NHS Greater Glasgow & Clyde

Food Fluid and Nutritional Care Planning and Implementation Group (PIG)

Policy: Management of People with Swallowing Difficulties as a result of Oro-pharyngeal Dysphagia NHS Greater Glasgow and Clyde (NHSGGC)

Prepared by:	Representatives of the Acute and Partnerships Food Fluid and Nutrition Operational Groups.
Lead Manager:	Jan Stanier, Lead Speech & Language Therapist South Sector (Formerly led by Catherine Dunnet : CSM, Speech and Language Therapy)
Responsible Director:	Fiona Smith
Approved by:	NHS GGC Board Clinical Governance Group
Date Approved:	12/4/21
Date for Review:	1/2/23
Amendment	Amendment vs 4.0 7/11/19

Contents

Introduction

NHS Greater Glasgow and Clyde recognises the need to identify and appropriately manage people with oro-pharyngeal dysphagia. This policy is intended to improve shared understanding of this caseload and the associated risks and management required. The policy aims to clarify assessment and management approaches across all ages and settings.

Oropharyngeal Dysphagia - Definition

Oro-pharyngeal dysphagia is the term used to describe a swallowing disorder arising as a result of impairment in the oral and pharyngeal stages of the swallowing process. Impairment at this level can result in a number of increased risks including the risk of aspiration of food and or fluids into the airway, obstruction and pharyngeal residue. These factors may increase the risk of aspiration pneumonia and may also impact on recovery and wellbeing. In some cases oro-pharyngeal dysphagia can be life-threatening.

Scope

This policy concerns oro-pharyngeal dysphagia only. Oesophageal swallowing disorders are not part of the scope of this policy. The policy applies to all ages and settings. It aligns with Food, Fluid and Nutritional Care Standards (HIS 2014), National Catering and Nutrition Specification (2008) and Complex Nutrition Standards (2015)

Aims

This policy and the associated standard operating procedures (SOPs) aim to ensure a consistent, standardised approach to the assessment and management of oro-pharyngeal dysphagia across NHS Greater Glasgow and Clyde. The intention is to promote holistic, person centred and individualised care where risk is considered equally in terms of both medical management and wellbeing.

Assessment

Nursing staff/Care staff and relevant others will:

- Ensure all possible measures are taken to identify any existing or suspected oro-pharyngeal dysphagia as early as possible.
- Review all available information and records promptly and identify any previous or existing information regarding oro-pharyngeal swallowing status.
- Conduct discussions as a priority with the person or their proxy to establish any reported history of oro-pharyngeal dysphagia.
- Complete appropriate screening assessments suitable to the setting and fully document and act upon the outcome.
- Consider the risk of malnutrition and complete appropriate assessments according to the setting.
- Appropriately communicate all findings to relevant people promptly.
- Ensure that capacity and consent issues have been considered throughout the care pathway.

Speech & Language Therapy (SLT) will:

- Review all available information and speak to relevant people (as available and according to the setting) prior to conducting an assessment
- Complete a full assessment of the oro-pharyngeal swallowing mechanism including an assessment of oro-motor functioning, assessing function across an appropriate range of food/ fluid consistencies and trialling swallowing strategies or further approaches to minimise risk as indicated.

- Include a full consideration of the wider context (including onset, static or changing status, co-morbidities, fatigue, general condition, behavioural issues, Mental Health, posture, medication etc).
- Aim to determine the suspected cause, nature and severity, of oro-pharyngeal dysphagia and the estimated level of risk.
- Consider ethical and legal factors including capacity and consent, guardianship and power of attorney as appropriate as part of multi-disciplinary team discussions (MDT).
- Make recommendations regarding which diet/fluid management strategies are suggested in order to attempt to manage the risk as effectively as possible.
- Discuss and agree a management plan as part of the MDT acknowledging risks and burdens as appropriate.
- Provide written advice regarding the outcome of the assessment and any recommendations
- Recommend further investigation as indicated including SLT video-fluoroscopy radiological assessment or onward referral to other specialist services as indicated.

Wider considerations

Physical and psychosocial impact.

In cases where additional support is required to help maintain maximum quality of life, mental health and wellbeing, referral to specialist services such as psychology or palliative care teams should be considered. Referral to other specialist members of the MDT eg OT, Dietetics, PT should be considered as indicated.

