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HANDOUT-ABLE: NPO has been Recommended due to Dysphagia, What Does This Mean, and What Now?

Typically, if a patient has been recommended to be placed on NPO status (nothing by mouth) due to swallowing concerns, instrumental testing has been conducted, such as a video swallow assessment (also called a modified barium swallow study or videofluoroscopy) or FEES (fiber optic endoscopic evaluation of swallow) that shows evidence of aspiration, and swallows have been deemed not safe at this time. In some cases, this may be recommended at a bedside swallow evaluation, but this is typically rare occurs -- and only in the case of unusual mitigating circumstances.

When patients and families are faced with this information, there are typically a lot of questions, because decisions have to be made in how to proceed medically. There is a lot of information to consider. The purpose of this resource is to inform patients and families when “NPO” due to dysphagia is used. The sections include:

- explanation of the term “NPO”;
- explanation of the term “alternative means of feeding”;
- medical implications are involved in the recommendation for alternative means of feeding;
- options for swallowing treatment if the patient is recommended to be NPO;
- how alternative means of feeding as an intervention can assist with recovering from dysphagia;
- positive considerations and significant drawbacks of alternative means of feeding;
- drawbacks in choosing alternative means of feeding and following NPO guidelines when it has been recommended:
- positive effects and negative considerations of not following an NPO recommendation by a speech pathologist;
- questions to ask the provider and speech pathologist when NPO is recommended;
- options for patients and families regarding the traditional medical model option, the hospice model option and the palliative model option;

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- how a swallowing problem is typically managed in a hospice/palliative care settings vs, a traditional medical model, and,
- other considerations.

Explanation of the term “NPO”

NPO stands for “nil-per-os,” which is another way to communicate “nothing by mouth.” Some people are placed on NPO status temporarily before surgeries or as part of some sort of treatment or testing, but these tend to be very short-lived, perhaps only part of a day or one night. When a patient does not perform well on instrumental testing, and NPO is recommended, this type of swallowing status change can last weeks, months, or even years — depending upon how the patient responds to speech pathology swallowing treatment. One major factor in this involves if alternative meals of feeding are pursued to allow for nutrition for healing/strengthening in therapy. NPO status beyond a day or night in preparing for a test or surgery is categorically a different statement and in a longer context -- as compared to a swallowing recommending of NPO. Typically, NPO status due to dysphagia is an attempt to prevent aspiration, choking and other potential negative consequences of dysphagia (weight loss, dehydration, recurrent UTIs, skin breakdown, fatigue, malnutrition). If a speech pathologist recommends NPO for a patient after speech pathology swallowing testing (and the patient/family agrees to alternative means of feeding), the expectation is that the patient remains NPO until a repeat test occurs to lift the restriction due to improvements/passing of consistencies that can be presented orally.

For a patient that performs on speech pathology instrumental testing at the level of difficulty to the extent that NPO is recommended, typically all strategies, consistencies, etc., have been attempted and were not successful in allowing for the clearance of the status of safe oral intake. In instrumental testing, techniques are attempted, such as (but are not limited to) use of chin tucks, smaller bites/sips, placing food in one side of the mouth, head turns, different postural changes, effortful swallows, etc. When NPO is recommended after swallowing testing, it has been deemed that at this point in the patient’s medical course that it is unsafe to swallow any intake orally. After treatment occurs (which could take weeks or months, typically) repeat instrumental testing can occur to allow for consideration of a change to an oral status for swallowing. It is important that the patient and family understand that until instrumental testing by a speech pathologist is re-conducted, that the recommendation remains, even if the patient feels he or she would pass but decide to not to testing. Speech pathologists make recommendations on swallowing to MDs, who then create physician orders on NPO status, or diet/liquid consistencies. Physicians tend to respect and seriously consider the recommendations of speech pathologists as part of the patient’s overall medical care team.

