

Speech-Language Therapy

Guidelines for Competence Required for Independently Working with Clients with Dysphagia and Feeding Issues

1 Aim

This document provides a guide on knowledge and entry-level competencies needed before practising clinicians can work independently with clients with dysphagia. It also provides a guide to the amount of training hours needed in order to achieve independent competency. Clinicians are to obtain the competencies required for a specific client group e.g. paediatrics or adult, before working independently with that caseload, so that he/she has sufficient knowledge, skills and experience to practise safely and effectively. Competency with one of the client groups (i.e. paediatric or adult) does not equate to competency in the other group. Clinicians working with each client group are to receive training for that specified group.

This paper relates to regular and routine clients/cases. It is expected that practising clinicians know how and when to seek help with complex clients/cases of dysphagia beyond the scope of their proficiency.

2 Adult Population

2.1 Working with the Adult Population

Professionals working with the adult population (those aged above 18 years of age) should ensure that the following specific knowledge and competencies are met.

2.1.1 Core Knowledge

- a) Anatomy and physiology of the head and neck
- b) Normal swallow physiology (oral preparatory, oral, pharyngeal and oesophageal phases) and changes throughout the lifespan
- c) Neurology and neurophysiology of swallowing and the coordination of swallowing, respiration and phonation
- d) Congenital and structural abnormalities that may precipitate dysphagia
- e) Acquired neurological conditions that may precipitate dysphagia

- f) Oral motor functioning in relation to speech, feeding and swallowing skills
- g) Atypical and disordered eating, drinking and swallowing patterns
- h) Psychosocial factors related to dysphagia

Specific knowledge and skill-base of the following in relation to assessment, diagnosis and intervention of clients presenting with eating, drinking and swallowing disorders

- a) Professional terminology specific to area of eating, drinking and swallowing disorders/dysphagia
- b) Psychosocial impact of eating, drinking and swallowing disorders/dysphagia on the individual and caregivers
- c) Roles and scope of practice of multidisciplinary team members
- d) Ethical, legal and service influences on decision making
- e) Referral processes and typical clinical pathways
- f) Different aetiologies of dysphagia and implications for management
- g) Key factors to be identified from the case notes and history prior to and during assessment
- h) Commonly used subjective and objective assessments including oral motor examination, assessment of oral preparatory, oral and pharyngeal swallow stages, including trials of food consistencies
- i) Indicators for instrumental assessment e.g. videofluoroscopy, Endoscopic Evaluation of Swallowing (EES)
- j) Differential diagnosis and management intervention processes for clients with swallowing disorders/dysphagia
- k) Needs of clients with complex conditions e.g. people with tracheostomies, those who are ventilator dependent and dysphagia arising from rare conditions
- l) Signs and symptoms of oesophageal dysphagia and to assist in differential diagnosis of dysphagia
- m) Prognostic indicators in common case presentation
- n) Caseload management and service delivery practices
- o) Caregiver and client roles in management plans/intervention programmes

- p) Direct and indirect management programmes including oral motor and sensory treatment programmes, behavioural management, caregiver training and exercises
- q) Management strategies including rehabilitation and compensatory techniques e.g. physical positioning and modifying food and liquid consistencies
- r) More common aspects of alternative, non-oral feeding options e.g. Percutaneous Endoscopic Gastrostomy (PEG), Naso-gastric tubes (NGT)

Competencies Expected in Adult Dysphagia Assessment and Management

2.1.2 Assessment

- a) Independently conduct a comprehensive clinical assessment based on the client's presentation
- b) Conduct a cranial nerve assessment as part of oro-motor examination
- c) Demonstrate ability to interpret physiologic causes for breakdown of swallowing function
- d) Make recommendations on referral for instrumental assessment eg. videofluoroscopy, EES
- e) Determine safety of oral feeding versus the need for alternative feeding
- f) Determine swallowing safety with a variety of food and fluid textures
- g) Consider psychosocial factors related to dysphagia

2.1.3 Management

- a) Be able to understand and recommend management strategies eg. change of diet, compensatory techniques and therapy exercises
- b) Recommend appropriate oral intake method and quantity that is safe for swallowing, and alternative methods of feeding eg. PEG, NGT where appropriate
- c) Contribute to the decision making process regarding risk factors and non-oral feeding
- d) Interpret videofluoroscopic and EES reports and recommend appropriate management and swallowing rehabilitation techniques
- e) Provide feedback to client/referral source regarding status of swallow and feeding recommendations
- f) Determine the need for referrals to other professionals e.g., otolaryngologist, gastroenterologist, dietitians

- g) Liaise with other professionals regarding further assessment/management
- h) Optimise the environment for the client and caregivers during eating and drinking
- i) Advise on aspiration risk management
- j) Provide patient and caregiver training
- k) Provide basic training within the multi-disciplinary team
- l) Participate in a multi-disciplinary team approach

2.1.4 Professional

- a) Adhere to service provider's health, safety and infection control policies and procedures and provide safe care within the scope of practice
- b) Independently manage a caseload of routine dysphagia cases
- c) Prioritise and manage a dysphagia caseload within the context of a larger caseload
- d) Documents all assessment and intervention findings in SOAP format, including diagnosis, recommendations, prognosis and intervention plan
- e) Collaborate and communicate effectively with other healthcare professionals and caregivers in the institution and community to ensure continuity of care

3 Paediatric Population

3.1. Working with the Paediatric Population

Professionals working with paediatric populations (those aged from birth to 18 years old) should ensure that the following specific knowledge and competencies are met.