Management

Education and training

Staff and those assisting patients at mealtimes should have appropriate training to ensure their competence to fulfil the required role with regard to the management of people with dysphagia. (Supervision, accountability and delegation of activities to support workers. (2006))

Nursing staff/Carers/others will:

- Check for recommendations prior to offering food or drinks
- Follow recommendations as indicated
- Discuss any issues promptly with the person concerned and the wider team
- Ensure that any documentation remains with the person during transitions or movement across all care settings.
- Alert SLT or the wider team to any changes

Speech & Language Therapy (SLT)

Will recommend one, or a combination of, the following: (Advice and recommendations will be provided in the most appropriate and accessible manner to maximise understanding of the rationale and opportunity for discussion).

Safer Swallow Strategies

Postural modification (e.g.head position)

Presentation changes,(e.g. placing food towards the back of the mouth)

Swallow technique – (eg swallowing in a specific way)

Seating changes (e.g.help to maintain an upright position)

Environmental modification, (e.g. reducing distractions)

Supervision requirements at mealtimes (e.g trained staff required)

What to look for (eg signs and symptoms of aspiration)

What to do (eg advice if symptoms exacerbate)

How to manage issues (e.g. choking episodes)

When to discuss alternative options

Texture Modified Diet and/or Thickened Fluid recommendations

The least modified option will always be the aim. Recommendations will seek to align to IDDSI terminology as appropriate (International Dypshagia Diet Standardisation Initiative) (Appendix)

Eating and Drinking with accepted risk - (GGC guideline currently in development)

When to consider - oro-pharyngeal dysphagia that is neither transient nor treatable alternative feeding options are either declined, inappropriate or in place alongside oral intake.

What to consider - prognosis, capacity, consent, advance directives, quality of life.

Who to consider – Collaboration of patient, carers, Power of Attorney / Welfare Guardian and other parties according to the situation.

What to do next Discussions and decisions must be clearly documented and communicated to all relevant parties.

These discussions should always take place with the relevant MDT members in particular Medical, Nursing, Dietetic and Specialist Nutrition Nurses

Artificial Nutrition and Hydration support including "nil by mouth"

When to consider High risk oro-pharyngeal swallowing, active ongoing aspiration pneumonia, people with limited intake, other situations as indicated by discussions with the MDT regarding artificial nutrition and hydration.

What to consider cautious oral intake supported by SLT recommendations, short term nil by mouth period.

Who to consider people too unwell to manage oral intake safely, where it may increase distress other situations as indicated by discussions with the MDT.

What to do next These discussions should always take place with the relevant MDT members in particular Medical, Nursing, Dietetic and Specialist Nutrition Nurses.

Nil by mouth without artificial nutrition and hydration

When to consider

Dysphagia due to acute, potentially reversible cause,

Chronic dysphagia with temporary deterioration due to being unwell,

What to consider

Discussion with the MDT, in particular Medical, Nursing, Dietetic and Specialist Nutrition Nurses. Relevant members of the MDT should document evidence that explains the rationale for 'Nil by Mouth' and a plan for nutrition, hydration (which may include intravenous or subcutaneous fluids), medication route and oral care. If immediate recourse to enteral feeding, in the form of a short term nasogastric tube, is not considered appropriate the rationale for this decision must be documented and discussed with both the patient and their family. A clear timeframe for review must be recorded in medical case notes. These issues may be more appropriate for patients in an acute setting.

Who to consider

Complex cases where artificial nutrition and hydration is not indicated

What to do next

Discussion and decisions must be clearly documented and communicated to all relevant parties. These discussions should always take place with the relevant MDT members in particular Medical,

Nursing, Dietetic and Specialist Nutrition Nurses.

Ethical and legal considerations

The MDT team should ensure that in all cases, ethical and legal considerations addressed within the Adults with Incapacity Act, (2000) and Children and Young People Act are considered.

Oral Care and managing secretions

Oral care should be maximised to reduce the risk of the spread of oral bacteria and increase patient wellbeing. Secretion management is essential for safety and wellbeing and may require behavioural and/or medical management. Appropriate staff should be trained in providing oral care. Consider referral to other Specialists eg Physiotherapy.

