



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

# Evaluation of the Management of Patients with Feeding and Swallowing Problems in Veterans Health Administration Facilities

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## Executive Summary

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) evaluated the management of patients with feeding and swallowing problems in Veterans Health Administration (VHA) medical facilities. The purpose of our evaluation was to determine if VHA medical facilities were appropriately managing the feeding of patients with dysphagia (a swallowing disorder) and those requiring feeding assistance at meals.

We selected seven VHA medical facilities, which comprised a mix of facility size and geographic location. We visited the facilities from December 1, 2003, through May 15, 2004. At the seven medical facilities visited, we interviewed clinicians involved in the management of these patients. We also reviewed 121 medical records, interviewed 89 patients, and conducted 116 feeding observations. We collected data on 176 unique patients.

Significant differences in the management of this patient population existed between sites reviewed; however, we found evidence of efforts to improve processes, promote patient safety, and facilitate the feeding of patients at all seven facilities. Three facilities had created volunteer feeder programs, and all had developed modified diets for dysphagic patients. In addition, facilities were performing well in many aspects of the meal delivery and feeding process. During our observations, we found that patients received the diet ordered for them 99 percent of the time, and we did not identify compliance problems with tube feeding protocols at any of the seven facilities. Despite limited speech-language pathologist (SLP) staffing in some facilities, we found prompt response to consultation requests for swallowing evaluations on inpatients and detailed documentation of results.

We identified opportunities for improvement related to: identification of dysphagia; referral for evaluation; provision, documentation, coordination, and continuity of care; meal delivery schedules; and diet terminology. We also found that VHA has not issued guidance on the clinical management of patients with feeding and swallowing problems.

We found that not all initial nursing assessment forms "triggered" referrals when feeding or swallowing problems were identified; also errors in the completion of these forms caused referrals to be missed or delayed. We found problems with identification of dysphagia and referral for evaluation for dysphagic patients on mental health units. In addition, mental health units had fewer measures to improve patient safety while eating, such as suction equipment in patient dining areas. We found dysphagia listed in the electronic medical record problem list for only 31 percent of dysphagic inpatients; there was limited use of clinical alerts for choking risk. We also found that some facilities did not directly refer patients to the SLP when the nursing assessment identified swallowing problems, causing delays in treatment.

We recommend that initial nursing assessment forms contain feeding and swallowing risk assessments, are correctly completed, and are used on appropriate units. We also recommend that providers consistently document dysphagia in the problem list and include choking risk in the clinical alert system. We further recommend that processes to refer patients to the SLP for swallowing evaluations are streamlined.

We found that only 43 percent of the dysphagic inpatients in our sample evaluated with an instrumental swallowing evaluation had a clinical swallowing evaluation first to determine the necessity of the instrumental evaluation. We recommend that facilities develop and follow guidelines for the appropriate use of instrumental swallowing evaluations.

We found that medical records of 42 percent of the dysphagic inpatients and 43 percent of the non-dysphagic inpatients in our sample did not contain documentation to support that the patients had received daily oral care. Documentation of meal consumption was also inconsistent. We found that SLPs were not allowed to post their feeding guidelines at the patients' bedsides at 5 of 7 facilities reviewed. We recommend that nursing staff provide and document oral care and document meal consumption more consistently. We further recommend that SLPs are allowed to post feeding guidelines at patients' bedsides.

We found that discharge diet orders were often incorrect. We also found that SLP follow-up with the dysphagic inpatients they evaluated was limited at some facilities. We found that only 16 percent of the dysphagic outpatients appropriate for follow-up in our sample were scheduled a return appointment with the SLP; only 60 percent of dysphagic inpatients' medical records had documentation of SLP follow-up post evaluation. In addition, we found that treatment teams did not always monitor appropriateness of long-standing diet orders. We recommend that discharge instructions regarding diet be consistent and accurate, that swallowing consultation recommendations are followed up, and that appropriateness of long-standing diet modification orders is monitored.

We found that only 17 of the 93 inpatients we observed at mealtime used assistive feeding devices and that staff were uncertain about who had responsibility for cleaning the devices. Thirty-five percent of the patients we interviewed who required assistance with feeding told us that they waited too long after tray arrival for this assistance. We recommend that patients be appropriately assessed for, and provided with, assistive feeding devices if indicated, and that these devices be adequately cleaned and stored.

At 4 of 7 facilities, the time between the evening meal and breakfast on some units exceeded 14 hours, and snacks or supplemental meals were not always ordered for patients who could have received them on these units. We recommend that facilities comply with Food Service Management Policy related to meal hours and supplemental meal orders.

We found that diet modification (including the thickening of liquids) was often the only intervention implemented for some dysphagic patients and that not all the facilities

provided commercially available pre-thickened liquid products to their dysphagic inpatients or thickener to outpatients through their Pharmacy or VA retail store. We also found that diet names and terminology used to describe diet consistencies varied greatly between facilities. We recommend that pre-thickened liquid products are made available to inpatients, that prescribed thickening agents are provided or made readily available to outpatients, and that diet terminology be simplified and standardized.

There is no national guidance related to the management of patients with feeding and swallowing problems, and we found considerable variability in practice. We recommend that the Under Secretary for Health establish a work group of relevant healthcare providers to develop a comprehensive policy that defines multidisciplinary responsibilities for assessment and management, with the goal of improving the coordinated medical care provided to patients with feeding and swallowing problems.

### **Under Secretary for Health Comments**

The Under Secretary for Health concurred with the report and the recommendations and agreed that a comprehensive policy that addresses multi-disciplinary responsibilities for assessment and management is essential. VHA's Patient Care Services will lead an interdisciplinary task force in developing a comprehensive national policy that will improve the coordinated medical care provided to patients with feeding and swallowing problems. The Under Secretary for Health anticipated that the final Directive establishing national policy would be issued in April 2006. While the task force prepares its report and directive, appropriate program offices will take interim actions that also address the recommendations. The Under Secretary for Health provided a detailed action plan addressing each recommendation.

### **Assistant Inspector General for Healthcare Comments**

The Under Secretary for Health agreed with the findings and recommendations and provided a detailed action plan addressing each recommendation. The proposed actions are appropriate and responsive to the recommendations. We will follow up on the planned actions until they are completed.

*(original signed by:)*

**JOHN D. DAIGH JR., M.D.**  
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for Healthcare Inspections

## Introduction

### Purpose

The purpose of our evaluation was to determine the degree to which individual VHA medical facilities reviewed had developed policies, implemented procedures, and initiated interventions to ensure safe feeding and optimal quality of life for patients with feeding and swallowing problems. Areas of review included: national guidance; identification and evaluation of feeding and swallowing problems; provision, documentation, and continuity of care; appropriateness of feeding procedures; efficiency of meal delivery; and diet modification.

### Background

#### Dysphagia

Dysphagia, a swallowing disorder, not only disrupts eating pleasure and makes the maintenance of nutrition and hydration difficult; it can also have potentially severe or fatal consequences. Dysphagic symptoms may include difficulty chewing, excessive drooling, coughing, choking, and pocketing of food in the cheeks. The most significant clinical problems associated with dysphagia are aspiration pneumonia (infection of the lungs as a result of inhaling fluid or food), weight loss, compromised nutritional status, or any combination of these. The symptoms of dysphagia can have a severe adverse effect on a patient's health, nutritional status, and quality of life.

Before the early 1970s, patients incapable of swallowing received nutrition primarily by tube feedings. Today, health care providers agree that good nutrition is a prerequisite for maintaining and improving health, and that receiving nutrition orally may give comfort, pleasure, and a sense of autonomy and dignity to an individual.<sup>1</sup> Health care professionals have discovered that active intervention with dysphagic patients, including carefully planned diagnostic evaluations with subsequent management and rehabilitative techniques, often assists a patient's return to normal feeding and swallowing; a result that speeds recovery and enhances the quality of life.<sup>2</sup>

#### Prevalence of Dysphagia

A 2003 article in the journal *Laryngoscope* states that approximately 8 million people in the United States report some degree of dysphagia annually.<sup>3</sup> ECRI (formerly the Emergency Care Research Institute) estimates that approximately 300,000 to 600,000 people each year are affected by dysphagia resulting from neurological disorders.<sup>4</sup> Aspiration pneumonia is the leading cause of death in nursing homes and the leading cause of residents' transfers from nursing homes to hospitals.<sup>5</sup>

## Management of Dysphagia

An interdisciplinary approach is required for optimal management of the dysphagic patient and typically includes the speech-language pathologist (SLP), the Registered Dietitian (RD), nursing staff, and the physician. Sometimes consultation with other disciplines, such as an Occupational Therapist (OT), is indicated.