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Explanation of the term “alternative means of feeding”

When providers and other clinicians mention “alternative means of feeding,” they are primarily referring to peg-tubes or j-tubes, which are feeding tubes that are inserted during a surgery that is typically performed under general anesthesia. Peg tubes are the primary option for patients, but j tubes also are an option if a feeding tube needs to occur higher in the GI tract, due to other medical reasons. These are tubes that allow for the administration of a feeding formula, much like a health shake, direct access into the stomach or GI tract for access, bypassing the traditional method of swallowing orally. This intervention allows for the attempt at halting of the cycle of swallowing problems causing weakness, then weakness causing more swallowing problems, and more swallowing problems causing other medical complications – which can result in a ripple effect on the patient’s health. Alternative means of feeding can also refer to a more temporary feeding tube in the nasal passage, also called a naso-gastric (NG) tube, which does not require surgery but the placement of the tube through the nose into the stomach, and then a follow-up an x-ray to ensure proper placement into the esophagus (leading to the stomach) and not into the lungs. A rarer source of alternative meals of feeding that is less permanent than a feeding tube is TPN (Total Parenteral Nutrition, which allows for a PICC (peripherally inserted central catheter) line to provide nutrition through the patient’s veins. This access bypasses the GI tract altogether and may be an option for patients that cannot or choose not to pursue a feeding tube (this is a rare procedure for a swallowing deficit only), but is typically not chosen as an alternative means of feeding option.

Medical implications are involved in the recommendation for alternative means of feeding

When a patient consents to alternative means of feeding due to recommended NPO status, the expectation is that the patient will receive nutrition via this alternative route until repeat instrumental swallowing testing shows the patient is safe to swallow again. For some patients, not having the ability to orally eat or drink is undesirable to the extent that they decide to not pursue this route. In this case, there is chance that the potential negative medical consequences that accompany aspiration will present themselves. In some patients, over time, these symptoms will present themselves more intensely over time. For patients that do consent to alternative means of feeding, there are different types of feeding schedules and methods for the person with a feeding tube. There is a continuous feed, which means the patient is receiving a slow-drip of the feeding solution and will require to be hooked up to a machine. There is also a bolus feeding, which is where a caregiver pours in the solution at recommended times of the day, which is less restrictive since the hookup to a machine would not be continuously required. There is also feeding tube care and cleaning that would need to occur for feeding tube use. A feeding tube is inserted via a surgical procedure -- but could be removed if it is no longer needed. Some primary care physicians make the decision independently regarding if the tube is ready to be removed, if the patient is back to oral status. Other primary care physicians tend to contact the

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surgeon who conducted the surgery – and confer regarding this decision. Some physicians require a six-month period of only needing to flush the tube (no tube feeding formula or medication via the tube) as evidence that it is time to remove the tube prior to performing the office procedure to remove the tube. It also should be noted that patients sometimes receive alternative means of feeding not related to safety of swallowing — due to an oral aversion, poor oral intake, or other factors, etc. It should be noted that feeding tube presences, if a peg or j-tube, may or may not be a permanent part of the patient’s ongoing medical care. Once improvements are made and there is not a need for a feeding tube, it is up to the doctor to consider.

Options for swallowing treatment if the patient is recommended to be NPO

Treatment options range from oral motor exercises, laryngeal strengthening exercises, Vitalstim/neuromuscular-electro-stimulation treatments. On rarer occasions, thermal stimulation or deep pharyngeal neuromuscular stimulation (DPNDS) may be utilized. For some NPO patients, placing frozen lemon glycerin swabs orally are helpful to assist with addressing the desire to eat/drink and help patients tolerate the fact they are not safe to eat and drink as before. The theory is that glycerin evaporates, so this is a safe product to use in the event of the patient aspirating on the saliva produced with it. It is important to maintain good NPO oral care at this time to avoid bacteria from growing in the mouth, as this could lead to lung bacteria growth when the patient will swallow saliva.

How alternative means of feeding as an intervention can assist with recovering from dysphagia

The aspects of swallowing recovery are complex, but one very important aspect is building up strength in muscles that have atrophied that contribute to the dysfunction of the swallow. For re-strengthening of the swallow, the patient will need adequate nutrition and hydration so for treatments to work to the full capacity that is possible. Alternative means of feeding are the intervention that provides 100% of the nutrition and hydration, if feedings are administered correctly, so this will mean that the exercises and other treatments that will build muscle have the full capacity for strengthening. This occurs in patients who demonstrate good absorption, stomach-wise. Without this nutrition and hydration via alternative access, the patient may not have the full benefit of nutrition in order to build muscles back up to a level that allows for a safe swallow.

