

Dysphagia Policy

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1. Policy summary

The dysphagia management policy is a clinical policy to assist and guide colleagues with respect to the safe management of patients who have or present with eating, drinking or swallowing difficulties (dysphagia).

It outlines what dysphagia is, who it can affect and how dysphagia may present in service users or patients. The clinical signs and symptoms of dysphagia are identified along with the subsequent risks to health that may be experienced as a consequence of dysphagia. Thus, highlighting the need for effective and safe management of this condition.

In addition, the policy details how to refer someone with a swallowing difficulty to the speech and language therapy service and how the potential risks associated with swallowing difficulties can be safely and appropriately managed.

1.1 Identify dysphagia

- Be aware of the clinical signs or symptoms indicating possible dysphagia.
- Consider patients and service users who may be at greater risk of swallowing difficulties due to medical conditions, general health and wellbeing or behaviours displayed.
- Clearly document any observed or reported swallowing difficulties or adverse signs.

1.2 Associated risks

- Be aware of the potential negative effects to health as a result of dysphagia and take any appropriate action for example, ensure any safe swallow strategies are being followed. Speak to your speech and language therapist or dysphagia trained practitioner for further details.

1.3 Referral

- Referrals should be made to the speech and language therapy service in a timely manner.
- Referrals should be made to the relevant service within each care group.

1.4 Management

- Ensure all colleagues involved in the patient or service user care are made aware of any recommendations regarding diet and, or fluid modification and any relevant strategies or techniques to aid safe swallowing.
- All food or fluids provided for the patient or service user should be of the recommended consistency and viscosity.
- Where thickening agent is required for fluids, this should be safely stored away when not in use (please see appendix C).

1.5 Incidents

- Any choking incidents or incidents of concern (such as non-adherence to recommendations) should be reported using the trust reporting system.

2. Introduction and aim

The trust is committed to providing a high standard of care to all patients. As part of that care, procedures must be in place for the identification, assessment and management of patients at risk of dysphagia (eating, drinking and swallowing difficulties) whether this is on an emergency basis or part of long-term management.

Disruption of swallowing can have serious medical implications, increasing risk of malnutrition, dehydration, weight loss, pulmonary aspiration (fluid or food going into the lungs) and choking. It is associated with increased morbidity, mortality and a reduced quality of life due to the emotional, psychological and social issues that occur as a consequence of not being able to eat a regular diet and or drink regular fluids.

Nutrition is a vitally important aspect of our lives. All colleagues have an important role to play to ensure that food provided is nutritious and well presented, and that patients find eating an enjoyable and pleasant experience.

It is important that patients with known swallowing difficulties or those with behaviours that could affect the safety of the swallowing process receive the recommended modified diet or fluid consistency to reduce the possible risk of aspiration (food or fluids entering the lungs) and choking. It is also important that these patients receive information and guidance regarding any exercises, compensatory strategies, or techniques that might reduce the possible risk of aspiration (food or fluids entering the lungs) and choking.

Choking has several causes, but it is often the result of either a foreign object, such as food lodged in the windpipe or in some adults there may be no problem with the swallow physiology. Instead, cognitive or behavioural problems, such as issues around eating, over filling the mouth, taking and hiding food or self-harm by occluding the airway could be the cause.

When a person chokes, key signs are redness of face, inability to breathe, inability to speak, inability to cough and clutching of the throat. Recognition and emergency action to take if a patient is choking is outlined in the trust life support training and resuscitation policy (see section 8).

Swallowing problems (dysphagia) are seen in people with a variety of clinical diagnoses, for example dementia, stroke, respiratory conditions, traumatic brain injury or progressive neurological conditions such as Huntington's Disease, Parkinson's Disease, Multiple Sclerosis or Progressive Supranuclear Palsy. Dysphagia is common in acute stroke and can be experienced in 40-78% of cases, such patients should be considered for compensatory measures and adaptations to oral intake with appropriate assessment and management (National Clinical Guideline for Stroke, 2023). Dysphagia can also be experienced by patients who are generally medically unwell or who may be elderly or frail, furthermore swallowing problems can occur in the majority of people who are approaching the end of life.

Similarly, people with learning disabilities experience a higher incidence of health problems than the general population and dysphagia is an important area of risk for people with learning disabilities throughout their life and as they approach end of life.