End of Life Considerations

Diagnosing dying can involve an element of uncertainty. When there is recognition and acceptance by the multidisciplinary team that the patient is dying "Guidance at the End of Life for Health Care Professionals (GAEL)" should be accessed and the advice of relevant staff such as Palliative Care, Dietetic and specialist nursing staff sought as indicated

GAEL highlights the most important aspects of holistic care in the last few days of life and crucially includes the need for continuous review of nutrition, hydration, oral fluids and oral care.

As stated in GAEL, a daily holistic assessment should be carried out. If there is any change it may be appropriate to discuss future care options in relation to clinically assisted hydration/nutrition, always respecting the patient's wishes and preferences.

In caring for the dying patient the goal is to maintain comfort, dignity and quality of life ensuring symptom control and effective communication are paramount. Local hospital palliative care teams are available to provide advice and support.

The Scottish Palliative Care Guidelines provide comprehensive guidance for symptom control at end of life.

References

Adults with Incapacity (Scotland) Act (2000)
http://www.gov.scot/Topics/Justice/law/awi

Care of Older People in Hospital Standards (2015)
www.healthcareimprovementscotland.org/his/idoc.ashx?docid=a196fdcc

Caring for Smiles
http://hub.careinspectorate.com/media/176816/nhs-caring-for-smiles.pdf

Children and Young People (Scotland) Act 2014
www.legislation.gov.uk/asp/2014/8/contents/enacted

Complex Nutrition Standards (2015) Complex Nutrition Standards
http://www.healthcareimprovementscotland.org/our_work/patient_safety/improving_nutritional_care/complex_nutrition_standards.aspx

Food in Hospitals: National Catering and Nutrition Specification (2008)
www.gov.scot/Publications/2008/06/24145312/0

Food, Fluid and Nutritional Care Standards (HIS 2014) Food, Fluid and Nutritional care standards
http://www.healthcareimprovementscotland.org/our_work/patient_safety/improving_nutritional_care/nutritional_care_standards.aspx

Guidance At End Of Life (GAEL) for Health Care Professional. NHSGGC 2017
www.palliativecareggc.org.uk/professional/eolc

Hospital Episode Statistics Admitted Patient Care - England, 2014-15. Health & Social Care Information Centre.

NHS GGC Consent Policy
http://www.staffnet.ggc.scot.nhs.uk/Corporate Services/Clinical Governance/Key Information/Consent to Treatment/Consent Policy FINAL.pdf

Oral Care for Adults in Care Homes. NICE July 2016 Guidance NG48
Royal College of Physicians. 2010. Oral Feeding Difficulties and Dilemmas. A guide to practical care particularly towards the end of life. U.K. RCP.

Scottish Palliative Care Guidelines
http://www.palliativecareguidelines.scot.nhs.uk/guidelines/end-of-life-care/care-in-the-last-days-of-life.aspx

Starved Of Care - Mrs V (Full report) 1 October 2011
https://www.mwcscot.org.uk/media/52047/Starved%20of%20Care%20Mrs%20V.pdf

Supervision, accountability and delegation of activities to support workers. A guide for registered practitioners and support workers. (2006)

Intercollegiate information paper developed by the CSP, RCSLT, BDA and the RCN.

World Gastroenterology Organisation. Dysphagia Global Guidelines and Cascades. World Gastroenterology Organisation, Update September 2014.

Additional References

Bannister, P. Early feeding management. In: Watson, A.C.H. Sell, D.A. Grunwell, P., eds. Management of Cleft Lip and Palate. London: Whurr Publishers; 2001: 137–147

Chadwick, D.D. 2009. A descriptive investigation of dysphagia in adults with intellectual disability. Journal of Intellectual Disability.

Katzan, I. L., Dawson, N. V., Thomas, M. E., Votruba, M. E. and Cebul, R. D. 2007. The Cost of Pneumonia after Acute Stroke. Neurology, 68:1938-1943

LEDER, S. B. & SUITER, D. M. (2009) An Epidemiologic Study on Aging and Dysphagia in

the Acute Care Hospitalized Population: 2000-2007. Gerontology, 55, 714-718.

Lyons et al. Oral Care after Stroke – where are we now? European Stroke Journal May 2018

Martino, R., Foley, N., Bhogal, S., Diamant, N., Speechley, M. and Teasell, R. 2005. Dysphagia after stroke: Incidence, diagnosis, and pulmonary complications. Stroke. 36 (12):2756-2763.