Clinical management of patients with dysphagia usually includes physician referral to the SLP for a swallowing evaluation. A swallowing evaluation begins with a clinical (sometimes called bedside) evaluation that includes an oral-mechanism examination with test boluses (food, liquid, or other material placed in the mouth for ingestion) as indicated. If the SLP observes clinical signs of oropharyngeal dysphagia or identifies risk factors, an instrumental swallowing evaluation may be recommended<sup>6</sup> to further define the problem and determine if aspiration is occurring. Videofluoroscopic swallowing studies (VFSS),<sup>A</sup> which are done in the radiology suite, are the most frequently performed instrumental swallowing evaluation. The fiberoptic endoscopic examination of swallowing (FEES)<sup>B</sup> is another instrumental swallowing evaluation sometimes used by SLPs.

The SLP assesses airway protection and appropriateness of oral feeding and communicates these findings and diet recommendations to the physician. The SLP and RD collaborate on diet modifications, and the SLP usually instructs patients, the nursing staff, or others who may feed patients about implementation of feeding guidelines, aspiration precautions, and liquid thickening procedures. The SLP provides treatment if there is potential for remediation. The treatment team monitors the patient for complications such as aspiration pneumonia, as well as for improvement, which might warrant reducing dietary restrictions.

Patients have the right to be involved in decisions about how and what they will eat, and clinicians should respect their choices. Patients or their families may acknowledge the risk of aspiration, yet refuse tube feeding, pureed foods, or thickened liquids recommended by their treatment team. Documentation that clinicians explained the consequences of refusal to patients and their families must be adequate.<sup>7</sup>

## Feeding Problems

Not all patients who require assistance at mealtime are dysphagic. Some patients have the ability to swallow normally but cannot or will not feed themselves. Visual problems, confusion, arm or hand immobility, injury, weakness, or restrictions on activities or positions may prevent a patient from feeding himself. Some patients merely need

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<sup>A</sup> The SLP, and sometimes a Radiologist, observe by monitor and simultaneously record radiographic images of the patient ingesting food or liquid mixed with barium.

<sup>B</sup> Requires the transnasal passage of a flexible laryngoscope into the hypopharynx, followed by the presentation of food or liquid. May be performed at bedside.

assistance with tray set-up (opening milk cartons or utensil packages, cutting meat, buttering bread, etc.), while many patients require total feeding. Other patients require encouragement, cueing, or monitoring for safety while eating. As feeding patients is primarily a nursing responsibility, adequate nurse staffing is critical to the appropriate management of patients with feeding or swallowing problems.

### Prevalence of Feeding Problems

A national nursing home survey found that almost half of all residents with psychiatric disorders required feeding assistance,<sup>8</sup> and some medications prescribed in their treatment may cause problems with swallowing as well. A Department of Health and Human Services (HHS) report to Congress on the appropriateness of minimum nurse staffing ratios in nursing homes indicated that nearly one half of nursing home residents needed some assistance with feeding; over one-fifth were totally dependent in feeding.<sup>9</sup> Experts agree that feeding assistance interventions are an important component of nursing home care.

### Management of Feeding Problems

Feeding problems need to be identified soon after admission, and the plan of care should outline interventions necessary to facilitate a patient's eating. The physician may write orders for the patient to be out of bed or assisted with positioning for meals. The physician will consult Occupational Therapy to evaluate for assistive feeding devices, which can help patients who have limited arm mobility, grasp, range of motion, or coordination.

### National Guidance

VHA currently does not have a national policy to manage patients with feeding and swallowing disorders; program management is implemented at the local level. In 1991, a VA Task Force on Dysphagia drafted a policy entitled "Comprehensive Clinical Examination of Swallowing Function: VA Recommended Procedure." The director of VHA's National Program Office for Audiology and Speech Pathology told us that VHA decided not to implement this policy on clinical practice; rather, they expect compliance with American Speech-Language-Hearing Association (ASHA) professional standards.

Concern about the need for standardized food properties and common terminology to aid in the management of dysphagia prompted collaboration between RDs, SLPs, and food scientists called the National Dysphagia Diet Task Force (NDDTF). Their efforts resulted in the National Dysphagia Diet (NDD) being published by the American Dietetic Association (ADA). Although a number of certified SLPs were members of NDDTF, the product was not peer reviewed or approved by representatives of ASHA or its Special Interest Division for swallowing disorders. The Division does not support or endorse use

of the diets in clinical practice due to concerns that the NDD was developed by consensus rather than evidence based methods.<sup>10</sup> This issue is not resolved.

### Incidence in VHA

During fiscal year (FY) 2004, 16,364 unique patients with diagnoses related to feeding and swallowing problems were discharged from VHA medical facilities nationally. Many more patients with these diagnoses remain in long-term care. We found that 9,298 unique outpatients had swallowing evaluations at VHA medical facilities in FY 2004. Nurse Managers at our seven review sites reported that 629 of their current inpatients required total feeding or feeding assistance.

We searched the OIG hotline database and found 40 cases in the past 5 years with complaints related to feeding and swallowing. Tube feeding issues were the most frequent complaint, followed by concerns about malnutrition, dehydration, choking, aspiration pneumonia, and inadequate feeding assistance. Complainants also alleged inadequate provision of oral care.

### VHA Staffing Issues

National issues of increasing demand for services due to the aging of the population and staffing levels impact VHA's ability to manage patients with feeding and swallowing problems. The number of speech-language pathology full-time employee equivalents (FTE) in VHA is decreasing. There are 158 VHA medical facilities in the nation and approximately 219 speech-language pathology FTE. The previous year, there were approximately 252 speech-language pathology FTE. Nursing shortages are also well documented.

## **Scope and Methodology**

Prior to initiating our review, we surveyed clinical employees at VHA medical facilities about challenges they faced in caring for patients with feeding and swallowing problems. Concerns noted by 115 respondents were used in the development of our review guide. We also conferred with VHA dysphagia experts who are members of the Field Advisory Council for Speech-Language Pathology and also attended seminars on the National Dysphagia Diet. We reviewed VHA Directives, relevant JCAHO standards, and clinical practice standards related to the management of this patient population.

We selected seven VHA medical facilities, which comprised a mix of facility size, geographic location, and Veterans Integrated Service Networks (VISNs). We visited the facilities from December 1, 2003, through May 15, 2004. At the seven medical facilities visited, we interviewed SLPs, Nurse Managers (NMs), Nutrition and Food Service managers, and RDs. When appropriate, we interviewed the Interdisciplinary Dysphagia Committee and the Voluntary Service Chief or Coordinator of the Volunteer Feeder

Program. We reviewed local policies and procedures, volunteer feeding program training materials, documents related to scopes of practice, diet manuals, and performance improvement activity reports.

SITE DEMOGRAPHICS

<i>Site</i>	<i>Total # of Operating Beds</i>	<i>SLP FTEE for Dysphagia Management</i>	<i>Interdisciplinary Dysphagia Committee</i>	<i>Volunteer Feeding Program</i>
A	882	3	No	Yes
B	692	4.5	No	Yes
C	484	1	Yes	No
D	238	.63	No	No
E	158	1	No	No
F	143	.25	No	Yes
G	125	1	No	No

We reviewed 121 medical records, interviewed 89 patients, and conducted 116 feeding observations. Half of our meal observations occurred in patient rooms, and the other half in patient dining rooms. We observed 54 percent of the patients during the lunch meal, 29 percent at breakfast, and 17 percent during the evening meal. We collected data on 176 unique patients.

We communicated our findings, interpretations, and suggestions to the responsible managers and facility Directors.

We conducted the evaluation in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

## Results and Conclusions

We assessed the degree to which the seven VHA medical facilities we reviewed had developed policies, implemented procedures, and initiated interventions to ensure safe feeding and optimal quality of life for patients with feeding and swallowing problems. We identified opportunities for improvement related to: national guidance; identification of dysphagia; referral for evaluation; provision, documentation, coordination, and continuity of care; meal delivery schedules; and diet terminology.

We found evidence of efforts to improve processes, promote patient safety, and facilitate the feeding of patients at all seven facilities. These efforts included: establishing an interdisciplinary dysphagia committee; creating volunteer feeder programs; allocating staff to dysphagia management; chartering a task group to identify areas of improvement needed in the management of patients at high risk for feeding difficulties; and developing modified diets for dysphagic patients.

Facilities were performing well in many aspects of the meal delivery and feeding process. During our observations, we found that:

- Staff fed patients slowly enough 100 percent of the time.
- Patients received the diet ordered for them 99 percent of the time.
- Patients were allowed adequate time to finish their meals 98 percent of the time.
- Staff fed patients bites of appropriate size 96 percent of the time.
- Patients only requiring tray set-up or positioning were satisfied with the assistance they received 88 percent of the time.
- Patients were satisfied with the assistance they received when being fed 83 percent of the time.