3.1.1 Core Knowledge

- a) Distinct differences in anatomy and physiology of the swallowing mechanism between infants, young children and adults
- b) Neonatal neuroanatomy, anatomy, physiology, brain development, neuromotor and fetal reflex development, developmental acquisition of infant motor behaviours
- c) Developmental milestones for feeding and swallowing and communication in the infant, young child and adolescent.

- d) Normal swallowing physiology (oral preparatory, oral, pharyngeal and oesophageal phases) and developmental differences
- e) Neurology and biomechanics of swallowing and the coordination of swallowing, respiration and phonation
- f) Differences in the normal ranges of vital stats for neonatal and paediatric patients compared to adult patients (e.g. heart rate, respiratory rate)
- g) Immature and abnormal feeding patterns due to prematurity or global developmental delays that may precipitate dysphagia
- h) Basic knowledge of breastfeeding (e.g. techniques and positioning, timings, how to determine if the child has sufficient intake for adequate growth etc.)
- i) Congenital and structural abnormalities (e.g. craniofacial anomalies, left palates, oesophageal strictures or stenosis) that may precipitate dysphagia
- j) Congenital neurological conditions (e.g. cerebral palsy, muscular dystrophies, Down syndrome) that may precipitate dysphagia
- k) Acquired neurological conditions (e.g. traumatic brain injury or encephalitis) that may precipitate dysphagia
- l) Behavioural issues (e.g. psychosocial difficulties, negative feeding behaviours shaped and maintained by internal or external reinforcements, emotionally based difficulties) that may precipitate feeding difficulties
- m) Oral motor functioning in relation to speech, feeding and swallowing skills
- n) Atypical and disordered feeding, eating, drinking and swallowing patterns
- o) Gastrointestinal issues (e.g. reflux, tracheoesophageal fistula) that may negatively impact emotional developmental milestones important for feeding and swallowing.
- p) Sensory impairment that may negatively impact feeding and swallowing
- q) Impact of feeding and swallowing on adequate nutrition / hydration and growth that is appropriate for child
- r) Drooling and secretion management
- s) Basic knowledge of appropriate and adequate nutrition for children of various ages

Competencies Expected in Paediatric Dysphagia and Feeding Assessment and Management

3.1.2. Assessment

- a) Integrate pertinent information from case notes and case history taking, prior to and during assessment and identifies aetiology for dysphagia and implications for management
- b) Independently conduct a comprehensive clinical assessment depending on the client's presentation. This may include, oro-motor examination, non-nutritive sucking assessment, postural assessment, monitor vital statistics and assess for oral and facial hypersensitivity
- c) Assess and accurately identify normal or abnormal oral preparatory, oral and pharyngeal phases of swallowing through bedside evaluation
- d) Assess and accurately identify physical, sensory and behavioural factors that may impact on feeding.
- e) Assess and accurately identify normal or immature suck: swallow: breathe coordination of neonates and infants, through bedside evaluation
- f) Accurately identifies and responds to signs of distress and signs of aspiration in the child during feeding
- g) Demonstrate ability to interpret physiologic causes for swallowing breakdown, or suck:swallow:breathe incoordination
- h) Interprets, integrates and synthesizes observations during assessment and case history information to develop an appropriate diagnosis and prognosis for oral feeding
- i) Makes recommendations for instrumental assessment eg. videofluoroscopy or Endoscopic Examination of Swallowing (EES).
- j) Determine safety of oral feeding versus alternative feeding
- k) Determine swallowing safety with a variety of food and fluid textures
- l) Make recommendations for onward referral to other multidisciplinary team members for interdisciplinary assessment of feeding and swallowing (e.g. Occupational Therapist for positioning or sensory issues, Dietitian for nutritional intake)

3.1.3. Management

- a) Provide intervention strategies for oro-motor difficulties, sensory and behavioural difficulties including change of diet (e.g. types of food appropriate for weaning, chewing), compensatory techniques (e.g. pacing during bottling for neonates and infants) and therapy exercises
- b) Recommend appropriate oral intake method (e.g. type of teat, cup drinking, straw drinking), quantity, frequency and length of feeding that is safe for swallowing
- c) Recommend alternative methods of feeding eg. PEG or NGT where appropriate
- d) Recommend an appropriate feeding plan (e.g. texture, taste, environmental) for children with sensory or behavioural difficulties.
- e) Provide age-appropriate and adequate motivational or behavioural procedures and cueing during intervention
- f) Contribute to the decision making process regarding aspiration risk factors and non-oral feeding
- g) Interpret videofluoroscopic and EES reports and recommend appropriate management
- h) Provide feedback to client/referral source regarding status of swallow and feeding recommendations
- i) Liaise with other professionals regarding assessment/management
- j) Optimise the environment for the client and caregivers in relation to eating and drinking
- k) Advise on aspiration risk management
- l) Ensure adequate patient and caregiver training for safe swallowing
- m) Provide basic training within the multidisciplinary team
- n) Participate in a multi-disciplinary team approach (e.g. medical team, dietitians, occupational therapists, nurses, teachers) for feeding

