Somerset Partnership NHS
NHS Foundation Trust

Video-fluoroscopic Evaluation of Oropharyngeal Swallowing Disorders in Adults Policy

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Relevant Staff Groups:	All speech and language therapists working in community and mental health

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DOCUMENT CONTROL

Reference Number DH/Dec14/VEOSDAP	**Version** 2.0	**Status** Final	**Author** Adult Speech and Language Therapy Service Manager
Amendments	• inclusion of examples • inclusion additional contra-indication • various word amendments • Appendices amended to reflect written consent • Further amendments made to relevant groups involved. • now moved to procedural document		
Document objectives: To identify the roles and responsibilities of staff carrying out videofluoroscopic evaluations of swallowing to ensure the procedure is carried out safely and effectively.			
Intended recipients: Speech and Language Therapists, Radiography staff in Acute Trusts.			
Committee/Group Consulted: Videofluoroscopy Working Group.			
Monitoring arrangements and indicators: Clinical audits, complaints monitoring, incident reports and investigations.			
Training/resource implications: Staff will be fully competent working with dysphagia and will need to develop and receive further training to gain their videofluoroscopy competences.			
Approving body and date	Clinical Governance Group	Date: November 2014	
Formal Impact Assessment	Impact Part 1	Date: November 2014	
Clinical Audit Standards	NO	Date: N/A	
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Contact for review	Adult Speech and Language Therapy Service Manager		
Lead Director	Director of Nursing and Patient Safety		

CONTRIBUTION LIST Key individuals involved in developing the document

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CONTENTS

1. INTRODUCTION

1.1 This policy outlines local videofluoroscopy procedures and protocols for adults, undergoing videofluoroscopy examination of swallowing within Somerset Partnership. Access to the service will be based on clinical need and be available regardless of age, disability, ethnicity, gender or creed. It is based on the best practice policy statement issued by Royal College of Speech and Language Therapists in 2007.

2. PURPOSE AND SCOPE

2.1 Videofluoroscopy examination of swallow is a modification of the standard barium swallow examination used in the assessment and management of oropharyngeal swallowing disorders. It is a dynamic fluoroscopic imaging procedure. The physiology of swallowing is graphically revealed, typically by means of employing a range of food and fluid consistencies.

2.2 Videofluoroscopy is described in a number of sources as the 'gold standard' for the assessment of oropharyngeal dysphagia (Daniels, McAdam, Brailey, and Foundas, 1997; Robbins, Coyle, Rosenbek, Roecker, and Wood, 1999 cited in RCSLT, 2007).

2.3 Videofluoroscopy can be used for the assessment, treatment and management of swallowing in a range of client populations where the suspected condition or disease process impacts on swallow function and may result in a risk of death, pneumonia, dehydration, malnutrition and psychosocial issues related to discomfort and difficulty eating and drinking.

3. LEGAL REQUIREMENTS

Consent and Capacity

3.1 Patient's have a legal and ethical right to determine what happens to them. The main purpose of seeking consent is to protect and respect the patients' autonomy and individual rights, whilst ensuring medical accountability, involving the patients and carers in all aspects of their care. Every reasonable adjustment will be made to enable this to happen.

3.2 The Somerset Partnership Consent Policy and Capacity to Consent to Treatment policy sets out standards and procedures that define 'consent' between patients and health professionals providing treatment. The Mental Capacity Act Code of Practice must be followed. A person is assumed to have capacity unless it is proved otherwise.

3.3 If there is any doubt about an individual's capacity the Consent and Capacity to Consent to Treatment Policy and procedures must be followed.

3.4 It is essential that all healthcare professionals clearly document assessments, patient's wishes and preferences and the decisions made.

4. EXPLANATIONS OF TERMS USED

4.1 **Swallowing:** A series of rapid, integrated movements of the oral cavity, pharynx, larynx, trachea and oesophagus that cannot be observed directly.

4.2 **Aspiration** refers to the entry of material (including food and drink) into the larynx and lower respiratory tract.

4.3 **Videofluoroscopy** refers to an x-ray procedure which films the swallow process from oral intake through to and including the swallow.

4.4 **Dysphagia** refers to difficulty at any stage of the mechanical process of eating, drinking and swallowing.

4.5 **Mental Capacity** refers to the ability to act and make informed decisions.

5. DUTIES AND RESPONSIBLITIES

Trust Responsibilities

5.1 The Trust Chief Executive and Trust Board have overall accountability for the effective and safe operation of the Trust, ensuring the safety and well-being of service users and others are taken fully into account at all times.

5.2 Trust managers are responsible for ensuring all their staff are fully aware of this procedure and for making sure they follow it at all times.