We did not identify compliance problems with tube feeding protocols at any of the seven facilities. Although only one facility had a policy which specifically referred to patient refusal of a recommended feeding regimen, all the facilities indicated that they handled such issues by counseling about potential risks and consequences, documenting these exchanges, and sometimes referring cases to the Ethics Committee.

We also identified the following organizational strengths:

- Evidence-based management of dysphagia practiced by SLPs at the pilot site.
- Participation in ASHA's National Outcome Measurement System (NOMS) by SLPs at another site.

- Innovative modifications to meal tray delivery including kitchen staff performing set-up before tray delivery and specially colored trays delivered early to patients on dysphagia diets.
- A local facility-wide policy addressing identification of dysphagic patients, referral procedures, patient refusal of recommended diet, and assignment of responsibility.
- Interdisciplinary performance improvement monitors by an interdisciplinary Dysphagia Committee that reported to Quality Management.

## Issue 1: National Guidance

### Findings

There is no national guidance related to the management of patients with feeding and swallowing problems, and we found considerable variability in practice. We assessed the degree to which individual VHA medical facilities reviewed had developed policies and procedures to manage the coordinated care of this patient population. Although we found some protocols developed by the individual disciplines involved in provision of care to these patients, only one of the seven facilities we reviewed had established a formal Interdisciplinary Dysphagia Committee that addressed issues, conducted performance improvement monitors, developed policies, and reported to Quality Management.

Given the high incidence and prevalence of dysphagia, and the potentially severe and even fatal consequences, appropriate diagnosis and management of swallowing and feeding disorders are critical. In addition, dysphagia's impact on health care economics, quality of life, and caregiver burden is significant.<sup>11</sup> VHA should provide guidelines regarding standards of care to enhance patient safety, improve quality of care, and minimize inconsistencies.

**Recommended Improvement Action 1.** The Under Secretary for Health should establish a work group of relevant healthcare providers to develop a comprehensive policy that defines multidisciplinary responsibilities for assessment and management, with the goal of improving the coordinated medical care provided to patients with feeding and swallowing problems. The work group should address, but not be limited to, the action items identified in issues 2–8.

The Under Secretary for Health concurred with the recommendation and provided acceptable improvement plans. The Office of Patient Care Services will be responsible for the development and progress of the multi-disciplinary task force charged with developing a national policy. The Under Secretary anticipated that the Directive will be published by April 2006. We will follow up on the planned actions until they are completed.

## **Issue 2: Identification of Dysphagia and Referral for Evaluation**

### **Findings**

#### Initial Nursing Assessment Form

Nursing identification of dysphagia on initial nursing assessment forms was inconsistent. Only five of the seven facilities had an initial nursing assessment form which “triggered” referrals when feeding or swallowing problems were identified, and we found errors in the completion of these forms that caused referrals to be missed or delayed. In addition, not all inpatient units screened for dysphagia.

Assessment forms used on Mental Health (MH) units often did not contain screening questions for feeding and swallowing issues. MH patients are often prescribed neuroleptic medications that can cause tardive dyskinesia (a syndrome involving dysfunctional, involuntary movements). These patients are at increased risk of choking episodes and other swallowing problems.<sup>12</sup> We included several dysphagic patients on MH units in our sample and found problems with identification of dysphagia and referral for evaluation. Additionally, the MH units had fewer measures to improve patient safety while eating, such as suction equipment in patient dining areas. Identifying these patients as being at risk of choking could improve staff monitoring and appropriateness of diet orders.

#### Identification in Medical Record

Dysphagia was listed in the Computerized Patient Record System (CPRS) problem list in only 31 percent of the medical records we reviewed for dysphagic inpatients. In addition, we found limited use of clinical alerts for choking risk in the CPRS patient posting boxes. Use of these alerts would increase clinicians’ awareness of dysphagia and enhance patient safety.

#### Referral for Swallowing Evaluation

Two facilities did not directly refer patients to the SLP from the nursing assessment when swallowing problems were identified, and therefore unnecessarily invited delays in treatment.

At one facility, dysphagia was not a specifically assessed factor on the nursing assessment form. Rather, nurses screened for nutritional status and consulted Nutrition Service for at-risk patients. The RD had 48 hours to complete an assessment and determine if the patient needed a swallowing evaluation. The RD informed the physician, who then consulted the SLP. At this facility, an RD did not routinely perform a nutritional assessment on each new admission unless consulted by nursing staff. If

nursing staff failed to identify the problem initially, or failed to request a Nutrition consultation, significant delays could occur. We found one patient was not referred to Nutrition Service for 11 days after admission, even though “swallowing difficulty” was indicated on the initial nursing assessment. The nurse did not mark the box requesting a nutrition consult.

At the second facility, the SLP was a Rehabilitation Medicine Service (RMS) employee. Providers sent requests for swallowing evaluations to this Service, and the Service routed these consults through an RMS supervisor, who then assigned the case to the SLP. The “mean days to complete” time of 4.73 days for inpatient swallowing consults exceeded the Service’s policy requiring 48-hour response. As there was only one SLP at the facility, and therefore, only one individual who could respond to the request, this appeared to be an unnecessary processing delay that could potentially jeopardize patient safety.

**Recommended Improvement Action(s) 2.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that:

- a. Initial nursing assessment forms contain feeding and swallowing risk assessments, are correctly completed, and are used on appropriate units.
- b. Providers consistently document dysphagia in the CPRS problem list, and include choking risk in the clinical alert system.
- c. Processes to refer patients to the SLP for swallowing evaluations are streamlined.

The Under Secretary for Health concurred with the recommendations and provided acceptable improvement plans. Pending development of national policy, VHA will identify best practices for conducting swallowing risk assessments and provide these to the task force for consideration and inclusion in the national policy by March 2006. SLPs will be instructed to document dysphagia in the CPRS problem list, and the Office of Information will add “choking risk” to the CPRS clinical alerts system. The task force will develop national policy for referrals to speech-language pathology which will require high-risk patients to be referred to the SLP for swallowing evaluation. We will follow up on the planned actions until they are completed.

## **Issue 3: Evaluation of Dysphagia**

### **Findings**

SLPs at three of the seven sites did not always conduct a basic clinical (bedside) swallowing evaluation before completing a more complex and resource intensive instrumental evaluation. A swallowing evaluation typically begins with a bedside or clinical evaluation, which includes a comprehensive medical and swallowing history, an

oral motor and sensory evaluation, and the ingestion of test boluses of food or liquid, if indicated. If SLPs observe clinical signs of dysphagia or identify risk factors, they may recommend an instrumental swallowing evaluation. Guidelines for the Management of Stroke Rehabilitation, an evidence-based approach, recommend that all patients have a swallow screening, and if abnormal, a complete bedside swallow examination.<sup>C</sup> According to ASHA guidelines, an instrumental examination is not indicated if, in the SLP's judgment, the instrumental examination would not change the clinical management of the patient.<sup>13</sup>

Only 43 percent of the dysphagic inpatients in our sample evaluated by VFSS had a clinical swallowing evaluation first to determine the necessity of the instrumental examination. We found instances where physicians requested routine bedside examinations, but instrumental evaluations were completed instead. In many of these cases, the rationale for necessity of an instrumental evaluation was unclear. Additionally, some of the SLPs told us that they often scheduled a VFSS initially instead of a clinical evaluation for outpatients, to save the patients from having to make return trips if the clinical evaluation indicated the need for an instrumental evaluation. In FY 2004, SLPs performed 7,042 instrumental swallowing evaluations and 3,386 clinical swallowing evaluations on unique outpatients at VHA facilities nationally.

We found requests for swallowing evaluations at one facility pending the "patient's ability to go to radiology for a VFSS." In addition, VA nursing home patients referred for swallowing evaluations traveled 90 miles to the parent facility for a VFSS. This activity usually involved the patient spending all day in travel or waiting, even though a bedside or clinical evaluation may have been sufficient. As a result, VA nursing home physicians infrequently referred patients for swallowing evaluations.

Although VFSS provide more information on anatomy and physiology than does the clinical examination, studies of acute-care stroke patients<sup>14</sup> found that "the very low pneumonia rates observed in dysphagia management programs that used full bedside exams indicate that these exams are capable of detecting most aspiration, even silent aspiration."<sup>D</sup> Most VFSS<sup>E</sup> are resource intensive (requiring a radiology suite, SLP, Radiology Technician, and sometimes a Radiologist), and more difficult for fragile patients to endure. Clinical testing could reduce the number of patients inappropriately referred for instrumental testing, which would then reduce unnecessary assessment costs.