The importance of the need for coordination of services, continuity of care and person-centred care at the end of life is emphasised in the NICE guidelines (National Institute for Health and Care Excellence), code number NG142 (NICE, 2019). Furthermore, NICE guideline (code number NG96) and NHS England encourage the continued involvement of learning disability services and the coordination with palliative care teams when patients approach end of life (NICE, 2018; NHS England 2017).

In some patients there may be no problem with the swallow physiology. Instead, cognitive and behavioural problems may result in disorganised feeding or drinking; eating too much too fast without attention to safety, spitting out foods or fluids, prolonged chewing and holding food or fluid in the mouth.

Some patients may also have an increased risk of swallowing difficulties due to the long-term side effects of some medications, such as benzodiazepines, that might alter neuromuscular function.

There is also an emerging understanding that mental health difficulties such as anxiety disorder may also lead to symptoms of swallowing difficulty, such as a sensation of food 'sticking', or a fear of choking.

A holistic and person-centred approach to patient care, considering the patient's physical needs as well as mental health needs, is essential to improve the safety of individuals with swallowing difficulties. Introducing individualised care management guidelines is good practice to ensure the safety of individuals with eating, drinking and swallowing difficulties and therefore reducing the risk of ill health associated with dysphagia like aspiration and choking.

For some individuals, the complexity or stage of their medical condition(s) or health and social care needs may mean that it is impossible for them to have oral nutrition and hydration safely and without them being exposed to increased risks to their health and wellbeing. This is often termed as 'Eating and drinking with acknowledged risks' (EDAR) and refers to "the decision to continue eating and drinking despite the associated risks from having dysphagia. As indicated by the Royal College of Speech and Language Therapists (RCSLT) these risks may refer to aspiration, malnutrition, dehydration and choking" (RCSLT, 2026).

EDAR is an area which has received greater attention in recent years and highlights the need for further local and national guidance to support clinical decision making and processes in this area. Furthermore, it identifies the importance of person-centred care and collaboration of healthcare professions, the patients and their carers or family to ensure that the most appropriate decision is made for the individual concerned. Current guidance regarding this is available from the RCSLT (2021), please see appendix A.

The aim of this policy is to assist colleagues in identifying patients with Dysphagia and associated risks and ensuring appropriate management. It applies to all clinical areas where food and drink is provided. This policy also links to the [resuscitation manual](#) (see also section 8).

RDaSH fully adopts the International Dysphagia Diet Standardisation Initiative (IDDSI); the globally standardised descriptors of texture modified foods and

thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures ([International dysphagia diet standardisation initiative \(opens in new window\)](#)). See also Appendix B.

The final framework consists of a continuum of 8 levels numbered from 0 to 7. Levels are identified by numbers, text labels and colour codes (see appendix D). Drinks are represented by levels 0 to 4, and food is represented by levels 3 to 7. Each level has a label and texture and viscosity definition along with specific testing methods. Opting for foods and drinks from certain levels may help to alleviate symptoms of swallowing difficulty in some people. A dysphagia trained practitioner is able to assess and advise regarding the most appropriate levels of diet and fluids for a patient with eating, drinking and swallowing difficulties.

The imprecise term 'soft diet' must no longer be used as a texture descriptor. A review of the national reporting and learning system (NRLS) highlighted seven occasions where patients appear to have come to significant harm over a two-year period including two patient deaths due to confusion about the meaning of the imprecise term 'soft diet'. These incidents ranged from coughing to choking with support being required from an emergency team, and aspiration pneumonia (patient safety alert, 2018).

2.1 Definition or explanation of terms used

- Dysphagia is the medical term used to describe difficulty with eating, drinking and swallowing. Difficulties may occur in the oral, pharyngeal or oesophageal stages of the swallow. Speech and language therapists and dysphagia practitioners assess and manage dysphagia in all but the oesophageal stage of the swallow. Dysphagia can result in, or contribute to, critical negative life conditions including weight loss, malnutrition, dehydration, choking, aspiration pneumonia and a reduced quality of life. The ability to swallow safely can be influenced by a number of factors which can include coordination and strength of the musculature, posture, bolus size, texture of bolus, and disuse of swallow due to pain, illness, change in taste, nausea, ageing, cognition, respiratory, and cardiac problems.
- Aspiration is defined as the inhalation of food or drink particles into the lungs. This can be either acute or chronic in presentation. Aspiration can cause serious pulmonary complications including aspiration pneumonia.
- Choking is defined as the accidental introduction of a foreign object into the airway, which becomes lodged in the airway and reduces or obstructs the air flow into the lungs. This can be a consequence of dysphagia.