National Statute Responsibilities

5.3 It is a requirement of the IR(ME)R 2000 statutory instrument that the employing organisation must establish clear roles and responsibilities for the 'practitioner', 10 ITEM 6 'operator' and 'referrer'. These roles are defined by the IR(ME)R 2000 statutory instrument as follows:

Practitioner – The practitioner shall be responsible for the justification of a medical exposure and such other aspects of a medical exposure as is provided for in these Regulations. 'Practitioner' means a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the employer's procedures to take responsibility for an individual medical exposure. In this regard it will be the Speech and Language Therapist taking the session who will be the practitioner.

Operator – The operator shall be responsible for each and every practical aspect which he carries out as well as for any authorisation given pursuant to regulation 6(5) where such authorisation is not made in accordance with the guidelines referred to in regulation 6(5). Operator means any person who is entitled, in accordance with the employer's procedures, to carry out practical aspects including those to whom practical aspects have been allocated pursuant to regulation 5(3), medical physics experts as referred to in regulation 9 and, except where they do so under the direct supervision of a person who is adequately trained, persons participating in practical aspects as part of practical training as

referred to in regulation 11(3). In this respect it will be the Radiographer responsible for running the recording equipment who will be the operator.

Referrer – The referrer shall supply the practitioner with sufficient medical data (such as previous diagnostic information or medical records) relevant to the medical exposure requested by the referrer to enable the practitioner to decide on whether there is a sufficient net benefit as required by regulation 6(1)(a). Referrer means a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the employer's procedures to refer individuals for medical exposure to a practitioner, in this regard it will be a Speech and Language Therapist.

Speech and Language Therapy Responsibilities

5.4 The individual Speech and Language Therapist's right to practise in the area of videofluoroscopy is governed by the regulations of the Heath Care Professions Council. Their role is 'to safeguard the health and wellbeing of people who use the services of the professionals registered with them'.

5.5 Adherence to the Health Care Profession Council's codes of practice is the professional responsibility of the individual therapist.

5.6 When an Allied Health Professional is employed by an NHS organisation, that organisation has vicarious liability for their actions. This is in addition to their accountability to the HCPC (Department of Health, Practitioners with Special Interests).

5.7 The treating Speech and Language Therapist will have completed an appropriate clinical assessment of swallowing prior to videofluoroscopy being undertaken. This should:

- Assist in determining the nature and severity of the swallowing disorder. It will also identify any other factors that will need to be considered when conducting the videofluoroscopy such as cognition, presence of the carer, feeding arrangements, positioning, anxiety etc.

- Determine the appropriateness, timing, and type of instrumental assessment most likely to yield relevant information to guide clinical decision making, such as videofluoroscopy or FEES (Fibreoptic Endoscopic Evaluation of Swallowing).

- Include completion of the Internal Videofluoroscopy Referral Information Sheet (Appendix A). The videofluoroscopy can then be tailored to address specific questions raised during the clinical assessment. This will maximise the clinical relevance and effectiveness of the procedure.

- Include provision to the patient with information in an appropriate format about the planned instrumental assessment procedure and to gain informed consent.

5.8 It is the responsibility of the referring Speech and Language Therapist to inform the patient's General Practitioner, medical or surgical team prior to the assessment that a videofluoroscopy is planned.

Radiography Responsibilities

5.9 The Radiographer will be responsible for the running of the x-ray equipment for the procedure and the clinic room.

5.10 The x-ray department will be responsible for appointment booking.

5.11 The x-ray department is responsible for ensuring the safety of clients under-going videofluoroscopy and will ensure there is immediate access to emergency trained personnel (e.g. crash team) and fully operational equipment (e.g. suction). The procedure will **NOT** take place without the appropriate safety measures in place.

5.12 The Radiographer will be responsible for the control and limitation of ionising radiation, ensuring all staff in the room are familiar with radiological safety procedures and have been educated in the safe use of P.P.E. (lead aprons, lead gloves and thyroid shields).

6. INDICATIONS FOR CARRYING OUT A VIDEOFLUOROSCOPY

6.1 Videofluoroscopy will be considered when oropharyngeal dysphagia is suspected as part of a clinical examination but the nature of the problem has not been accurately defined.

6.2 Videofluoroscopy can be used as a tool in the decision making process regarding oral versus non-oral feeding.

6.3 Videofluoroscopy can be used if aspiration is suspected from clinical observations such as temperature spikes coupled with deteriorating chest status. The videofluoroscopy can be used to assess the presence of and severity of aspiration.

6.4 Videofluoroscopy is indicated in clients suspected of having difficulties of the Upper Oesophageal Sphincter.

6.5 Videofluoroscopy is a useful tool for diagnosing stricture (a segment of narrowing or complete closure in the pharynx) which occurs in 8% to 24% of patients treated with chemoradiation. If stricture is suspected when carrying out videofluoroscopy, the Speech and Language Therapist will inform the ENT Head and Neck Consultant to discuss possible treatment options.

6.6 Videofluoroscopy can be used to get an objective assessment of the effectiveness of compensatory strategies used with the aim of alleviating or minimising aspiration and / or improving swallow efficiency.