SLPs at three sites consistently performed clinical evaluations prior to recommending an instrumental evaluation. The SLP at another site performed clinical evaluations first half of the time. However, SLPs at two other sites performed only instrumental evaluations on almost all patients referred for swallowing evaluation, while instrumental evaluations

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<sup>C</sup> The Guidelines for the Management of Stroke Rehabilitation also recommend that stroke patients at high risk for aspiration or dysphagia should also undergo VFSS.

<sup>D</sup> Aspiration occurs, but patient does not cough.

<sup>E</sup> One facility had the capability of performing bedside VFSS with mobile c-arm fluoroscope.

were not performed on any patients in our sample at one site. The following table shows the variability in dysphagia evaluation practices at the seven facilities we reviewed.

**VARIABILITY IN DYSPHAGIA EVALUATION PRACTICES**

<i>Site</i>	<i>SLP requires consult</i>	<i>SLP consult response time meets facility policy</i>	<i>SLP can schedule instrumental evaluation without MD order</i>	<i>Clinical prior to instrumental evaluations</i>	<i>Radiologist must be present for VFSS</i>
A	Yes	83%	Yes	0%	Yes
B	No	100%	Yes	100%	No
C	Yes	71%	No	100%	No
D	Yes	100%	Yes	0%	No
E	Yes	100%	No	100%	Yes
F	Yes	50%	No	NA*	Yes
G	Yes	75%	No	50%	Yes

*\*No instrumental evaluations in sample, all clinical evaluations.*

Although SLP staffing at the seven facilities reviewed varied widely, all facilities required the SLPs to respond to consultation requests for swallowing evaluations on inpatients within 24 to 72 hours. We found compliance with these timeframes about 85 percent of the time, despite limited staffing in some facilities.

**Recommended Improvement Action 3.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that facilities develop and follow guidelines for the appropriate use of VFSS.

The Under Secretary for Health concurred with the recommendation and provided acceptable improvement plans. Pending development of a national policy on the use of bedside and instrumental swallowing exams, the Audiology and Speech Pathology (ASP) program will develop practice recommendations on the evaluation of dysphagia and report these to the task force for consideration and inclusion in the Directive. We will follow up on the planned actions until they are completed.

**Issue 4: Provision and Documentation of Care**

**Findings**

Provision of Oral Care

Medical records of 42 percent of the dysphagic inpatients and 43 percent of the non-dysphagic inpatients in our sample did not contain documentation to support that the patients had received daily oral care. In addition, 44 percent of the inpatients we interviewed told us they needed help to perform their oral care, but only 33 percent of these patients told us that they had received this assistance.

SLPs at six of the seven review sites were dissatisfied with the provision of oral care for their patients with swallowing problems. We found progress notes written by one SLP documenting the condition of a patient's mouth and requesting increased attention to oral care. At another facility, we found comments from Dental Service staff in the patients' medical records documenting the inadequate oral care provided to several of their long-term care patients. The dentist noted that some patients dependent on nursing staff for oral care had "debris" in their mouths, and documented "extremely poor oral hygiene" in these progress notes. However, nursing flow sheets indicated that these patients received oral care. Guidelines from an SLP on one dysphagic patient included aggressive oral hygiene. We asked the head nurse what that involved, and she said "oral care three times a day." This patient had oral care documented only once in three days. A clinical service chief at this facility told us that oral care was low on the nurses' list of priorities.

Many dysphagic patients aspirate their oral secretions, and the micro aspiration of saliva containing bacteria is a leading cause of pneumonia. An aggressive protocol of oral care reduces colonization with potentially pathogenic organisms, decreases the bacterial load, and can reduce the risk of pneumonia.<sup>15</sup> SLPs frequently recommend increased aggressiveness in oral care for patients at risk for aspirating their oral secretions.

#### Documentation of Oral Care

Provision of oral care was documented inconsistently, incorrectly, or not at all. Forms or flow sheets used to document activities of daily living (ADLs) did not always include oral hygiene. Nursing documentation on some patient flow sheets reflected that oral care had been performed, but when we interviewed the patients, they told us that they had not received oral care. Good oral care is essential in the management of the dysphagic patient, and nursing documentation should correctly reflect the type and frequency of oral care provided.

#### Documentation of Meal Consumption

Documentation of meal consumption was inconsistent, non-existent, or meaningless. ADL flow sheets on MH and acute medical and surgical units did not always include a place to document meal consumption. On those flow sheets that did include a place to document meal consumption, nursing staff often initialed the box rather than documenting the percentage of meal consumed. If staff did not assist a patient with his meal, and were not present when the tray was picked up, they had no way of knowing how much the patient had consumed. It is important to know how much of a meal a patient is consuming when he is at nutritional risk due to a feeding or swallowing problem. Tolerance of a diet modification, whether adequate time was spent in the feeding process, changes in a patient's mood, or other changes in status can be better monitored with this additional information.

We found a physician's progress note stating that the physician was unclear how the patient's laboratory results could indicate dehydration when the ADL flow sheet documentation indicated the patient was consuming 100 percent of the additional fluids ordered. Accurate documentation is necessary for the physician to monitor the patient's status and prescribe dietary regimes.

One facility had an effective system to accurately and consistently record percentage of meal consumed. At that facility, the food service worker who retrieved the meal tray wrote the percentage of meal consumed on the patient's meal ticket and gave the ticket to nursing staff to record on the flow sheets or in the patients' medical records.

### Posting of Feeding Guidelines

SLPs were not allowed to post their feeding guidelines at the patients' bedsides at five of the seven facilities reviewed. Feeding guidelines are recommendations for the patient or those assisting him with feeding to enhance safe swallowing and prevent aspiration. Feeding guidelines may include compensatory techniques and postural adjustments. Although communicated to the patient and placed in the medical record, we found few feeding guidelines posted at bedside as an accessible reference for patients, family, or staff. The SLPs we interviewed told us they would prefer to post their feeding guidelines at bedside. Facility managers at the five sites told us they thought this practice did not comply with JCAHO standards and could be a violation of patient privacy; however, JCAHO told us that as long as the posting did not contain identifying diagnostic information, it was an acceptable practice that could enhance patient safety.

The following example illustrates how the posting of feeding guidelines would be beneficial:

We observed one nursing assistant feeding a patient who was choking and coughing during the meal. The nursing assistant told us that he had been "pulled" from another unit just prior to lunchtime to assist with feeding. He observed that this patient was not feeding himself, so he began to feed the patient. The nursing assistant was unaware that the patient was dysphagic. He had not been given specific instructions regarding the feeding of this patient, and feeding guidelines were not posted at the patient's bedside.

**Recommended Improvement Action(s) 4.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Nursing staff assess and document the need for assistance with oral care and consistently record its provision to patients for whom oral care is identified as high priority.

- b. Nursing staff assess and document the need for monitoring of meal consumption and consistently record percentage of meal consumed for patients in need of such monitoring.
- c. SLPs are allowed to post feeding guidelines at patients' bedsides.

The Under Secretary for Health concurred with the findings and recommendations and provided acceptable improvement plans. Pending the development of the national policy, VHA will require nursing staff to assess and document the need for assistance with oral care and incorporate this documentation into patient care plans by March 2006. The task force will develop a form to document a subjective measurement of percent of tray/meal consumed. After clarification of privacy issues, ASP will develop practice recommendations and templates on posting feeding guidelines for consideration and inclusion in the Directive. We will follow up on the planned actions until they are completed.

## **Issue 5: Continuity of Care**

### **Findings**

#### Discharge Instructions

We found discrepancies between the diet noted on the nursing discharge instructions (which patients sign and take home) and the physicians' discharge summaries. Also, discharge diet orders did not always match the diet noted in the last RD note or the diet recommended by the SLP. This occurred because none of the seven facilities had an interdisciplinary discharge form which incorporated input from other disciplines (such as Speech Pathology or Occupational Therapy) into the nursing discharge instructions, and SLPs at six of the seven sites did not regularly attend interdisciplinary team or discharge planning meetings. At one facility, four of six outpatient records we reviewed had incorrect discharge instructions regarding modified diets. In these four cases, the diets were incorrectly upgraded to a regular consistency with no restrictions although the patients had been on modified consistency diets just prior to discharge. At another facility, we found that one patient had been discharged on a more restricted diet than he had been consuming while hospitalized.

#### Follow-Up

SLPs at three of the seven facilities did not consistently follow up with the dysphagic patients they evaluated to assess clinical progress or the need for care plan revision. In addition, we found that follow-up provided was often limited to meal management and rarely included swallow treatment.

*Outpatient Follow-Up.* We reviewed the medical records of dysphagic outpatients evaluated by SLPs during hospitalization. Most of these patients had feeding guidelines while in the hospital, and many were on aspiration precautions. Although most of these dysphagic patients were discharged on modified consistency diets (and a few still needed thickened liquids and crushed medications at discharge), only 16 percent of those who were appropriate for follow-up were scheduled a return appointment with the SLP.