Factors that could be considered positive and negative considerations of alternative means of feeding

—Positives in choosing alternative means of feeding and following NPO guidelines when it has been recommended:

- 100% of nutrition and hydration needs should be met (patients should follow-up with a dietician this if this not the case for further recommendations in feeding solutions, and different methods of using alternative means of feeding)

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- Because all nutrition/hydration needs are met, the patient has the nutritional building-blocks for allowing for speech treatment progress, as much as it is possible. There is potential for improvements in the swallowing function. Adequate nutrition and hydration is required for the full benefit of dysphagia treatment by an SLP.
- Other treatments like physical therapy and occupational therapy have the best chance of the most potential outcomes due to all nutrition that is needed to build muscle will be available to the patient.
- There are opportunities to managing oral cravings, such as using frozen lemon glycerin swabs
- There is a chance that the alternative meals of feeding can be halted when it is no longer necessary
- There exists an easy access process to adding-in additional water if the patient requires it.

—Drawbacks in choosing alternative means of feeding and following NPO guidelines when it has been recommended:

- For some, the tubing is restricting and depending upon the method of alternative means of feeding and the setting, it can be isolating
- Patient's miss out on the social aspect of eating
- There is still a risk of aspirating on saliva or refluxed feeding solution (risk of medical effects from this can be avoided with good NPO oral care and medical management of GERD). This factor is significant enough for patients to decide to not pursue alternative means of feeding.
- Placement of a feeding tube requires outpatient or inpatient surgery
- There is a risk of infection at the feeding tube site, but it can be avoided with good feeding tube care

Factors that could be considered positive and negative consideration of not following an NPO recommendation by a speech pathologist

—Positives of continuing to eat when NPO has been recommended:

- Patient's will then not need to modify their lifestyle due to swallowing problems. They would enjoy eating and drinking what they desire for quality of life
- There are palliative care programs and hospice programs to provide support as negative medical consequences arise from the continuous aspiration
- Families will less likely experience the feelings of guilt at holidays and meals, knowing their loved one isn't able to eat. This can be a significant factor in some families.
- Quality of life can be the focus

—Drawbacks of continuing to eat when NPO has been recommended:

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- There are likely negative medical consequences that accompany aspiration: such as aspiration pneumonia, other upper respiratory infections, dehydration, malnutrition, weight loss, loss of energy/fatigue, recurrent urinary tract infections, skin breakdown, etc. When aspiration pneumonia diagnoses occur, and the patient continues to eat and drink when it has been recommended that NPO status be maintained, if aspiration pneumonia occurs -- each time the aspiration pneumonia occurs, it will be more difficult to treat, and eventually, many persons with recurrent aspiration pneumonia diagnoses pass away.
- The protein and other nutrients that are necessary for building muscle will likely not be available, as alternative meals of feeding has been recommended as alternative access because of the disordered swallow.
- If a patient and family members choose to not pursue alternative meals of feeding when NPO has been recommended due to a swallowing problem — and if hospice or palliative care is not consented to — this is an “in limbo” position for the patient. This is because the medical model would not be pursued for rehabilitating the swallow, and at the same time, quality of life/hospice care is not being pursued due to this not being the focus in the care. Neither benefits of each model can fully be attained. If a family denies hospice or palliative care in this case, the specialized care is not available to prepare the family and patient for end-of-life issues to the full extent that is available with hospice or palliative care.
- Modifications of food or using techniques have likely proven to not be effective in preventing aspiration, so attempts at reducing the aspiration may not be an option that would reduce aspiration.
- If a patient experiences silent aspiration (there are no outward signs that aspiration is occurring to observers – no coughing, choking, throat clears, etc.) , it may appear to the family or other caregivers that the swallow is intact — which can be confusing. Confirmation of silent aspiration can only be determined via instrumental testing, and only so many instances of instrumental testing can occur each year for safety. Video swallow assessments involve radiation exposure, although lead protection is provided. FEES tests do not put the patient at risk for being exposed to radiation.

Questions to ask the provider and speech pathologist when NPO is recommended

- “What are his risk factors for having difficulties with the feeding tube?”
- “If the feeding tube is pursued, and based on the treatment you are recommending, what would be the likely time frame range for when you would like to repeat instrumental testing, so we can see if he/she is cleared to eat again?”
- “What resources do you have to help me understand the swallowing problem?”
- “What can we do outside of speech treatment sessions to help make improvements?”
- “What is the most significant part of the follow that isn’t functioning correctly?”
- “Can you show me how to perform NPO oral care?”
- “What tips can you suggest that will help him/her tolerate not being able to swallow food or liquid?”