6.7 Videofluoroscopy can be used as an objective baseline measure of swallow function before a client embarks on a swallowing rehabilitation programme. In

this case the videofluoroscopy should be repeated post treatment as an objective outcome measure.

6.8 Videofluoroscopy should only be considered if the results are likely to change the way the patient is managed. There is little reason to expose a client to ionizing radiation if the management is not going to change. Neither should videofluoroscopy be used as the sole basis of clinical decisions regarding oral intake and dysphagia management.

6.9 Clients with dysphagia with the following conditions could benefit from videofluoroscopy:

- Acquired neurological disorders, e.g. stroke, traumatic brain injury, degenerative neurological conditions etc.
- Benign and malignant head and neck conditions, e.g. laryngectomy, post radiotherapy problems etc.
- Tracheotomised and / or ventilated patients.
- Respiratory conditions such as Chronic Obstructive Pulmonary Disease.
- Spinal injuries.
- Burns or trauma.
- Adults with cerebral palsy or learning disability.
- Adults with cleft lip / palate / velopharyngeal insufficiency.

6.10 Possible contra-indications include:

- Pregnancy.
- Medical instability, such as drowsiness and including conditions where portable ventilation is not possible (client must be able to maintain alertness for at least 30 minutes).
- Difficulty maintaining an appropriate stable position.
- Difficulty co-operating with the procedure.
- Known or suspected adverse reaction to contrast media (extremely rare).
- Nil by mouth for reasons other than dysphagia.
- Unnecessary exposure to radiation of client.
- Videofluoroscopy will not be carried out for tracheotomised and ventilated patients unless appropriately trained staff are present to support any suction or ventilation / oxygenation needs.

6.11 High risk clients include the following:

- Suspicion of large volume aspiration.
- Suspicion of undiagnosed cancers of head and neck, trachea or oesophagus.
- Recent history of respiratory distress / arrest due to aspiration.
- Assessment of impact of surgery or penetration injury (e.g. fistula).

7. VIDEOFLUOROSCOPY REFERRAL PROCEDURE / PROCESS

7.1 All clients undergoing videofluoroscopy must have had a bedside swallowing assessment completed prior to videofluoroscopy. This is required to gather case history information, to ensure a valid rationale for the procedure and to identify clients who are not appropriate for the procedure and / or any contraindications.

7.2 It is good practice for Speech and Language Therapists requesting videofluoroscopy for one of their patients to discuss the referral with a Senior Speech and Language Therapist trained to lead the videofluoroscopy clinic to ensure the videofluoroscopy is appropriate.

7.3 If the treating Speech and Language Therapist requests assessment of specific strategies, these should have been demonstrated to the patient before the videofluoroscopy is carried out.

7.4 The treating Speech and Language Therapist will complete the Internal Videofluoroscopy Referral Information Sheet (Appendix B). This should be uploaded to RIO and forwarded to the Speech and Language Therapist who will be leading the videofluoroscopy clinic.

7.5 Clients must be fully informed about the videofluoroscopy procedure prior to the examination. Consideration should be given to providing information in accessible spoken, written and / or visual formats, including the nature, purpose and likely effects of the examination.

7.6 Consent for the procedure should be gained subject to the requirements of the written Mental Capacity Act (2005).

7.7 Where the videofluoroscopy is deemed appropriate the request must be sent to the x-ray department either by a medical practitioner or a Speech and Language Therapist specifically trained and authorised to request videofluoroscopy.

8. AGREED PROCEDURE FOR CARRYING OUT VIDEOFLUOROSCOPY

8.1 A Consultant Radiologist is not present during the procedure, however they are available to offer support as required. Clinics will be cancelled when a radiologist is not available to support the videofluoroscopy clinic.

8.2 The Radiologist will be consulted if there is suspicion of an anatomical abnormality.

8.3 The Radiologist will be consulted if it is felt that conventional barium swallow would be beneficial.

8.4 If the Radiologist has been involved in the procedure, a radiology report will be provided.

8.5 The Speech and Language Therapist will arrange for a nurse trained in tracheostomy suctioning to be present for tracheostomy clients.

8.6 The Speech and Language Therapist will provide the Radiographer and the Radiologist (if present) with a verbal summary of the client's clinical history, bedside assessment results and rationale for the videofluoroscopy. This information will be used to facilitate joint control and direction of the procedure.

8.7 The Speech and Language Therapist responsible for the client's management will attend the videofluoroscopy clinic to ensure an optimal client outcome where possible.

8.8 If in the best interests of the client, the client's carer will be encouraged to attend where possible.

8.9 The Speech and Language Therapist will advise whether the use of Omnipaque or Gastromiro is indicated (i.e. where large volume aspiration is suspected). Additionally, the initial test swallow should be small volume (<5ml).