*Inpatient Follow-Up.* Although 98 percent of the swallowing evaluations of the dysphagic inpatients in our sample had abnormal findings, only 60 percent of these patients' medical records had documentation of SLP follow-up. SLPs recommended feeding guidelines for 79 percent and diet modifications for 67 percent of these patients.

An ASHA position statement says that SLP dysphagia management includes providing treatment for swallowing and feeding disorders, documenting patient progress, and determining appropriate dismissal criteria.<sup>16</sup> Swallow treatment is designed to change the swallow physiology. Swallow management may involve diet modification, compensatory adjustments, and feeder training, but does little to remediate the condition.<sup>17</sup> Follow-up to an evaluation in which SLPs recommended diet modifications and/or provided feeding guidelines is a critical element in achieving improved patient outcomes. At a minimum, observing the patient at mealtime is indicated to determine tolerance of the new diet and patient or feeder compliance with feeding guidelines.

A SLP at one facility told us that due to staffing limitations, she predominately provided diagnostic services and very few therapeutic or swallowing management services to dysphagic patients. She said she did not provide any follow-up unless re-consulted by the physician to do so. This facility had designated one of the RDs as the "dysphagia dietitian." This RD was to identify dysphagic patients for referral to the SLP, follow-up with patients after their swallowing evaluation, and refer any problems to the SLP. The following example reflects the inadequacy of this system:

The SLP recommended, based on results of the VFSS, that a patient be removed from NPO (nothing by mouth) status. Neither the "dysphagia dietitian" nor the SLP monitored the patient following the evaluation. The regular unit RD documented concerns that the patient could not meet his nutritional needs with the amount he was consuming by mouth. The patient expressed concerns about choking. Four days following the VFSS, the patient suffered a serious aspiration episode and developed aspiration pneumonia.

While we found documentation that SLPs at four of the sites provided appropriate follow-up to dysphagic inpatients after evaluation, SLP follow-up at three sites was inadequate. The following table illustrates the variability we found in dysphagia management practices:

**VARIABILITY IN DYSPHAGIA MANAGEMENT PRACTICES**

Site	SLP FTEE for dysphagia management	SLP can post feeding guidelines	SLP provided F/U* post evaluation (inpatients)	Policy regarding F/U	SLP attends Interdisciplinary Team or Discharge Planning meetings
A	3	Yes	29%	Yes	As needed
B	4.5	No	100%	Yes	As needed
C	1	Yes	100%	No	As needed
D	.63	No	0%	No	As needed
E	1	No	100%	No	Yes
F	.25	No	100%	No	As needed
G	1	No	25%	No	No

*\*Follow-up to check on implementation of evaluation recommendations, swallow treatment, or swallow management.*

The following example illustrates the need for follow-up to ensure patient safety:

An inpatient was referred for a swallowing evaluation. An SLP performed an instrumental swallowing evaluation one week later. Based on abnormal results of the VFSS (including aspiration), the SLP recommended a modified consistency diet with all liquids thickened, and monitoring at mealtime. We were told the patient was currently being followed by the SLP. We observed the patient during mealtime one week after these recommendations were made. A nursing assistant was monitoring him in a small dining room, where he took some of his meals. He told us this was only the second time he had been assisted at mealtime. The patient received a regular diet with thin liquids. He was unable to chew his meat and coughed throughout the meal. The nursing assistant told us she did not know if the patient had any feeding guidelines, or if he was being seen by the SLP. After we left the room, we observed the nursing assistant leave the patient unattended to complete his meal.

We found feeding guidelines posted at the patient’s bedside. The guidelines described diet and liquid modifications, and provided detailed instructions including thermal stimulation<sup>F</sup> before meals and aggressive oral hygiene. However, according to nursing documentation, the patient received oral care only once in the past three days. In addition, the physician’s regular diet order had never been modified. When we returned to observe the patient at his next meal, we found him eating alone in the dark. He claimed no knowledge of his feeding guidelines. Because the physician did not implement requested consultation recommendations,

<sup>F</sup> Temperature change is thought to facilitate lingual motion and/or improve triggering of the pharyngeal swallow. (Bisch et.al. 1994)

nursing staff did not follow the plan of care, and the SLP did not monitor the patient, he was placed at higher risk for choking or aspiration pneumonia. We notified the patient's treatment team about these issues.

### Monitoring Appropriateness of Diet Modifications

Treatment teams did not always monitor appropriateness of long-standing diet orders. Dysphagia experts say that SLPs should follow instrumental assessments with meal observations and clinical examinations before diet consistencies are changed to avoid patients being placed or maintained on inappropriate diets. SLPs recommended diet order changes for 67 percent of the patients in our sample following abnormal swallowing evaluations; however, we found notations in 58 percent of these evaluation reports that the patient required no further follow-up from the SLP.

At one facility, we found that a patient on a diced diet with mostly pureed items had a standing order for bologna sandwiches. We observed this patient with an opened bag of potato chips on his lap, his bologna sandwich in his hand, and his meal tray untouched. An RD documented in his medical record that "Patient is at risk of choking." This patient had never been referred to the SLP for a swallowing evaluation. We questioned why a patient at risk of choking was allowed to eat bologna sandwiches and potato chips, and why a patient who could handle these items had a modified diet. A swallowing evaluation was promptly scheduled for this patient.

This same facility immediately initiated a review of diet orders for all their long-term care patients, and assessed documentation of the rationale for placement on a modified consistency diet, such as aspiration risk, poor dentition, dysphagia, etc. Other facilities could benefit from a similar review to ensure patients are not maintained indefinitely on modifications they may not need.

**Recommended Improvement Action (s) 5.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Discharge instructions regarding diet are consistent and accurate.
- b. Swallowing consultation recommendations are followed up.
- c. Appropriateness of long-standing diet modification orders is monitored.

The Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. A work group will develop guidelines for documenting and verifying diet orders at discharge. An SLP task force will review evidence-based practices and develop practice recommendations related to post evaluation follow-up. VHA will also develop practice recommendations for monitoring the appropriateness of diet modification and report these to the task force in March 2006

for consideration and inclusion in the Directive. We will follow up on the planned actions until they are completed.

## **Issue 6: Feeding**

### **Findings**

Nursing staff at the seven facilities reviewed reported that they had 463 patients on their units requiring assistance with feeding at the time of our review, and an additional 166 patients required total feeding. These numbers do not include patients requiring tube feeding.

#### Assistive Feeding Devices

Only 17 of the 93 inpatients we observed at mealtime used assistive feeding devices. Three patients we observed had trouble managing their devices. One patient told us that, although he had his assistive feeding device at his bedside, nursing staff preferred to feed him as they felt it took too much time to put on the device. An RD documented that another patient needed finger foods, as he couldn't use utensils, yet we found no referral to Occupational Therapy for this patient.

Various feeding devices, called assistive feeding devices or adaptive feeding equipment (AFE), can assist patients with self-feeding and often enable them to be independent in feeding. Most devices can be readily provided to any patient; however, some devices need to be specifically fitted for a patient and ordered through Prosthetics Service. Assistive feeding devices include plate guards to block food from spilling off the plate, swivel spoons for limited range of motion (ROM) in the forearm, universal cuffs for patients with diminished grasp, long-handled utensils for patients with limited ROM in the elbow and shoulder (or for amputees), utensils with built-up handles, and special sipping cups.

Two inpatients that used assistive feeding devices at home had not been supplied with replacements while they were hospitalized. One patient had been without his equipment for five days, and the other, a bilateral above the elbow amputee who had been dependent on assistive devices for self-feeding for many years, had been without any AFE for over two weeks. Therefore, he was dependent on nursing staff to pour his liquids in a cup and hold the cup for him. He told us that this was not being done. Had his assistive feeding device been available, he could have managed independently. During our visit, the patient developed a urinary tract infection and his physician acknowledged that inadequate hydration was probably a contributing factor.

During our review, we found problems with cleaning assistive feeding devices. At two of the seven facilities, the equipment came with the meal tray and was returned with the tray and sterilized in the kitchen. At the remaining five sites, the equipment stayed on the unit

to prevent loss. At these sites, staff were uncertain about who had responsibility for cleaning the devices. Some staff felt it was nursing, other staff felt it was Occupational Therapy, and some said it was a patient responsibility. Many RDs did not know how the equipment was cleaned. It seems improbable that patients with deficits causing them to need this type of equipment would have the ability to adequately clean these items themselves. There was no consistency in the way devices were cleaned and no assurance that devices were appropriately cleaned.

### Timeliness of Feeding Assistance and Time Spent in Feeding

Thirty-five percent of the patients we interviewed who required assistance with feeding told us that they waited too long after tray arrival for this assistance. However, we observed that patients waited less than 5 minutes 51 percent of the time and less than 10 minutes after tray arrival 73 percent of the time.