3. Procedure

3.1 Identifying dysphagia

The severity of dysphagia can vary from individuals having difficulties with certain consistencies of food, liquids, fluids or saliva to being completely unable to swallow. These difficulties may be caused by mechanical (physical), neurological or behavioural problems. Some people may also complain of pain or discomfort while swallowing.

The following are signs and symptoms that colleagues may notice which are indicative of a possible dysphagia:

- individual's inability to recognise food
- prolonged chewing time or taking a long time to finish meals
- pocketing or storing of food, or food residue remaining in the patient's mouth
- difficulties with chewing and manipulating food in the mouth
- poor lip closure or difficulties in controlling foods, fluid or saliva in the mouth
- dribbling or drooling after drinking
- gurgling sound (wet voice) after liquids
- inability to cough or a weak ineffective cough when eating
- coughing during or immediately after eating or drinking
- history of recurrent chest infections and, or deterioration in chest status
- regurgitation of food or nasal regurgitation
- poor oral hygiene- for training on mouthcare, please see references (E-Learning for Health Care, 2026)
- slurred speech and, or facial weakness

The following are examples of possible behaviours that may cause disorganised feeding and drinking and thus increase the risk of aspiration and choking:

- lack of interest or attention to food and drink and the feeding environment
- cramming or overloading of food into mouth
- will overload their mouth having taken food from others or from available sources such as fruit bowls.
- holding food or drink in the mouth
- will accept or put any item into the mouth
- swallowing without chewing
- has issues around eating with others
- speed of eating
- pacing and agitation whilst eating
- mood levels
- levels of alertness

Difficulties with swallowing means that if food and drink penetrate the patient's airway or enters the lungs this will manifest itself acutely as choking, coughing, wheezing and respiratory distress. Please refer to the trust life support training for management of choking (please see section 5.5 below). A serious and possible fatal lung infection such as aspiration pneumonia may result. In some patients who have no cough reflex there may be no sign of aspiration (silent aspiration) or if this is a slow, ongoing problem, as opposed to an acute one, the patient may have chronic symptoms.

3.1.1 Signs of acute aspiration

- Pyrexia.
- Coughing and choking.
- Change of colour of face and, or lips.
- Sounds of respiratory distress.
- Loss of voice or changes in voice quality.
- Gasping.

- Rapid heart rate.

3.1.2 Signs of chronic aspiration

- Loss of weight.
- Repeated chest infections.
- Hunger.
- Excess or changes in oral secretions.
- Respiratory problems.
- Coughing and choking history.
- Refusal to eat.

3.2 Referring to speech and language therapy

Each care group and, or service area within RDaSH has their own referral pathway (see appendix D).

3.3 Managing dysphagia

All colleagues and carers need to be aware of the patient's individual requirements in order to maintain their nutritional needs and to minimise the risk of aspiration and choking. Nursing presence at mealtimes is a good time to build on relationships with patients and to observe and assess for any difficulties highlighted above. If recording of food and, or fluid intake is required, the nurse and or senior clinical colleagues are the health professionals best situated to perform or supervise this task.

There must be robust procedures in place to ensure that all colleagues are aware that a patient is on a modified diet and, or fluid consistency and this must be communicated to all colleagues involved in that patient's care on a daily basis as per ward procedure. Patients on a recognised modified texture diet or fluid consistency must be given only the correct diet or fluid consistency and this includes snacks or foods or drinks given outside meal times and across all settings.

Colleagues should ensure that food and any fluids are well presented, served at the right temperature, and at the right consistency recommended for any patient who has been assessed by a dysphagia trained practitioner. For patients who require thickened fluids, colleagues should ensure that the thickening agent or powder is stored away appropriately (see appendix C). This follows nationally identified patient safety incidents where harm has been caused by the accidental swallowing of the thickening powder when it had not been properly stored out of reach (Patient safety Alert, 2015). The dietitian and speech and language therapist can provide advice regarding individual's needs, and all requirements should be accurately documented in the electronic patient record and any written dysphagia recommendations updated (for example on the ward or in patient correspondence). Contact details for speech and language therapy are attached (see appendix F).