8.10 The Speech and Language Therapist running the clinic will introduce themselves to the client, to explain their role and to describe what the procedure will involve. In addition they ask for an update regarding the client's dysphagia problems.

8.11 Verbal consent will be gained from the client for the procedure to be carried out subject to the requirements of the Mental Capacity Act (2005). Consent will be documented.

8.12 The Speech and Language Therapist will document in the client's medical notes if these are available (for example if the patient is an in-patient).

8.13 During the procedure, the Speech and Language Therapist will document the sequence of events and rationale for presentation of boli, introduction of manoeuvres etc, by completing the Videofluoroscopy Record Sheet which includes completion of the Rosenbek Penetration-Aspiration Scale (Rosenbek *et al* 1996) (see Appendix C).

8.14 The Speech and Language Therapist will be responsible for preparing trial food and fluid consistencies (they will have attended an appropriate food handling course).

8.15 To avoid the risk of contamination between clients, prepared food and fluid should only be made up for one client at a time, and should be appropriately

disposed of in the clinical waste at the end of the client's appointment. The area should then be cleaned before preparing bolus trials for the next client.

8.16 Clinical judgement will determine whether or not it is appropriate to offer a range of bolus sizes in various presentations (e.g. spoon feeding, sipping etc). Ideally the videofluoroscopy should be representative of what the client would be doing in their home setting (e.g. self feeding or fed by a known carer).

8.17 Disposable utensils are recommended and should be single client use.

8.18 The Radiographer will be responsible for obtaining captured images during the procedure and ensuring these are available on PACS in a timely way, to enable the Speech and Language Therapist to review and report on the images.

8.19 The first image should be captured without boli to assess pre-swallow anatomical features.

8.20 The client should be seated in an upright position.

8.21 Images should be captured in lateral and, where indicated, antero-posterior planes.

8.22 Images should be captured in oblique and supine if clinically indicated (i.e. by joint discussion between the Speech and Language Therapist and Radiographer).

8.23 If a client is seen to be silently aspirating during the procedure they should be instructed to cough.

8.24 If a swallow is not triggered spontaneously the client should be given a verbal prompt to swallow. The verbal prompt will be recorded on the videofluoroscopy recording sheet.

8.25 Postures and manoeuvres with a clear rationale should be introduced when clinically appropriate. The rationale will be documented on the recording sheet.

8.26 The examination must answer the clinical question that prompted the x-ray dose which will be documented on the recording sheet.

8.27 The procedure will be terminated when:

- There is large volume aspiration.
- Client has exceeded recommended x-ray dose (determined by Radiographer).
- The client is no longer fit to continue with the assessment.
- The client requests the procedure is terminated.

8.28 At the end of the procedure, the Speech and Language Therapist and Radiographer will confer and agree whether there has been significant aspiration during the procedure.

8.29 The Radiologist or supervising Doctor from the ward will be responsible should a significant aspiration occur. Further intervention will be available if needed from the Physiotherapy Service on site.

8.30 The Speech and Language Therapist will be responsible for viewing and analysing the images after the procedure and writing the report.

8.31 The Speech and Language Therapist will record the contact details on their electronic patient record system.

8.32 The treating Speech and Language Therapist will arrange appropriate follow-up for the client.

9. REPORTING PROCEDURE

9.1 The Speech and Language Therapist leading the clinic will log into PACS and analyse and interpret each set of images.

9.2 A detailed report will be written. This will be written in a standard format for consistency (Appendix D). It is the responsibility of the treating therapist during the follow-up session to interpret the report findings and present them to the patient/carer in a way that is meaningful and accessible to them.

9.3 The minimum reporting standards are:

- Client identification.
- Diagnosis and relevant medical history.
- Relevant feeding history.
- Clinical Question (purpose of the videofluoroscopy).
- Views obtained.
- Anatomical features / abnormalities.
- Consistencies evaluated.
- Oral swallowing phase (report by consistency, similar features may be reported in groups, e.g. moderate aspiration on all consistencies).
- Pharyngeal swallowing phase (report by consistency, similar features may be reported in groups, e.g. moderate aspiration on all consistencies).
- Upper oesophageal sphincter function.
- Results of interventions attempted (i.e. manoeuvres / postures).

- Aspiration / penetration (presence of, client response and perceived risk).

- Conclusion / impression (to include severity; salient features; functional implications; hypothesis of possible mechanisms of salient features).

- Recommendations (to include procedures / exercises for swallowing therapy; additional dysphagia management issues, e.g. risk of aspiration in the context of quality of life issues etc; optimum oral intake; Nil By Mouth; management strategies; arrangements for review; other investigations; involvement of other professionals).

- Effectiveness of clearing swallows.

10. TRAINING REQUIREMENTS

10.1 The Trust ensures that all staff are appropriately trained in-line with the organisation's Staff Training Matrix (training needs analysis).

10.2 All Speech and Language Therapists with videofluoroscopy responsibilities have undertaken specialist training in dysphagia management.