We observed that nursing staff spent more than 15 minutes in the feeding process 65 percent of the time. Studies have shown that nursing home residents take between 16 and 39 minutes, on average, to complete a meal.<sup>18</sup> These studies suggest that professional caregivers usually spend from as few as 6 minutes to as long as 20 minutes feeding a resident, compared to an average of 24 minutes per meal they estimate family caregivers spend feeding their family member. We generally found nursing personnel to be appropriately assisting patients with feeding at all but one of the facilities we reviewed.

One facility had significant problems with timeliness of feeding assistance. More than 50 percent of the patients we observed on two units were not fed in a timely manner. Delays were as long as 48 to 55 minutes and in one case, the patient waited over an hour from the time his tray was delivered until someone from the nursing staff fed him. We found the breakfast and lunch trays of one patient being weaned from tube feeding untouched in the storage room. Another patient's tray was delivered and placed by his bedside but nursing staff made no attempt to feed him. We learned that this patient was also being weaned from tube feeding.

**Recommended Improvement Action(s) 6.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Patients are appropriately assessed for, and provided with, assistive feeding devices if indicated.
- b. Assistive feeding devices are adequately cleaned and stored.

The Under Secretary for Health concurred with the findings and recommendations and provided acceptable improvement plans. The task force will develop national policy regarding the provision of assistive feeding devices. The policy will address patient

assessment and device cleaning and storage. We will follow up on the planned actions until they are completed.

## Issue 7: Meal Tray Delivery

### Findings

At four of the seven facilities, the time between the evening meal and breakfast on some units exceeded 14 hours. Current VHA Food Service Management policy (M-2, Part III Chapter 3) states that "...meal hours for clients are spaced to conform to the accepted normal eating pattern, with priority given to the welfare of the client over any administrative consideration. The span between the evening and morning meals does not exceed 14 hours (Section 3.03 Meal Hours)."

At one facility, patients told us that they were not hungry for their lunch, as it was served too soon following their breakfast. We found that all three meals were served within a 9-hour time span. The facility had recently changed its food delivery system and had reduced the number of hours a day needed to staff the kitchen. This change caused some patients to wait 15 hours between their evening and morning meals, and had them receiving dinner as early as 4:05 p.m. Facility managers told us that "bulk" snacks, such as graham crackers and pudding, were available on the unit for patients that wanted them in the evening; however, snacks not specifically ordered for a patient may not be appropriate or provided on a consistent basis, especially to those patients unable to ask for them.

The Director of Nutrition and Food Service at VA Central Office told us that the policy was being revised to allow up to 16 hours between a substantial evening meal and breakfast the following day, if a supplemental feeding is offered at bedtime. This policy has not been finalized. The Director told us that a "bulk" snack did not constitute a supplemental feeding. According to the policy, the RD, in consultation with the physician, reviews all orders for supplemental feedings, and Nutrition and Food Service delivers them in individual portions marked with an expiration date and method to identify the patient.<sup>19</sup>

We reviewed diet orders for patients on a unit at one of the sites where the time span between dinner and breakfast exceeded 14 hours. We determined that 11 of 17 patients that could have received snacks or supplemental meals had no supplemental meals or snacks ordered for them.

**Recommended Improvement Action 7.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that facilities comply with Food Service Management Policy related to meal hours and supplemental meal orders.

The Under Secretary for Health concurred with the findings and recommendation and provided acceptable improvement plans. Nutrition and Food Service (NFS) will ensure that the time between evening and breakfast meals does not exceed 14 hours, and that supplemental feedings are provided to patients when indicated. We will follow up on the planned actions until they are completed.

## **Issue 8: Modified Diets**

### **Findings**

#### Diet Modification

SLPs recommended a downgrade in diet consistency 68 percent of the time and that all liquids be thickened 46 percent of the time following abnormal swallowing evaluations for the dysphagic inpatients in our sample. Diet modification was often the only intervention implemented for some dysphagic patients. Diet modification may involve altering the textures of solid foods and downgrading their consistencies (from regular to soft, chopped, ground, or pureed) to make it easier to chew and swallow, or altering the viscosity<sup>G</sup> of liquids by thickening (from thin to nectar, honey, or pudding/spoon thick) to reduce the risk of aspiration.

A renowned SLP in the field of dysphagia teaches that diet modification should be considered the last management option, after postural changes, increasing sensory input, and other maneuvers.<sup>20</sup> Diet modification as an intervention has its disadvantages: not all patients accept it; poor compliance is common; it is more costly; and it is more inconvenient than other options. Thickening liquids continues to be one of the most frequently used compensatory interventions in hospitals and long-term care facilities, yet there is little research in the literature to support or guide this practice.

Only four of the seven facilities provided commercially available pre-thickened liquid products to their dysphagic inpatients although all of the SLPs we interviewed preferred these pre-thickened liquids to liquids thickened by nursing staff. Consistently achieving accurate thickness is difficult when liquids have to be thickened by potentially a different person at every meal. All but two of the facilities provided thickener to outpatients through their Pharmacy. Patients at those two facilities were required to purchase thickener on their own, wherever they could find it, as it was also not available in their VA retail store. Facilitating the procurement of this recommended item could enhance patient compliance with use of thickeners.

The number of patients in our sample who received downgraded diets and thickened liquids, and the number who were seen for therapy by the SLP, indicated that SLPs

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<sup>G</sup> Liquids with greater viscosity have more resistance to flow.

frequently recommended diet modification before exhausting other treatment options that might allow the patient to receive a more normal diet.

### Nomenclature

Diet names and the terms used to describe the diet consistencies varied greatly between facilities. We found puree diets referred to by all of the following names: puree, dysphagia I, non-chew, and pudding-thick foods. We found the next level of solid consistency referred to as: mechanical, ground, diced, chopped, dysphagia II, dental, dental ground, mechanically altered, Kutter, and soft chew. We also found references to soft, soft mechanical, and mechanical soft diets, as well as regular diets. Nomenclature was so confusing at one facility that even the SLP referred to a patient's diet differently in every note she wrote. At the same facility, physicians requested a simplification of the diet ordering process. One physician there was confused about thickening agents, providing the following discharge instruction to a patient: "Use 1 measure by mouth every day if needed to thicken liquids."

Using the simplest and most descriptive terminology to describe food consistencies would facilitate the ordering process for the physician and reduce confusion. Terms such as pureed, chopped, and ground mean the same thing to most people, and could enhance clarity of discharge instructions and improve outpatient compliance with diet orders. Terms such as mechanical and dental are less transparent. Continuity of care could be improved by standardizing terminology.

All of the facilities were able to provide dysphagic patients diets modified to meet their specific needs, and some labeled these diets "dysphagia diets." Two facilities only used the term "dysphagia diet" when the diet recommendation included thickened liquids. At these two facilities, a dysphagic patient that could handle thin liquids, but needed a modified solid consistency, was not on a dysphagia diet. We found problems identifying patients as dysphagic at these two facilities. At one, the RD told us that there were only four dysphagic patients currently in the facility. This seemed too few for a facility its size. When we inquired further, we learned that the RD only included patients who needed thickened liquids and were on "dysphagia diets."

We found similar problems at the other facility with a dysphagia diet that always included thickened liquids. There, dysphagic patients were identified by a colored dot on their nameplate, armband, and chart. This safety measure alerted caregivers that the patient might be at risk of choking, aspirating, or other swallowing problems. We asked the SLP to give us the names of 20 dysphagic patients at the facility. Some of these patients needed thickened liquids, and some did not. We found that 100 percent of the patients on "dysphagia diets" were identified by nursing as dysphagic by the dot system. Only 20 percent of the dysphagic patients who were not on a "dysphagia diet," as they did not require thickened liquids, were identified by nursing as dysphagic. Therefore, these patients, also at risk of choking or other swallowing difficulty, did not benefit from

this risk alert strategy. We shared this finding with the Interdisciplinary Dysphagia Committee who devised the dot alert system.

Each dysphagic patient has deficits and problems that are unique; not all dysphagic patients need thickened liquids. Calling the diets ordered for some, but not all, dysphagic patients “dysphagia diets” is problematic; this may lead to a failure by some staff to recognize a patient as dysphagic.

**Recommended Improvement Action(s) 8.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Pre-thickened liquid products are readily available.
- b. Prescribed thickening agents are easily obtained by outpatients.
- c. Diet terminology is simplified and standardized.

The Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. NFS will implement national guidelines on procurement of pre-thickened liquid products. NFS, in consultation with the Pharmacy Benefits Management Strategic Healthcare Group, will prepare an Information Letter for outpatients regarding thickening agents. NFS will collaborate with ASP program office in standardizing diet terminology. We will follow up on the planned actions until they are completed.