McGeachan, A.J. and Mcdermott, C.J. Management of oral secretions in neurological disease. Practical Neurology, (2017) 17 (2). pp.96-103.

McKinstry, M., Tranter, M., and Sweeney, J. 2009. Outcomes of Dysphagia Intervention in a Pulmonary Rehabilitation Program. Dysphagia, pub online 18 July 2009.

NEY, D. M., WEISS, J. M., KIND, A. J. H. & ROBBINS, J. (2009) Senescent Swallowing: Impact, Strategies, and Interventions. Nutr Clin Pract, 24, 395-413.

O'Loughlin, G. and Shanley, C. 1998. Swallowing Problems in the nursing home: a novel training response. Dysphagia, 13:172-183.

Pizzorni N. (2017) Social and Psychologic Impact of Dysphagia. In: . Medical Radiology. Springer, Berlin, Heidelberg

Regan J, Sowman R, Walsh I. Prevalence of dysphagia in acute and community mental health settings. Dysphagia. 2006;21:95–101.

ROBBINS, J., LANGMORE, S., HIND, J. & ERLICHMAN, M. (2002) Dysphagia Research in

the 21st Century and Beyond: Proceedings from Dysphagia Experts Meeting, August 21st,

2001. Journal of Rehabilitation Research and Development, 39, 543-548.

Van den Elzen, A et al. Diagnosis and treatment of the Pierre Robin sequence: Results of a retrospective clinical study and review of the literature. In ;European Journal of Pediatrics 160 January 2001.

Acknowledgements

Development group:

Alison Bain:	Clinical Specialist Speech and Language Therapist
Gillian Callander:	Speech and Language Therapist
Fiona Clark:	Lead Dietitian
Helen Davidson:	Catering Strategy Dietitian
Catherine Dunnet:	Speech and language Therapy Clinical Service Manager for Adult Acute Service
Elaine Hamilton:	Nursing Practice Development
Claire Higgins:	Advanced Speech and Language Therapist, Forensic Service
Joanne Logan:	Practice Development Dietitian
Cairsty O'Rourke:	Clinical Specialist Speech and Language Therapist, Adult Acute Service
Emma Peters:	Practice Development Nurse
Kirsty Smart:	Speech and Language Professional Lead for Partnerships

APPENDIX

ADDITIONAL INFORMATION FOR REFERENCE

Swallowing mechanism

Oropharyngeal dysphagia may arise due to developmental neurological or physical impairment of the oral and/or pharyngeal mechanisms. The 'normal' swallow requires respiratory, oral, pharyngeal, laryngeal and oesophageal structures to function in synchrony. This is dependent upon the motor and sensory nervous system being intact. Due to the complexity of the swallow, there is a broad spectrum of children and adults who may be affected. Swallowing presentation can be acute, chronic, stable or deteriorating depending on underlying cause and current medical status.

Additional Background

In 2011, the Mental Welfare Commission published an independent report 'Starved of Care'. The recommendations included the need to 'ensure that there is clear guidance on decision-making on nutrition for people who lose the ability to swallow'.

Furthermore, an "Older People in Acute Hospital" inspection in 2015, recommended that NHSGGC must ensure that it has a multidisciplinary risk assessment process in place and clear guidance on decision making on nutrition for people with swallowing difficulties.

The Royal College of Physicians (Oral feeding difficulties and Dilemmas, 2010) points out:

"to avoid an obligation to advocate or decide on nutritional support is to fail to act as a moral agent. Even though sharp delineation of when to instigate or continue artificial nutrition and hydration is not possible because differences among patients preclude strict definitions, medically and socially, there is a need to document medical decision making when introducing and when withholding nutritional support."

There are times when patients are too unwell to manage oral intake safely and to introduce it would be to risk further deterioration in their medical condition. Furthermore, it may increase distress to patients prone to marked coughing or choking episodes in response to aspiration. In some circumstances however, cautious oral intake supported by SLT or a "nil by mouth" regimen may be appropriate to allow the patient to recover to their previous normal level of functioning, particularly in the presence of aspiration pneumonia.

Incidence and Prevalence of Dysphagia

Dysphagia can be caused by many pathologies and can also be a frequent and potentially serious complication; e.g.