10.3 Speech and Language Therapists with videofluoroscopy responsibilities will have evidenced competencies in videofluoroscopy theoretical and clinical knowledge (Appendix E). These will be reviewed annually during the appraisal process.

10.4 Band 6 Specialist Speech and Language Therapists will be supported in the development of videofluoroscopy competences.

11. EQUALITY IMPACT ASSESSMENT

11.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

11.2 Every reasonable adjustment will be made to ensure all patients are treated appropriately.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 Monitoring arrangements for compliance and effectiveness will be carried out by the Adult Speech and Language Therapy Manager.

12.2 Methodology to be used for monitoring:

- Service specific audits.
- Complaints monitoring.
- Incident reporting and monitoring.

Frequency of Monitoring

12.3 The Speech and Language Therapy Service will review the videofluoroscopy service on a yearly basis.

12.4 The Speech and Language Therapy audit results will be reported at the Nutrition Best Practice Group.

12.5 Any recommendations from the Best Practice Group will be reported to the Clinical and Social Care Effectiveness Group.

13. COUNTER FRAUD

13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur, and what action should be taken in such circumstances during the development of this procedural document.

14. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

The standards and outcomes which inform this procedural document are as follows:

Outcome	Section	Subject
1	Respecting and involving people who use services	Information and involvement
2	Consent to care and treatment	Information and Involvement
4	Care and welfare of people who use services	Personalised care, treatment and support
5	Meeting nutritional needs	Personalised care, treatment and support
7	Safety, availability and suitability of equipment	Safeguarding and safety

15. RELEVANT NATIONAL REQUIREMENTS

15.1 It is a requirement of the IR(ME)R 2000 statutory instrument that the employing organisation must establish clear roles and responsibilities for the ‘practitioner’, 10 ITEM 6 ‘operator’ and ‘referrer’. These roles are defined by the IR(ME)R 2000 statutory instrument and are stated in section 4.

15.2 Royal College of Speech and Language Therapists (2007): Videofluoroscopic Evaluation of Oropharyngeal Swallowing Disorders (VFS) in Adults Policy Statement 2007.

16. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

Cichero, J & Murdoch, B (2006) Dysphagia Foundation, Theory and Practice. John Wiley and Sons Ltd.

Feinberg, MJ (1993) Radiographic techniques and interpretation of abnormal swallowing in adults and elderly patients. Dysphagia 8:356-8.

Ku, P.K., Yuen, E.H., Cheung, D.M. *et al.* (2007) Early swallowing problems in a cohort of patients with nasopharyngeal carcinloa: Symptomatology and videofluorscip findings. *Laryngoscope* Vol. 117 pp 142-146.

Rosenbek J.C, Robbins, J.A, Roecker E.B et. Al (1996) A penetration-aspiration scale. Dysphagia 11: 93-8.

Rosenthal, D.I., Lewin, J.S. & Eisbruch, A. (2006) Prevention and treatment of dysphagia and aspiration after chemoradiation for head and neck cancer. *Journal of Clinical Oncology;* Vol 24(17) pp 2636-43.

Royal College of Speech and Language Therapists (2007): Videofluoroscpic Evaluation of Oropharyngeal Swallowing Disorders (VFS) in Adults: The Role of Speech and Language Therapists. Policy Statement 2007. Available [online] @ www.rcslt.org.

The Mental Capacity Act (2005) available: www.legislation.gov.uk/ukpga/**2005**/9/.

Cross Referencing Procedural Documents (Somerset Partnership)

Consent and Capacity to Consent to Treatment Policy and Guidance for Mental Health Staff

Consent to Examination and Treatment Policy- Community Health Directorate.

Dysphagia & Nutritional Support Policy for People Living in the Community (Draft April 2013).

Record Keeping and Records Management Policy.

Untoward Event Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

17. APPENDICES

Appendix A	Internal Videofluoroscopy Referral Information Sheet
Appendix B	Internal Videofluoroscopy Record Information Sheet (non-tick box)
Appendix C	Videofluoroscopy Record Sheet
Appendix D	Videofluoroscopy Report Template
Appendix E	Videofluoroscopy Competencies

Appendix A

Somerset Partnership NHS
NHS Foundation Trust

Adult Speech and Language Therapy Service

INTERNAL VIDEOFLUOROSCOPY INFORMATION SHEET

Name of Patient | **NHS Number**

GP Dr | **Medical Practitioner Informed** Click

Approval From VF Speech & Language Therapist Click | **Infection Risk** Click

Date Of Bedside Assessment | **Client Consent In Notes** Click

Carer To Attend Click | **Treating Speech And Language Therapist To Attend** Click

Allergies / Intolerance To Yoghurt / Banana / Bread Click
On Metformin Click (If Yes ReasonClick)

If YES, Have Alternatives Been Discussed & Patient Advised To Bring With Them? Click