## Conclusion

There is no national guidance related to the management of this patient population, and we found considerable variability in practice. While we found appropriate interdisciplinary coordination of care at some of the facilities, we found lapses in care and inadequate communication between disciplines at others. Physicians appropriately consulted SLPs for swallowing evaluations, yet often failed to refer to report recommendations before writing discharge diet instructions. SLPs promptly responded to swallowing consults and wrote detailed recommendations regarding diet modifications and techniques to facilitate safe swallowing and reduce aspiration risk. Too often, however, no follow-up was provided to ensure implementation of, or compliance with, the recommendations. In addition, patients were not routinely reassessed to determine the continuing appropriateness of long standing diet orders. Nursing employees were frequently unaware of feeding guidelines or did not provide care, especially oral care, as recommended. Patients were assisted with feeding more often than they were provided with the equipment and skills to enable them to independently feed themselves. Patients were ordered thickened liquids and more restrictive, less palatable diets more often than they were provided a trial of remediation.

SLPs remain the primary providers of dysphagia services, yet their numbers are declining in VHA medical facilities. They are functioning less often as interdisciplinary rehabilitation team members and more often as diagnosticians. We found only one facility where the SLPs regularly attended interdisciplinary team or discharge planning meetings. Given the high incidence of feeding and swallowing problems in the VA patient population, and the impact such problems can have on quality of life, VHA should strive to improve the coordinated medical care provided to these patients.

## Under Secretary for Health Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** February 7, 2006

**From:** Under Secretary for Health (10/10B5)

**Subject:** **Evaluation of the Management of Patients with Feeding and Swallowing Problems in Veterans Health Administration Facilities, Project Number 2003-00494-HI-0070**

**To:** Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and I concur with the report and the recommendations. I am concerned with the inconsistencies among our medical facilities in managing patients with feeding and swallowing problems, and I agree that a comprehensive policy that addresses multi-disciplinary responsibilities for assessment and management is essential. A detailed action plan addressing each recommendation is attached.

2. To ensure better compliance and consistency among facilities, VHA's Patient Care Services (PCS) will lead a task force in developing a comprehensive policy to improve the coordinated medical care provided to our patients with feeding and swallowing problems. This task force will be interdisciplinary, consisting of headquarters and field representatives, and will be tasked with developing national policy that addresses the recommendations identified in the report. I anticipate the task force will begin deliberating no later than February 15, 2006, with a final Directive establishing national policy issued in April 2006.

3. One goal of the task force will be to identify a standard for assessment and care of patients with feeding and

swallowing disorders in different clinical settings. The task force will also prepare a directive that, when implemented, will provide guidance to ensure that local facilities have and follow a policy that defines appropriate management and coordinated medical care for patients with feeding and swallowing problems. While the task force prepares its report and directive, appropriate program offices will take interim actions that also address the recommendations. These interim actions are outlined in the attached action plan.

4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

*(original signed by:)*

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

## **Under Secretary for Health Comments to Office of Inspector General's Report**

The following comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

### **OIG Recommendation(s)**

**Recommended Improvement Action 1.** The Under Secretary for Health should establish a work group of relevant healthcare providers to develop a comprehensive policy that defines multidisciplinary responsibilities for assessment and management, with the goal of improving the coordinated medical care provided to patients with feeding and swallowing problems. The work group should address, but not be limited to, the action items identified in issues 2-8.

Concur **Target Completion Date:** June 30, 2006

VHA will establish a multi-disciplinary task force to make recommendations on a consistent standard of care toward the development of national policy. The task force will consist of representatives from the Office of Patient Care Services, Audiology and Speech Pathology Service, Office of Nursing Service, Nutrition and Food Service, Medical Service, Office of Geriatrics and Extended Care, Pharmacy Benefits Management Strategic Healthcare Group, Physical Medicine and Rehabilitation Service, Office of the Deputy Under Secretary for Health for Operations and Management, and the Office of Information. We expect the task force to begin work no later than February 15, 2006. A Directive establishing national policy will be published by April 2006. Monitoring for implementation in facilities will occur by June 30, 2006. The Office of Patient Care Services will be responsible for the development and progress of the multi-disciplinary task force.

**Recommended Improvement Action(s) 2.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that:

- a. Initial nursing assessment forms contain feeding and swallowing risk assessments, are correctly completed, and are used on appropriate units.

Concur

**Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to ensure that initial nursing admission, screening and assessment forms contain feeding and swallowing risk assessments are correctly completed, and used on appropriate units. Pending development of national policy, VHA will take the following actions:

Registered Nurses, Registered Dietitians, including nurses and dietitians from the VA nursing home program, will identify best practices for conducting assessments and requesting consultations directly with the Audiology and Speech Pathology program (ASP) in all settings. The final best practices document will be reported back to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy by March 2006. In addition, the findings and recommendations of this report will be discussed on the national Office of Nursing Service conference call scheduled in February 2006.

b. Providers consistently document dysphagia in the CPRS problem list, and include choking risk in the clinical alert system.

Concur

**Target Completion Date:** June 30, 2006

Speech-language pathologists will be instructed to document oropharyngeal dysphagia in the Computerized Patient Record System (CPRS) problem list. The Audiology and Speech Pathology (ASP) program will hold conference calls with field-based speech-language pathologists, service chiefs, and managers on dysphagia, and collaborate with the Association of VA Speech-Language Pathologists (AVASLP) in developing topics for their annual meeting related to the OIG recommendations. The Audiology and Speech Pathology National Program Office will issue by February 2006 an Outlook alert to the speech language pathology group that includes all speech language pathologists, supervisors, managers, and chiefs. These individuals are to report monthly to the ASP program office beginning in March 2006 on the progress being made on documenting dysphagia in the CPRS problem list. Progress reports will initially be monthly, but will later move to quarterly when sufficient evidence demonstrates this reporting change. ASP will be responsible for ensuring that these actions are completed.

The Office of Information is working with Patient Care Service (PCS) to implement the recommendation and will add “choking risk” to the Crisis Notes, Warnings, Adverse Reactions Allergies, Directives (CWAD) posting

areas of the Computerized Patient Record System (CPRS) cover sheet and CPRS clinical alerts system, to be completed by June 2006. This is a CPRS setup issue that requires no programming. PCS will monitor the progress of this implementation, and develop a plan to educate practitioners through program offices and collaboration with network offices. This enhancement will allow ASP and other disciplines to document directly on the problem list in CPRS.

Facilities will be advised of their responsibility in a memorandum signed by the Deputy USH for Operations & Management, on the importance of conducting periodic reviews of the problem list and adding choking risk to the CWAD.

c. Processes to refer patients to the SLP for swallowing evaluations are streamlined.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. This task force will develop national policy for referrals to speech-language pathology. Policy developed by this task force will outline the process necessary for physicians to follow the current policy for third party billing for swallowing evaluation consultations. Pending further study and development of national policy by the task force, VHA will take the following actions:

Each Network Office will advise facilities in their regularly scheduled conference call, to review and comply with their policy and timeline stated therein on the referral of patients to speech-language pathology (SLP). Upon the issuing of the Directive establishing national policy, it will be mandatory for high-risk patients to be referred to SLP.

**Recommended Improvement Action 3.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that facilities develop and follow guidelines for the appropriate use of VFSS.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

**Recommended Improvement Action(s) 4.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

a. Nursing staff assess and document the need for assistance with oral care and consistently record its provision to patients for whom oral care is identified as high priority.

Concur **Target Completion Date:** April 30, 2006;

field monitoring by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. This task force will develop national policy on the documentation of oral care, and include guidance for nursing staff to assess and consistently document the need for assistance with oral care. Pending the development of the national policy, VHA will take the following actions:

Nursing staff, including members from the VA nursing home program, will assess and document the need for assistance with oral care and incorporate the documentation into the plans of care by March 2006. The Office of Nursing Service (ONS) will reinforce this through on-going communication between ONS and the field facilities. In addition, ONS will discuss the findings and recommendations of the report on the national Office of Nursing Service conference call in February 2006. The multi-disciplinary task force will develop an outcome monitoring process to assure this activity is completed on an ongoing basis, and for consideration and inclusion in the Directive establishing national policy.

b. Nursing staff assess and document the need for monitoring of meal consumption and consistently record percentage of meal consumed for patients in need of such monitoring.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to ensure nursing staff consistently assess and document the need for the monitoring of meal consumption, and recording of percentage of meals consumed by patients with feeding and swallowing problems. Each Medical Center will incorporate a subjective measure to be added to their local Intake and Output documentation process, i.e., zero percent, less than fifty percent, fifty percent, and one-hundred percent tray/meal consumed to monitor meal consumption.