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Questions to ask the provider and speech pathologist when NPO is recommended that will vary based upon the diagnosis that caused the swallowing problem:

- “If a feeding tube is placed, what is the prognosis for improvements in the swallow?”
- “If a feeding tube is not placed, what is the prognosis for improvements in the swallow?” (The answer will depend upon the diagnosis that caused the swallowing problem)
- What are the options for speech treatment if we decide to not pursue a feeding tube?”
- “What are the options for speech treatment if we decided to pursue a feeding tube?”

Options for patients and families regarding hospice

For patients and families that decide against alternative means of feeding for any reason, be it an advanced directive that includes the indication to not pursue alternative means of feeding, due to the medical risk factors which exist with feeding tubes, or any other factors --- some patients and families may opt to consider palliative or hospice services. To fully discuss this, it is beneficial to delineate the difference between the different service delivery models:

- Traditional medical model option = the aim is to rehabilitate and or restore function that has declined due to a medical event. It is about rehab, exercises, compensatory strategies, practice of helpful tips to improve function. It is about treatment in the attempt to improve the deficit areas. All medical procedures, treatments, strategies, medications, and interventions are pursued that are indicated.
- Hospice model option = This is an entirely different service delivery model. Hospice is a care model involved in an agency providing care that focuses on quality of life, control of pain or other uncomfortable symptoms, support for the patient and family for what is come as the progression of the condition continues, leading ultimately to passing away. It is about not treating the conditions to make improvements, but to allow for the time that remains to be meaningful, in focusing on comfort and the achievement of the goals the patient has in improving the quality of life in the time remaining. Typically, hospice is provided in the comfort of the patient’s home and nurses, hospice nursing assistants that provide bathing, chaplains, social workers, counselors other providers come into the patient’s home and the patient and the patient’s family and loved ones all receive support for the challenges that come with the progression of a condition and preparations for what is to come. There are also in-patient hospice models that are an option. There are specific guidelines that have to be met for a person to qualify for hospice services in terms of specific diagnoses, level of functioning with the specific diagnoses, response to standardized tests to meet hospice criteria for certain conditions, and the expectation that the progression of the condition that qualifies them for hospice

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will lead to the passing away of the patient in a certain timeframe. Hospice nurses have experience and training in the passing-away process and what specialized care is needed for patients and families in different stages of hospice.

- Palliative care model option = sometimes deemed “hospice-light,” palliative care also focuses on comfort, pain symptom control and focusing on quality of life – but the guidelines for palliative care are more open than that of hospice. Palliative care typically is delivered on an outpatient basis, and the timelines for the anticipated course of time left is more flexible.

How a swallowing problem is typically managed in a hospice/palliative care settings vs, a traditional medical model

In the medical model, treatment for dysphagia is structured in terms of once a day in a skilled nursing setting or hospital setting, or once or 1-3 times a week for home care or outpatient models. Because the focus is on improving the swallow to the prior level of function that existed prior the medical event for the patient, the visits are often and follow a course of time. Dysphagia treatment in the hospice and palliative care settings typically are limited in number, perhaps just an evaluation and one or two visits (if that) in order to focus on achieving the goals of the patient for comfort, and for strategies to allow for desired consistencies of the patient. Some hospice and palliative care programs do not have speech pathologists available in any capacity, but some do for consults perhaps just for an evaluation/or an evaluation plus one treatment or two. Treatment of dysphagia in a hospice or palliative setting is very limited and rare. If the focus for care is to rehabilitate the function of the swallow, then the medical model would be the option that would need to be considered, which would involve alternative means of feeding. If the objective for care is to not treat the condition -- but allow for comfort of the patient and to allow the patient to consume whatever consistencies or food they desire (regardless of the outcomes health-wise) then hospice or palliative care would be the service delivery model that would be indicated.

Other considerations

Hearing “NPO” can be frightening to patients and families. In having this information available, then the choice based on all of the options will aid in moving into the direction that is desired by the patient and family. Hopefully, this resource provided that information, so the next step can be identified.