Treating Speech & Language Therapist Name Click

Mobility

☐ Walking ☐ Walking with frame ☐ Hoist dependent
☐ Walking with stick ☐ Wheelchair ☐ Bed bound

Indications For VFS (*please tick as appropriate*)	
☐	To assess physiology of the swallow.
☐	To evaluate integrity of airway protection before, during and after swallowing.
☐	To evaluate effectiveness of postures / manoeuvres / bolus modifications / sensory enhancements / in improving swallowing safety and efficiency.
☐	To provide recommendations regarding the optimum delivery of nutrition and hydration.
☐	To determine appropriate therapeutic techniques.
☐	To obtain information in order to collaborate with and educate other team members / referral sources / care givers / patients regarding recommendations for optimum swallow safety and efficiency.

Summary Of Oro-Motor Assessment

Summary Of Results Of Bedside Swallow Assessment

Relevant Medical History

Relevant Feeding History And Current Feeding Status

Clinical Question/s To Be Addressed During VFS

Specific Textures And Or Strategies / Manoeuvres To Trial In VFS

Textures To Trial		Fluids To Trial	
☐	Texture A - Liquid Diet	☐	Normal
☐	Texture B - Thin Puree	☐	Stage 1 - Syrup Thick
☐	Texture C - Thick Puree	☐	Stage 2 - Custard Thick
☐	Texture D - Pre-Mashed	☐	Stage 3 - Pudding Consistency
☐	Texture E - Fork Mashable		

Techniques To Trial		Postures To Trial	
☐	Supraglottic Swallow	☐	Chin Tuck
☐	Supersupraglottic Swallow	☐	Head Turn To Right
☐	Mendleson Manoeuvre	☐	Head Turn To Left
☐	Effortful Swallow	☐	Head Tilt To Right
☐	Extra Clearance Swallows	☐	Head Tilt To Left
☐	Fluid Flush	☐	Head Tilt Back

Date	

Appendix B

Somerset Partnership NHS
NHS Foundation Trust

Adult Speech and Language Therapy Service

INTERNAL VIDEOFLUOROSCOPY INFORMATION SHEET (non- tick box)

Name of Patient: NHS Number:

GP: Medical Practitioner informed: YES / NO

Approval from VF SLT: YES / NO Infection Risk: YES / NO

Date of Bedside Assessment: Client Consent on Rio: YES / NO

Carer to Attend YES/NO Treating SLT to attend: YES / NO

Allergies / Intolerance to Yogurt / Banana / Bread: YES / NO

If Allergies to above, have alternatives been discussed: YES / NO

On Metformin: YES / NO (if yes, reason……...)

Treating Therapist Name:

Mobility:

Indications for VF

Summary of Oro-Motor Assessment

Summary of Bedside Assessment

Relevant Medical History

Relevant Eating and Drinking History and Current Status

Clinical Questions to be addressed:

Textures to Trial (Food)

Fluids to Trial

Specific Strategies or Manoeuvres to Trial

Date:

VIDEOFLUOROSCOPY RECORD SHEET

Name of Patient	
NHS Number	
Date of Assessment	
Assessor	

Verbal Update from

Client:……
……
……
……
……

CLIENT CONSENT DOCUMENTED: YES / NO

EMERGENCY SUPPORT AVAILABLE: YES / NO

SUCTION WORKING: YES / NO

RADIOGRAPHER UPDATED ON CASE: YES / NO

RADIOLOGIST AVAIALBLE: YES / NO

Rosenbek (1996) Penetration-Aspiration Scale (RPA)

Category	Score	Descriptions
No penetration or aspiration	1	Contrast does not enter the airway
Penetration	2	Contrast enters the airway, remains above vocal folds; no residue
	3	Contrast remains above vocal folds; visible residue remains
	4	Contrast contacts vocal folds; no residue
	5	Contrast contacts vocal folds; visible residue remains

Category	Score	Descriptions
Aspiration	6	Contrast passes glottis; no subglottic residue visible
	7	Contrast passes glottis; visible subglottic residue despite patient's response
	8	Contrast passes glottis ; visible subglottic residue ; absent patient response

Series No	Description (e.g. texture and / or manoeuvre)	Rationale	Narrative Description	RPA Score
1	**Still**			
2				
3				
4				
5				
6				
7				
8				

Category	Score		Descriptions	
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

Category	Score		Descriptions	

Appendix D

Somerset Partnership NHS
NHS Foundation Trust

VIDEOFLUOROSCOPY (VFS) REPORT

Adult Speech and Language Therapy Service, Bracken House, Crewkerne Road, Chard. TA20 1YA. Telephone 01823 617464

Name: **NHS No:** **DOB:**

Address:

Date of Assessment: **Location:** Click

Radiographer: Click **Assessor**: Click
Treating Therapist: Click
Client Consent: Consent given verbally prior to procedure
Others Present:
Contrast Agent: Click **Orientation of images:** Click