Pending the development of national policy, nursing staff and dietitians will assess and document the need for monitoring of fluid volume intake and percentage of meals consumed for patients with feeding and swallowing problems. The Office of Nursing Service (ONS), Nutrition and Food Service (NFS), and members from the VA nursing home program will

develop education and outcome monitoring processes to assure this activity is completed on an ongoing basis. The guidelines for assessing and documenting the need for the monitoring of fluid volume intake and percentage of meals consumed by these patients will be reported to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy in March 2006. Findings and recommendations of the report will be discussed on the national Office of Nursing Service, Geriatrics and Extended Care, and Nutrition and Food Service conference calls beginning February 2006. The need for nursing staff and dieticians to consistently assess and document the monitoring of fluid volume intake and percentage of meals consumed will be discussed on the calls on a monthly, then quarterly basis until the completion of the national policy. The ONS will be responsible for ensuring that these actions are completed.

c. SLPs are allowed to post feeding guidelines at patients' bedsides.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop a national policy to provide guidance for speech-language pathologists on posting feeding guidelines at the patients' bedsides, and clarification on the privacy issues involved regarding such posting. Pending the development of the national policy, VHA will take the following actions:

Audiology and Speech Pathology (ASP) program office will submit an inquiry to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), General Counsel, and the Office of Information (OI) Privacy Office for clarification on the privacy issues involved in posting the feeding guidelines at patients' bedsides. Upon clarification of privacy issues, a Fact Sheet on posting guidelines will be sent to facilities from the Network Office of Information's Privacy Office. ASP will also develop practice recommendations and templates on posting feeding guidelines for consideration and inclusion in the Directive establishing national policy. The Audiology and Speech Pathology Field Advisory Council (ASPFAC) will monitor these actions.

ASP will educate practitioners on practice recommendations during quarterly conference calls on dysphagia, and collaborate with the Association of VA Speech-Language Pathologists (AVASLP) on conference topics related to OIG recommendations. An Employee

Education System (EES) broadcast will also be used to educate clinicians on practice recommendations, and post- practice recommendations will be available on the ASP website. ASP will be responsible for ensuring that these actions are completed.

**Recommended Improvement Action (s) 5.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Discharge instructions regarding diet are consistent and accurate.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy on discharge summaries and orders and inter-disciplinary discharge planning. Pending the development of the national policy, VHA will take the following actions:

A work group, consisting of the Nutrition Food Services (NFS), two registered dietician (RD) field experts actively involved with a dysphagia team, the Office of Nursing Service, Medical and Surgical Services, and a member from the VA nursing home program will address this recommendation. The work group will develop guidelines for documenting and verifying diet orders at discharge. In addition, the RD field experts will utilize the National Dysphagia Diet as a tool for developing guidelines and national templates for patient education regarding diet and discharge orders. Guidelines developed by the work group will be reported back to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy.

- b. Swallowing consultation recommendations are followed up.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will give consideration to recommendations for follow-up of patients who have been identified with dysphagia, for inclusion in national policy. Pending the development of the national policy, VHA will take the following actions:

A speech-language pathology (SLP) task force will address this recommendation. Findings from the SLP task force will be reported back to the multi-disciplinary task force for consideration and inclusion in the

Directive establishing national policy. The SLP task force will review evidence-based practices on the management of dysphagia and develop practice recommendations on the evaluation of dysphagia. The Audiology and Speech Pathology Field Advisory Council (ASP FAC) will monitor the evidence review and practice recommendations. The Audiology and Speech Pathology (ASP) program office will also educate practitioners on practice recommendations during quarterly conference calls on dysphagia, and collaborate with the Association of VA Speech-Language Pathologists (AVASLP) on conference topics related to OIG recommendations. An Employee Education System (EES) broadcast will also be used to educate practitioners on practice recommendations, and post practice recommendations will be available on the ASP website. ASP will be responsible for ensuring that these actions are completed.

c. Appropriateness of long-standing diet modification orders is monitored.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy on monitoring appropriateness of diet modifications. Pending the development of the national policy, VHA will take the following actions:

The Audiology and Speech Pathology (ASP) program, in collaboration with designated field experts from the Nutrition and Food Service, and members from the VA nursing home program, will review evidence-based and clinical practices for monitoring diet modifications, and develop practice recommendations for monitoring the appropriateness of diet modification, including clinical examination, instrumental exams, and meal observations. Practice recommendations will state that dysphagia must be listed on the problem list in the Computerized Patient Record System (CPRS), and on treatment plans of all patients with swallowing problems. These practice recommendations will be monitored by the Audiology and Speech Pathology Federal Advisory Council (ASP FAC), and reported back to the multi-disciplinary task force in March 2006 for consideration and inclusion in the Directive establishing national policy.

On a national basis, the ASP program office will also educate clinicians on practice recommendations during quarterly conference calls on dysphagia, and collaborate with the Association of VA Speech-Language Pathologists (AVASLP) on conference topics related to OIG recommendations. An

Employee Education System (EES) broadcast will also be used to educate clinicians on practice recommendations, and post practice recommendations will be available on the ASP program website. ASP program office will be responsible for ensuring that these actions are completed.

**Recommended Improvement Action(s) 6.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Patients are appropriately assessed for, and provided with, assistive feeding devices if indicated.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy regarding ordering, training, and assessment of patients requiring assistance with feeding devices. Pending the development of the national policy, the Audiology and Speech Pathology (ASP) program office, in collaboration with the Nutrition and Food Service, Rehabilitation Strategic Healthcare Group, the Office of Nursing Service, and the Office of Geriatrics and Extended Care, and registered dietician field experts, will develop national guidelines regarding ordering, training, and assessment of patients for assistive feeding devices. The national guidelines developed in this collaboration will be reported back to the multi-disciplinary task force in March 2006 for consideration and inclusion in the Directive establishing national policy. ASP program office will be responsible for ensuring that these actions are completed.

- b. Assistive feeding devices are adequately cleaned and stored.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy for cleaning and storage of assistive feeding devices. The services responsible for cleaning and storage of assistive feeding devices will be indicated in national policy. The Office of Nursing Service, Geriatrics and Extended Care, and the Rehabilitation Strategic Healthcare Group will provide the field with education on the national guidelines.

**Recommended Improvement Action 7.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to ensure that facilities comply with Food Service Management Policy related to meal hours and supplemental meal orders.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to ensure facility compliance with the Food Service Management policy on meal hours and supplemental meal orders. Pending the development of the national policy, Nutrition and Food Service (NFS), including a dietitian from the VA nursing home program, will ensure compliance with the Nutrition and Food Service Management policy by including in the VA Food Service Management 1109.2 Handbook that the time between evening and breakfast meals should not exceed 14 hours, and that supplemental feeding schedules and meals be provided to patients when indicated. A group of NFS experts will be identified to develop a monitoring system for consideration and inclusion in the Directive establishing national policy.

**Recommended Improvement Action(s) 8.** The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to ensure that:

- a. Pre-thickened liquid products are readily available.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to ensure that pre-thickened liquid products are readily available. Pending the development of national policy, Nutrition and Food Service (NFS), including a dietitian from the VA nursing home program, will develop and implement national guidelines on procurement and availability of commercial or institutionally prepared pre-thickened liquid products that are readily available in the Nutrition and Food Service for distribution to inpatients/residents. The guidelines developed will be reported back to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy. NFS will be responsible for ensuring that these actions are completed.

- b. Prescribed thickening agents are easily obtained by outpatients.

Concur **Target Completion Date:** April 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to ensure prescribed thickening agents are easily obtained by outpatients, and to ensure guidelines for educating patients using a consistent standard of care on thickening agents for outpatients are developed. Field experts in NFS will develop guidelines for educating patients on obtaining thickening agents in the outpatient area. The guidelines developed will be reported back to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy. Patient Care Services (NFS/PBM) will be responsible for ensuring that these actions are completed.

c. Diet terminology is simplified and standardized.

Concur **Target Completion Date:** April 30, 2006;

field education by June 30, 2006

This recommendation will be studied by a multi-disciplinary task force. The task force will develop national policy to standardize diet terminology, with consideration to utilize the National Dysphagia Diet. Pending development of the national policy, the Nutrition and Food Service will collaborate with the Audiology and Speech Language Pathology (ASP) program office and recommend that the terminology in the National Dysphagia Diet be used when ordering diets, and for inclusion in national policy/guidance. This recommendation will be reported back to the multi-disciplinary task force for consideration and inclusion in the Directive establishing national policy. At the local and VISN level, the Nutrition and Food Service and the ASP program office will educate nurses, physicians and other providers on the National Dysphagia Diet terminology. NFS will be responsible for ensuring that these actions are completed.

## OIG Contact and Staff Acknowledgments

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