Dehydration and malnutrition can also result from dysphagia. Clinical colleagues can screen patients for possible signs of these as per the trust [nutrition policy \(promoting good nutrition for patients\)](#) and implement any appropriate dysphagia monitoring and recommendations and interventions. Any patients of concern should be escalated for medical review.

If an individual has an identified dysphagia this may impact upon safe management of oral medications. In such cases, advice should be sought from the general practitioner, consultant or appropriate prescribing professional.

Referrals made to speech and language therapy for problems or difficulties taking medications only (in the absence of signs of dysphagia) will not be accepted.

3.4 Choking Action

Any choking incidents must be reported on the trust's Safeguard incident reporting system.

Please refer to the trust life support training sessions and policy for recognition and emergency actions to take if a patient is choking ([resuscitation manual](#)).

4. Responsibilities

4.1 Dietitians

Dietitians interpret the science of nutrition to improve health and treat diseases or conditions by educating and giving practical, personalised advice to clients, patients, carers and colleagues. The dietitian will advise on the individual's diet, taking into consideration the person's swallowing difficulties whilst ensuring they meet their nutrition and hydration needs. A nutritional screening assessment, for example, MUST (Malnutrition Universal Screening Tool), can be completed as referred to in the trust's [nutrition policy \(promoting good nutrition for patients\)](#) see also section 8. and referral to a dietitian made where appropriate.

4.2 Speech and language therapist or dysphagia trained practitioner

Speech and language therapists or dysphagia trained practitioners will, when required, complete a comprehensive assessment of an individual's eating, drinking and swallowing skills and advise colleagues on the individual's requirements and safe swallowing management. They will also assess the risk from any cognitive or behavioural factors that could compromise the safety of the swallowing process. The assessment and management will also take into account an individual's preferences and beliefs as well as best interest and quality of life issues.

4.3 Inpatient clinical colleagues

Inpatient clinical colleagues are responsible for the following:

- identifying and appropriately reporting adverse signs in a timely manner
- making appropriate, thorough and timely referrals to the speech and language therapy service
- following recommendations made by a dysphagia trained practitioner to reduce the risk of aspiration and choking whilst meeting the nutritional and hydration needs of the individual
- to be aware of the safe storage of thickening agents (appendix C)

- reporting of choking incidents, 'near misses' and incidents of concern, and contributing to the investigation of such incidents.
- ensuring that any food or fluids brought into the ward or other settings by carer's and relatives are appropriate for the consistency recommended for the individual patient (appendix B)
- ensuring a regular mouth care routine is completed appropriately

4.4 Inpatient services managers

Inpatient services managers are responsible for the following:

- ensuring that colleagues within their areas of responsibility have an awareness of recognising and managing patients who are at risk of dysphagia
- reporting choking incidents and incidents of concern such as non-compliance with recommendations using the trust's Safeguard incident reporting system and investigating such incidents, involving the multidisciplinary team

5. Training implications

Colleagues should receive basic dysphagia awareness training where appropriate, for example, if required in relation to their working environment. Texture modified diet and fluid consistency advice booklets are available from all the speech and language therapy departments.

All colleagues must be compliant with trust mandatory and statutory training including life support training and choking.

All ward and inpatient colleagues and day service colleagues must have access to the IDDSI framework with available descriptors, information and advice (See appendix B).

6. Monitoring arrangements

6.1 Incidents of choking and near misses

- How: Radar Reporting system.
- Who by: The colleague involved in the incident.
- Reported to:
 - Resuscitation officer
 - matrons or service and ward managers
 - Local Speech and Language therapy (SALT) service(s)
- Frequency: As and when incidents or near misses occur.

6.2 Review of Incidents of choking

- How: Annual audit.
- Who by: Resuscitation officer.
- Reported to: Resuscitation committee.
- Frequency: Annually.

6.3 Incident Reporting system reports

- How: Radar report reviews.
- Who by: Resuscitation officer, matrons, service managers or Speech and Language Therapy clinical leads.
- Reported to: Relevant care group forum.
- Frequency: On exception basis.

