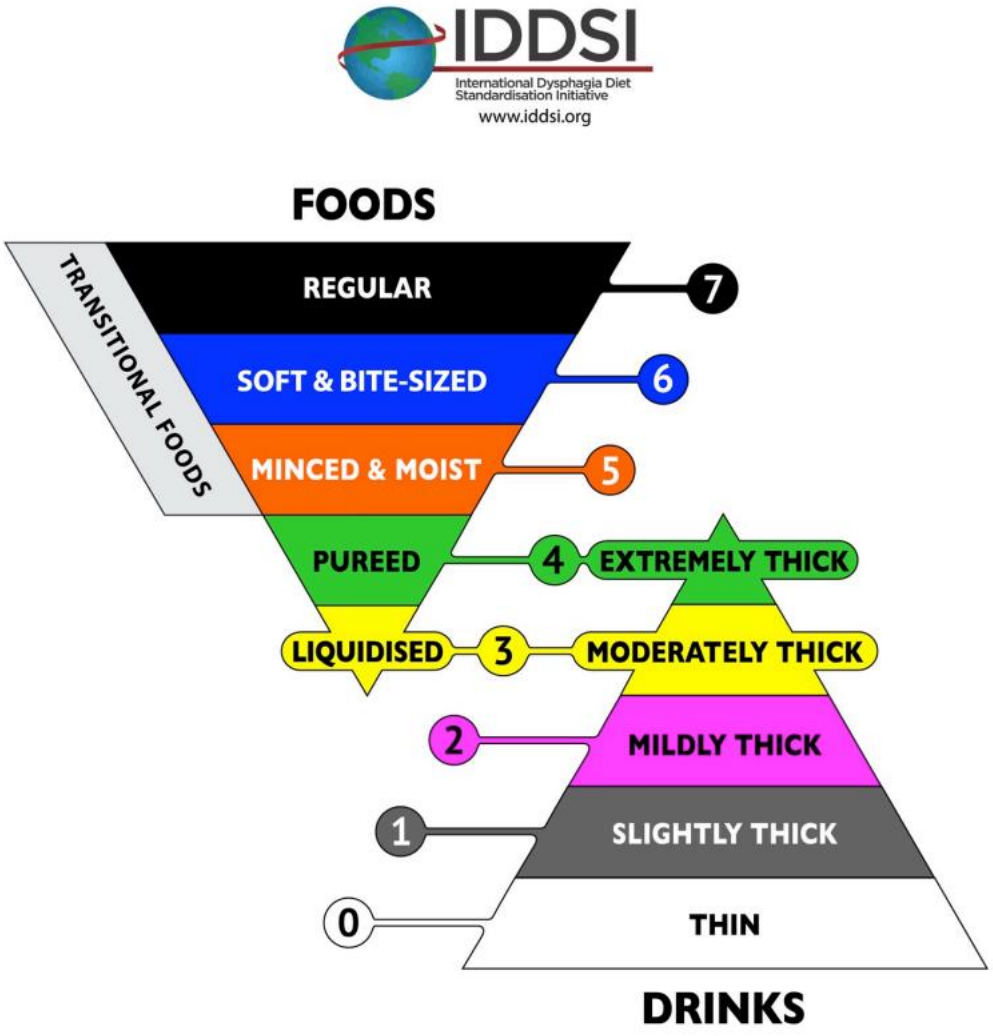
# Resources to support safer modification of food and drink – additional information for community pharmacy

## Background

NHS improvement, the British Dietetic Association and the Royal College of Speech and Language therapists have issued a Patient Safety Alert regarding the use of food thickening (or texture modifying) products for people with swallowing difficulties (dysphagia)[1]. There have been a number of incidents reported to the National Reporting and Learning System (NRLS) in England where patients have come to harm as a result of people misunderstanding the imprecise term 'soft diet', which has been broadly used for patients with or without dysphagia.

As a result, manufacturers have been directed to align their product administration instructions to a standardised framework developed by the International Dysphagia Diet Standardisation Initiative[2] (IDDSI). The aim is to standardise terminologies across food thickening products globally to reduce the risks associated with local interpretations of consistency descriptors. The IDDSI has adopted a numbered system to describe the desired consistency, as shown in the framework below:




[1] **NHS Improvement** Resource Alert: Resources to support safer modification of food and drink (June 2018) https://improvement.nhs.uk/news-alerts/safer-modification-of-food-and-fluid/

[2] **International Dysphagia Diet Standardisation Initiative** Framework (November 2015) http://iddsi.org/framework/

## Practical considerations: community pharmacy

Over the coming months manufacturers will be introducing new products and packaging. Community pharmacists and their teams should use appropriate resources when dispensing modified diet products (e.g. thickening powder) to help patients and their carers understand the changes to terminology.

The following points could be considered:

- Counsel patients and/or their carers that the directions and scoop sizes may have changed, and direct them to read the label to ensure they understand the changes as the number of scoops needed may have changed.
- Rotate stock to ensure products with the old directions are supplied first to avoid patient confusion. There is a potential for both old and new products to remain within the supply chain therefore always check stock when received from wholesalers. If products with the old directions are received ensure patients are counselled appropriately.
- Patients should be counselled to ensure they only use the scoop supplied with their specific product and discard any previously supplied scoops as the sizes and graduations are changing.
- Contact key healthcare partners, who may use these products, including care facilities or nursing homes to ensure their staff have been made aware of this alert.
- Advise patients or carers to contact their specialist for advice if they have any queries about the use of the product.
- Be mindful of the patient safety alert issued in 2015[3] which advised of the need to ensure these products were kept out of reach of vulnerable people to prevent the risk of asphyxiation by swallowing this medication inappropriately.

[3] **NHS England** Patient Safety Alert: Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder (February 2015) https://www.england.nhs.uk/wp-content/uploads/2015/02/psa-thickening-agents.pdf