- Neurological conditions such as Stroke, brain cancer tumour , head injury, dementia, Motor Neurone Disease, Multiple Sclerosis, Parkinson's disease, Huntington's Disease
- Respiratory difficulties associated with chronic obstructive pulmonary disease, lung cancer, prolonged intubation
- Head and neck cancers and their treatment
- Complex medical conditions, general deterioration and/or polypharmacy
- Mental illness. This can be due to multiple factors, for example, the nature of the mental health disorder, effects of medications, co-occurring physical and neurological conditions, and/or illness-related behavioural changes.
- Learning disability and related conditions
- Congenital and lifelong conditions, e.g. spina bifida, cerebral palsy, dystrophies
- Babies who have not developed feeding skills, or have medical conditions impacting on their ability to feed orally.
- Babies and children with cleft lip/ palate; cranio facial conditions; traumatic medical surgery including cardiac disorder and related surgery.
- Children and young people with a physical condition causing eating and drinking problems e.g., cerebral palsy

The exact prevalence of dysphagia is unknown due to the fact that dysphagia is usually reported as part of other health conditions for which the child or adult is being treated. However, it is known that in 2014-15, there were 38,921 admissions to hospitals in England with a broad primary diagnosis of dysphagia, accounting for 43,888 bed days (Hospital Episode Statistics).

Dysphagia is associated with increased morbidity for, example malnutrition, dehydration, slower skin healing, decreased concentration, increased fatigue, distress and choking – resulting in reduced quality of life and mortality. Additionally, pneumonia is a common sequelae of dysphagia and is associated with higher costs of care (Katzan et al 2007).

Ageing does not necessarily cause dysphagia, but the potential for developing dysphagia becomes increasingly common with advancing age (Leder and Suiter 2009). Age-related changes affect head and neck anatomy and physiology, increasing the risk of dysphagia. These include: tongue pressure changes, slower swallowing, increased airway penetration, sensory changes, and oesophageal motility changes (Ney et al 2009). These changes contribute to older people being more vulnerable to dysphagia, as a result of a decreased functional reserve (Robbins et al 2002).

Incidence of Dysphagia in frequently occurring conditions

- 40 - 78% of patients post stroke (Martino 2005)
- 60 - 80% of patients with neurodegenerative diseases (World Gastroenterology Organisation 2014).
- 60 - 75% of patients who undergo radiotherapy for head and neck cancer (World Gastroenterology Organisation 2014).
- 50 - 75% of Nursing Home residents (O'Loughlin et al 1998)
- 27% of patients with Chronic Obstructive Pulmonary Disease (McKinstry et al 2009)
- More than 8% of all adults with a learning disability (Chadwick 2009)
- 23% in a group of in-patients with schizophrenia (Regan et al 2006)
- 99% of children with severe cerebral palsy have dysphagia (Calis et al 2008).
- 18% of children have been found to be dysphagic after cardiac surgery (Khol et al, 2000)
- Cleft lip and palate affects approximately one in every 600-700 births, (WHO Expert Committee, 2002 Craniofacial Anomalies Network, 2003). This condition regularly compromises early feeding (Bannister, 2001) and if associated with a syndrome,feeding difficulties are common (Van den Elzen et al, 2001).

Roles and Responsibilities

The Food, Fluid and Nutrition Planning and Implementation Group is responsible for the governance of this policy.

The Food, Fluid and Nutrition Operational Group (Acute) is responsible for ensuring that this policy is applied across all paediatric and adult in-patient areas.

The Food, Fluid and Nutrition Operational Group (Partnerships) is responsible for ensuring that this policy is applied across all mental health in-patient settings and all adult areas within all NHSGGC Community Health & Social Care Partnerships

The Speech and Language Therapy (SLT) Professional Lead for Partnerships and CSM for Acute is responsible for ensuring that this policy is applied across all SLT services.

General Managers/ Clinical Service Managers are responsible for the distribution of this policy to staff within their sector/ directorate.

Chiefs of Medicine/ Nursing and Allied Health Professionals are responsible for ensuring that all staff have access to this policy, that it is implemented within their area of responsibility and that compliance is monitored.

All clinical and support staff e.g. speech and language therapists, dietitians, nursing staff, occupational therapists, physiotherapists, medical staff , psychologists , community psychiatric nurses, dentists , pharmacists , catering staff and healthcare support workers are responsible

for their own compliance, and for the compliance of others to whom they have delegated care responsibilities, with the guidance contained within this policy, identifying their own training needs and attending appropriate training when provided.