7. Related documents and references

- [Nutrition policy \(promoting good nutrition for patients\)](#)
- [Resuscitation manual](#)
- ELearning for Health Care (2026) <https://www.e-lfh.org.uk/programmes/mouth-care-matters/>
- [International Dysphagia Diet Standardisation Initiative \(opens in new window\)](#).
- National Clinical Guideline for Stroke; for the United Kingdom and Ireland (2023), available from <https://www.strokeguideline.org>
- National Institute for Health and Care Excellence (2018) NG96 Care and Support of people Growing Older with Learning Disabilities, available at <https://www.nice.org.uk/guidance>
- National Institute for Health and Care Excellence (2019) NG142 End of Life Care for Adults:Service delivery, available at <https://www.nice.org.uk/guidance>
- NHS England (2017) delivering High-Quality End of Life Care for People who have a Learning Disability available at <https://www.england.nhs.uk/wp-content/uploads/2017/08/delivering-end-of-life-care-for-people-with-learning-disability.pdf>
- [Patient safety alert, \(2015\) Risk of death from asphyxiation by accidental ingestion of fluid or food thickening powder, NHS improvement \(opens in new window\)](#).
- [Patient Safety Alert,\(2018\) Resources to support safer modification of food and drink, NHS improvement \(opens in new window\)](#).
- RCSLT (2021) Eating and drinking with acknowledged risks: Multidisciplinary team guidance for the shared decision-making process (adults). <https://www.rcslt.org/wp-content/uploads/2026/01/EDAR-multidisciplinary-guidance-2021.pdf>
- RCSLT (2026) <https://www.rcslt.org/members/clinical-guidance/eating-and-drinking-with-acknowledged-risks-risk-feeding/#section-1%20>
- JJ v Spectrum Judgment (2023) <https://www.judiciary.uk/wp-content/uploads/2023/07/JJ-v-Spectrum-judgment240723-2.pdf>

8. Appendices

8.1 Appendix A Eating and drinking with acknowledged risks: Multidisciplinary team guidance for the shared decision-making process

<https://www.rcslt.org/wp-content/uploads/2026/01/EDAR-multidisciplinary-guidance-2021.pdf>

8.2 Appendix B *[International dysphagia diet standardisation initiative \(opens in new window\)](#)*

8.3 Appendix C Guidance for use and storage of thickening agent

- [Guidance for use and storage of thickening agent \(staff access only\) \(opens in new window\)](#)

8.4 Appendix D Referral forms

8.4.1 Referral Doncaster GP and non-care home

- [Appendix D1 Referral Doncaster GP and non-care home \(staff access only\) \(opens in new window\)](#)

8.4.2 Referral Doncaster care home

- [Appendix D2 Referral Doncaster care home \(staff access only\) \(opens in new window\)](#)

8.4.3 Doncaster care home dysphagia monitoring chart diet

- [Appendix D3 Doncaster care home dysphagia monitoring chart diet \(staff access only\) \(opens in new window\)](#)

8.4.4 Doncaster care home dysphagia monitoring chart fluids

- [Appendix D4 Doncaster care home dysphagia monitoring chart fluids \(staff access only\) \(opens in new window\)](#)

8.4.5 Referral Doncaster learning disability service

- [Appendix D5 Referral Doncaster learning disability service \(staff access only\) \(opens in new window\)](#)

8.4.6 Referral Rotherham learning disability service

- [Appendix D6 Referral Rotherham learning disability service \(staff access only\) \(opens in new window\)](#)

8.4.7 Referral North Lincolnshire learning disability service

- [Appendix D7 Referral North Lincolnshire learning disability service \(staff access only\) \(opens in new window\)](#)

8.4.8 Referral Rotherham Older Peoples Mental Health wards

- [Appendix D8 Speech and language therapy referral form \(staff access only\) \(opens in new window\)](#)

8.5 Appendix E Speech and language therapy contact details

8.5.1 Doncaster care group

Doncaster physical health service

- Phone: 03000 218996
- Email: rdash.rehabservices@nhs.net

Learning disability service

- Phone: [03000 212878](tel:03000212878)
- Email: rdash.adultldservices@nhs.net
- [Learning disability services website](#)

8.5.2 North Lincolnshire care group

Learning disability service

- Phone: 03000 218963
- Email: rdash.actldnl@nhs.net

8.5.3 Rotherham care group

Learning disability service

- Phone: [03000 215220](tel:03000215220)
- Email: rdash.rotherhamldadmin@nhs.net

Older people's mental health service

- Phone: [01709 427015](tel:01709427015)
- Email: trftadultslt.mailbox@nhs.net