inc., Austin Texas, 2006. ([www.proedinc.com](http://www.proedinc.com))

**DDS Training Resources**

PowerPoint presentation: New Employee/On-going/Refresher Training on Safe Eating & Drinking and Swallowing Risks

1. **Attachments**

Health Standard No. 16-2 Attachment A [Swallowing Episode Report Form (SERF) and Instructions](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_a_swallowing_episode_report_form.docx)

Health Standard No. 16-2 Attachment B [Bedside Swallow Evaluation](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_b_bedside_swallow_evaluation.docx)

Health Standard No. 16-2 Attachment C [Aspiration Precautions Sample Protocol](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_c_aspiration_precautions.docx)

Health Standard No. 16-2 Attachment D [Reflux Precautions Sample Protocol](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_d_reflux_precautions.docx)

Health Standard No. 16-2 Attachment E [Guidelines for Consistency Modifications of Food and Liquids](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_e_guidelines_for_consistency_modifications_of_foods_and_liquids.docx)

Health Standard No. 16-2 Attachment F [Site Meal Observation Documentation Form](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_f_site_meal_observation_form.docx)

Health Standard No. 16-2 Attachment G [Individual Meal Observation Documentation Form](http://www.ct.gov/dds/lib/dds/dds_manual/ih/hs_16-2_attachment_g_individual_meal_observation_form.docx)