Patients with dysphagia and their carers may be affected by social and emotional issues such as increased fear of choking, anxiety regarding deteriorating health, limited enjoyment of modified food and drink options and reduced participation in social eating situations (Pizzorni, 2017).

Consideration should be given to additional risks such as non- adherence to recommendations by patients and their families. This may be due to the emotional and social factors attached to eating and drinking. These risks can be reduced if the management plan is agreed by all concerned and reviewed over time.

"Health and social care staff should encourage people with dementia to eat and drink by mouth for as long as possible. Nutritional support, including artificial (tube) feeding should be considered if dysphagia is thought to be a transient phenomenon, but artificial feeding should not generally be used in people with severe dementia for whom dysphagia or disinclination to eat is a manifestation of disease severity." – Nice Dementia Guideline (2016)

The Royal College of Physicians (Oral feeding difficulties and Dilemmas, 2010) points out:

"to avoid an obligation to advocate or decide on nutritional support is to fail to act as a moral agent. Even though sharp delineation of when to instigate or continue artificial nutrition and hydration is not possible because differences among patients preclude strict definitions, medically and socially, there is a need to document medical decision making when introducing and when withholding nutritional support."

End of Life Care

GAEL states that:

"Decisions about the use and/or discontinuation of artificial hydration/nutrition must be based on the individual needs of the person. Clinically assisted hydration may relieve distressing symptoms related to dehydration, but may cause other problems. Sensitive communication and explanation about the benefits and burdens must be explained to the patient, relative, carer, and friend."

For many patients in the last few days of life hydration/nutrition is often not desired or possible, however, some patients may wish to continue eating and drinking and should be supported to do so. Patients should be monitored for signs of aspiration/choking or distress and a clear management plan should be in place to reflect and act on any changes in clinical condition.

Resources

Resources should include:

- appropriately skilled staff to recognise, assist and manage patients with oropharyngeal swallowing problems.
- a range of texture modified meals that are nutritionally appropriate for the client group and will enable choice and suitable options at mealtimes.
- adequate mealtime management to ensure that the correct number of staff are available and able to assist patients to eat and drink as safely as possible.
- appropriate snacks available out-with mealtimes to maximise nutritional intake.
- a range of specialist mugs/beakers that may reduce the need for thickening of drinks.
- a range of written information available in accessible formats.

International Dysphagia Diet Standardisation Initiative (IDDSI)

Drink Descriptors

Drinks Level	Description
Level 0 (Normal, Thin)	Normal, thin fluids
Level 1 (Slightly Thick)	Leaves a coating on an empty glass and can be easily taken through a straw (if recommended).
Level 2 (Mildly Thick)	Leaves a thin coat on the back of a spoon, can be drunk from a cup and easily taken through a straw (if recommended).
Level 3 (Moderately Thick)	Leaves a thick coat on the back of a spoon, can be drunk from a cup, but too thick to be taken through a straw.
Level 4 (Extremely Thick)	Unable to be drunk through a straw or a cup due to thickness. Needs to be taken from a spoon.

Food Decriptors

Food Level	Description
Level 3 (Liquidised)	Food has been pureed or has a pureed texture. It does not require chewing. It does not hold its shape on a plate and cannot be eaten with a fork. It is smooth and does not have any bits.
Level 4 (Pureed)	Food has been pureed or has a pureed texture. It does not require chewing. It does hold its shape on a plate and can be eaten with a fork. It is smooth and does not have any bits.
Level 5 (Minced and Moist)	Food has been mashed or blended before serving, with bits no bigger than 4mm. It requires very little chewing. It is usually served with a thick, smooth sauce.
Level 6 (Soft and Bite-Sized)	Food is soft, tender and moist. It requires some chewing. Served in bite size pieces – no bigger than 15mm x 15mm. Food can be mashed with a fork. It is usually served with a sauce.
Level 7 Subcategory (Easy to Chew)	Normal, everyday foods of soft and tender texture. Food piece size is not restricted. Food should break apart easily with the side of a fork and can be squashed with pressure from a fork.
Level 7 (Regular Diet)	Full range of normal diet with no restrictions.

Monitoring and Review

This policy and associated SOPs will be reviewed every two years.