3.1.4. Planning, Maintaining and Delivery of Services

- a) Adhere to service provider's health, safety and infection control policies and procedures and provide safe care within the scope of practice
- b) Independently manage a caseload of routine feeding cases

- c) Prioritise and manage a paediatric caseload with feeding issues within the context of a larger caseload
- d) Documents all assessment and intervention findings in SOAP format, including diagnosis, recommendations, prognosis and intervention plan
- e) Collaborates and communicates effectively with other healthcare professionals and caregivers, in the institution and community to ensure continuity of care

4 Training and Supervision Requirements

4.1. Adult population

- a) Minimum 160 hrs of client related activities with supervision to be completed within 4 months. Depending on the individual's caseload and working schedule, the training period can be extended up to 6 months.
- b) 70% of the training time involves on the job training, which will require direct patient contact. Patient contact during this period should be under supervision.
- c) 30% of the training time may be dysphagia related but not limited to patient specific activity e.g. literature search, case conferences, documentation, dysphagia related workshops. This also includes minimum 8 hrs of observation
- d) Supervisors should have a minimum of 3 years of clinical experience in the area of dysphagia, working with the adult population (2 years independent clinical practice experience)
- e) Audit of all cases is required by supervisors during the 160 hrs of supervised practice
- f) Thereafter (after completion of 160 training hrs) 6-monthly peer-review/clinical audits should be carried out
- g) Training logs* should be maintained during this period with the following information clearly documented for all cases seen during the training period:
 - o Date of assessment/review
 - o Patient's name and identification no.
 - o Supervisor's name and signature

**(This document is to be kept confidential as it contains patient information and will serve only for record purposes.)*

4.2. Paediatric population

For professionals **without** prior experience in the adult settings:

- a) Minimum 240 hrs of client related activities with supervision to be completed within 4 months. Depending on the individual's caseload and working schedule, the training period can be extended up to 1 year
- b) 70% of the training time involves on the job training which will require direct patient contact. Patient contact during this period should be under supervision
- c) 30% of the training time may be dysphagia related but not limited to patient specific activity e.g. literature search, case conferences, documentation, dysphagia related workshops. This also includes minimum 8 hrs of observation
- d) Supervisors should have a minimum of 3 years of clinical experience in the area of dysphagia, working with the paediatric population (2 years independent clinical practice experience)
- e) Audit of all cases is required by supervisors during the 240 hrs of supervised practice
- f) Thereafter (after completion of 240 training hrs), 6-monthly peer-review/clinical audits should be carried out
- g) Training logs* should be maintained during this period with the following information clearly documented for all cases seen during the training period:
 - o Date of assessment/review
 - o Patient's name and identification no.
 - o Supervisor's name and signature

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For professionals **with** prior experience in adult dysphagia, supervision for paediatric and/or neonatal feeding cases is highly recommended and should meet with the following requirements:

- a) Minimum 80 hrs of client related activities under supervision. Suggested time frame to achieve this is within 4 months. Depending on the individual's caseload and working schedule, the training period can be extended up to 8 months.
- b) 70% of the training time involves on the job training which will require direct patient contact. Patient contact during this period should be under supervision.

- c) 30% of the training time may be dysphagia related but not limited to patient specific activity e.g. literature search, case conferences, documentation, dysphagia related workshops. This also includes minimum 8 hrs of observation.
- d) Supervisors should have a minimum of 3 years of clinical experience in the area of dysphagia, working with the paediatric population (2 years independent clinical practice experience)
- e) Audit of all cases is required by supervisors during the 80 hours of supervised practice
- f) Thereafter (after completion of 80 training hrs), 6-monthly peer-review/clinical audits should be carried out
- g) Training logs* should be maintained during this period with the following information clearly documented for all cases seen during the training period:
 - o Date of assessment/review
 - o Patient's name and identification no.
 - o Supervisor's name and signature

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4.3. Supervision can include but is not limited to

1. Direct observation of a clinical intervention or assessment
2. One-to-one case discussion or case audit discussions
3. One-to-one performance feedback discussion
4. Case presentation of selected cases in the presence of the supervisor, with feedback/input from the supervisor

References

1. Competence required for Working with Patients with Dysphagia, Speech Pathology Australia ABN 17 008 393 440
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3. American Speech-Language-Hearing Association. (2001). Roles of Speech-Language Pathologists in Swallowing and Feeding Disorders: Technical Report. Available from www.asha.org/policy.