Textures trialled:

Fluid consistancy: Thin Liquid ☐ Naturally thick ☐
Syrup Stage 1 ☐ Custard Stage 2 ☐ Pudding Stage 3 ☐

Solid texture: Normal ☐ Mixed Consistency ☐
Thick Puree 'C' ☐ Premashed 'D' ☐ Forkmashable 'E' ☐

Relevant Medical Background

-

Eating and Drinking History

-

Purpose of VFS

- To assess physiology of the swallow
- To evaluate integrity of airway protection before, during and after swallowing
- To evaluate effectiveness of postures / manoeuvres / bolus modifications / sensory enhancements / in improving swallowing safety and efficiency
- To provide recommendations regarding the optimum delivery of nutrition and hydration
- To determine appropriate therapeutic techniques
- To obtain information in order to collaborate with and educate other team members / referral sources / caregivers / patients regarding recommendations for optimum swallow safety and efficiency

Anatomy

-

Summary of Oral Stage Swallowing

- Adequate lip closure
- Adequate initiation of oral phase
- Adequate tongue control of bolus
- Adequate bolus preparation
- Adequate chewing
- Adequate ability to propel bolus orally
- No oral residue after swallowing

Summary of Pharyngeal Stage Swallowing

- Adequate soft palate elevation
- No initiation of the pharyngeal swallow
- Adequate tongue base retraction
- Adequate laryngeal elevation
- Adequate anterior hyoid excursion
- Adequate epiglottic movement
- Adequate laryngeal vestibular closure
- Adequate pharyngeal constriction
- No pharyngeal residue post swallow
- Penetration (penetration / aspiration Scale =)
- No aspiration
- No aspiration observed
- No cough reflex in response to aspiration

Upper Oesophageal Sphincter Function

- Adequate pharyngoesophageal segment opening
- Cricopharyngeal spasm

NB: This report does not include analysis of upper oesophageal function

Results of Manoeuvres/Positions/Strategies

-

Clinical Impression

-

Recommendations

- Normal Fluids
- Stage 1 Fluids (syrup thick)
- Stage 2 Fluids (custard thick)
- Stage 3 Fluids (pudding thick)
- Texture C diet (thick puree)
- Texture D diet (premashed)
- Texture E diet (fork mashable)
- Avoid all high risk foods (hand-out enclosed)
- 2-3 extra clearance swallows after all meals and drinks
- Swallow with chin down
- Small, high calorie portions of oral diet (textures above) as able, with nutritional support from dietician.
- Consideration of enteral feeding if unable to support nutritional requirements orally, or if swallowing becomes too fatiguing
- GP to prescribe Xerotin artificial saliva spray to help with clearance swallows
- GP to prescribe BioXtra moisturising gel to relieve dry mouth at night
- Continue Nil by Mouth with full enteral feeding regime
- For sips of cold water to moisten mouth providing mouth is fresh and clean and free from obvious oral candida
- To discontinue sips of water/oral trials if he/she develops signs of a chest infection (e.g. temperature, green sputum etc)

- High level (hourly) mouthcare
- Review by ENT
- Review by SLT
- Review by Dietitian
- Stringent management of reflux – suggest twice daily high dose PPI half an hour before breakfast and evening meal, in conjunction with an alginate medication (e.g. Gaviscon Advance) last thing at night
- Avoid foods likely to exacerbate reflux symptoms
- Trial steam inhalation to help ease pharyngeal phlegm
- Sipping carbonated water may help to relieve symptoms of thick phlegm in throat
- For follow-up with treating therapist to explain report findings

- Continue with full enteral feeding regime
- Swallowing rehabilitation to continue as an outpatient to monitor progress
-

Signed: .....

Click

Adult Speech and Language Therapist

Dictated but not scrutinised

ccs. Dr D Cooke, Consultant Radiologist, X Ray Dept, Musgrove Park Hospital
GP:
Manager Care Home
Patient
Rio

COMPETENCIES FOR VIDEOFLUOROSCOPY

The competencies are to be used in conjunction with: -

1. Somerset Partnership documents:
   - Videofluoroscopic Evaluation of Oropharyngeal Swallowing Disorders in Adults Policy
   - Assessing Competence in Clinical Practice Policy
   - Infection Control Policy
2. Other documents:
   - Royal College of Speech and Language Therapists:- Videofluoroscopic Evaluation of Oropharyngeal Swallowing function – VFS. The Role of Speech and Language Therapists. RCSLT Position Paper 2013

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners, to ensure safe practice in Videofluoroscopy.

Once the practitioner has reached a satisfactory level of competence following a period of supervised practice, ensure they are formally competency assessed–within three months of completing the initial theoretical/practical training.

The self–rating scale is to be used by the individual practitioner for self assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Only qualified practitioners with an NMC recognised teaching and assessing in practice qualification and who have completed recognised training and assessment in administration of medicines and can be identified as assessors.

<u>Key for Self-Assessment</u>
1 = No knowledge / experience
2 = Some knowledge / experience
3 = Competent
4 = Competent with some experience
5 = Competent, experienced and able to teach others

Author : (INSERT NAME AND TITLE)
Date : (MONTH AND YEAR)
Review : (MONTH AND YEAR to be 3 years from date above)

Assessment of competence for Videofluoroscopy

I confirm that I have self-assessed as competent to practice (insert skill) as below:

Practitioner Name: ……

Practitioner Qualification: ……

Practitioner Signature: …… Date: ……..

I confirm that I have assessed the named practitioner above as competent to perform the above skill.

Name & Title: ……

Signature: …… **Date:** …….

Upon successful completion of your assessment of competency please give a copy to your line manager and send a copy of this page to:

The Training and Development Department,
Somerset Partnership NHS Foundation Trust
Priory Health Park
Glastonbury Road,
Wells
Somerset
BA5 1XL

A record of your competency will be kept on your electronic staff record.

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	1. Read videofluoroscopy clinic protocol	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	2. Read Logemann chapter on VF	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	3. Read Logemanns manual for the Videofluorographic study of swallowing	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	4. Read RCSLT Guidelines on use of Videofluoroscopy	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	5. Understand roles of other professionals: • Meet with Radiographer • Meet with Radiologist	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	6. Knowledge of referral procedure	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	7. Knowledge of booking and transport	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	8. Understanding of radiation used	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	9. Understanding of different contrast agents and rationale for using different ones	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	10. Read relevant Radiology safety procedures re: • Protective Clothing • Patient Protection • Preparation of materials • Disposal of materials • Infection Control	1				
		2				
		3				
		4				
		5				
Stage 1 General (Roles, Polices & Procedures, Radiation, Contrast Agents)	11. Familiarisation with Radiology Suite used for procedure	1				
		2				
		3				
		4				
		5				
Stage 2 Rationale for Procedure	1. Understanding clinical rationale for recommending Videofluoroscopy for a patient	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 2 Rationale for Procedure	2. Understanding and identifying contraindications for VF	1				
		2				
		3				
		4				
		5				
Stage 2 Rationale for Procedure	3. Explaining clinical rationale for videofluoroscopy to MDT	1				
		2				
		3				
		4				
		5				
Stage 2 Rationale for Procedure	4. Explaining rationale for videofluoroscopy to patient	1				
		2				
		3				
		4				
		5				
Stage 2 Rationale for Procedure	5. Understanding rationale for use of therapeutic techniques in VF assessment	1				
		2				
		3				
		4				
		5				
Stage 2 Rationale for Procedure	6. Knowledge of rationale for abandoning procedure	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 3 **Performing Videofluoroscopy**	1. Take personal radiation-recording brooch	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	2. Observe videofluoroscopy procedure	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	3. Order food materials for assessment	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	4. Prepare assessment materials	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 3 **Performing Videofluoroscopy**	5. Explain procedure to patient	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	6. Feed the patient during the procedure	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	7. Instruct the patient	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	8. Instruct the Radiographer	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 3 **Performing Videofluoroscopy**	9. Trial therapeutic techniques during assessment i.e. posture, swallow manoeuvres	1				
		2				
		3				
		4				
		5				
Stage 3 **Performing Videofluoroscopy**	10. Abandon procedure where appropriate	1				
		2				
		3				
		4				
		5				
Stage 4 **Evaluation and interpretation of videofluoroscopy results**	1. View videofluoroscopy assessments	1				
		2				
		3				
		4				
		5				
Stage 4 **Evaluation and interpretation of videofluoroscopy results**	2. Complete rating scale in conjunction with Specialist SLT as part of videofluoroscopy analysis	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 4 **Evaluation and interpretation of videofluoroscopy results**	3. Lead completion of rating scale	1				
		2				
		3				
		4				
		5				
Stage 4 **Evaluation and interpretation of videofluoroscopy results**	4. Make management recommendations	1				
		2				
		3				
		4				
		5				
Stage 5 **Communication of videofluoroscopy assessment results**	1. Write videofluoroscopy report in conjunction with Specialist SLT.	1				
		2				
		3				
		4				
		5				
Stage 5 **Communication of videofluoroscopy assessment results**	2. Write videofluoroscopy report independently	1				
		2				
		3				
		4				
		5				

Competencies for Videofluoroscopy Assessment of Swallowing Function		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
Stage 5 **Communication of videofluoroscopy assessment results**	3. Feedback results of videofluoroscopy to patient	1				
		2				
		3				
		4				
		5				
Stage 5 **Communication of videofluoroscopy assessment results**	4. Feedback results of videofluoroscopy to medical team	1				
		2				
		3				
		4				
		5				
		1				
		2				
		3				
		4				
		5				
		1				
		2				
		3				
		4				
		5				