Clinical decision-making process of healthcare workers when feeding critically ill adults in public sector ICUs in South Africa

K Coutts, PhD; **K Eckmann,** MA (Speech Pathology)

Department of Speech Language Pathology and Audiology, University of the Witwatersrand, Johannesburg, South Africa

Corresponding author: *K Coutts (kim.coutts@wits.ac.za)*

Background. Feeding critically ill patients is a complex process because swallowing is heterogeneous, and dysphagia in critically ill patients can have multiple causes. Decisions regarding dysphagia in the critically ill need to be made as a team with all possible outcomes and factors taken into account to ensure the best possible outcomes for patients. However, research has shown that in South Africa (SA), the multidisciplinary team (MDT) approach is not generally used when making decisions around feeding.

Objectives. To explore the clinical decision-making (CDM) factors in feeding practices in adults of the MDT in public healthcare intensive care units (ICUs) in Johannesburg, SA.

Method. A qualitative design with non-probability purposive sampling was used. There were 15 MDT participants across two tertiary hospitals. Data were derived from observations, focus groups, and individual interviews and analysed using a reflective thematic approach.

Results. Three themes were reported on, namely decision-making factors in the ICU by the MDT, non-patient-related factors and the meaning and misconception of the word 'tolerance'. There are no protocols followed in the ICU and decisions are made on an individual basis. Non-patient-related factors impact the decisions and when the MDT collaborates, it positively influences the CDM process. Different MDT members use the word 'tolerance' differently in dysphagia, which needs to be considered.

Conclusion. Clinical factors were the primary consideration for all MDT members when selecting a feeding method for critically ill patients. Environmental factors were also considered when adaptations were necessary owing to contextual constraints. The findings indicate that a multidisciplinary approach to feeding is not consistently practised in SA public sector ICUs, and there is no standardised feeding protocol in place. This was evident from the infrequent communication and collaboration among MDT members. Improved interdisciplinary co-ordination is needed. Additionally, inconsistent use of medical terminology among team members may affect patient care. Clear communication of terminology is essential to ensure mutual understanding of clinical decisions.

Keywords: Dysphagia, multidisciplinary team, intensive care unit, clinical decision making

South Afr J Crit Care 2025;41(3):e2741. https://doi.org/10.7196/SAJCC.2025.v41i3.2741

Contribution of study

This study contributes to the understanding of feeding practices for critically ill patients in South African public sector intensive care units (ICUs) by highlighting the absence of standardised feeding protocols and the inconsistent application of a multidisciplinary team (MDT) approach. It highlights how clinical decision-making is influenced not only by patient-related factors but also by environmental and contextual constraints. Importantly, the research draws attention to the impact of inconsistent terminology, such as varied interpretations of 'tolerance', on patient care and team collaboration. By documenting these challenges, the study provides evidence for the urgent need to strengthen interdisciplinary communication, establish clear protocols, and promote coordinated MDT practices to improve patient outcomes in ICU feeding decisions.

The process of swallowing is heterogeneous in nature, which is also intricate and relies on the co-ordination of many different muscles and nerves to function optimally.[1] It is essential to comprehend the swallowing process and its potential influences, as numerous aspects of swallowing may be at risk in a critically ill patient. Therefore, it is crucial to consider these possible challenges when working with critically ill patients. This is to prevent avoidable complications such as dehydration, malnutrition, and aspiration pneumonia. For the purposes of this article, the authors refer to feeding practices as the initiation of enteral and/or oral feeds during the patient's time in the ICU. Given its heterogenous nature, it requires the input of all members of the multidisciplinary team (MDT) to provide input. Unfortunately, little is known about the clinical decision-making (CDM) process of feeding the critically ill in the MDT, especially in South Africa (SA), where we know there is minimal MDT management of patients.

Given the complex nature of swallowing and eating, an MDT must be involved in making joint decisions.[2] When it comes to the commencement of oral feeding in critically ill patients there is a CDM process that must take place and many factors must be considered to determine if it is safe for the patient to begin feeding.[3] These need

to be done by the MDT. Multiple team members would be involved in the care of these patients and would assist in the overall CDM. The ICU typically includes a range of professionals such as doctors (from medical officers to specialists), nurses, occupational therapists (OTs), physiotherapists (PTs), social workers, dietitians (DTs), speech therapists (STs), psychologists, and radiographers. However, this list is not exhaustive, and the composition of the team may vary based on the specific needs of each patient.[4] Overall, doctors are involved in assessing, diagnosing and managing the critically ill patient. Nurses are required to monitor, document, and manage the patient's condition. The rehabilitation team members are required to improve the quality of life, daily functioning and rehabilitation of the patient to assist them in regaining prior function.[5] However, an ST is specialised in swallowing assessment and management and should be actively involved in CDM regarding feeding of patients in the ICU and should also be one of the first members involved in their assessment.[6] Although there are international studies that highlight the importance and specific role of the ST in the ICU, this research also highlights that there is variability in the assessment, diagnosis and treatment of dysphagia as well as speech disorders in the ICU.[6] If this variation occurs within a single profession, it is likely that CDM patterns differ considerably across teams and settings, particularly within a complex context like SA. This is supported by some research that has highlighted gaps between theoretical guidelines and practice in everyday life[7] in international contexts, which suggests that this would be prevalent in SA as well.

Oral feeding practices and the role of the ST in the ICU also appear to be understudied in the SA ICU setting, which can influence CDM in these settings. The practices and involvement of the ST are dependent on when the MDT makes the appropriate referrals. Studies have mentioned that early involvement of the ST can lead to better outcomes for patients, but the ST is usually only involved at a later stage in the patient's care and often only after aspiration pneumonia is diagnosed.[8] This is problematic as preventable complications could have been avoided. In under-resourced settings in SA, where ICU beds are in high demand, it is important to identify at-risk patients earlier. MDT CDM has a clear role to play in these circumstances.

This article stemmed from a larger study that aimed to explore the CDM factors in feeding practices in adults of the MDT in public healthcare ICUs in Johannesburg, SA. The primary findings of the results are presented in this article.

Methods

A qualitative, descriptive, observational study design was used with a non-probability purposive sampling strategy. The participants were all members of the MDT working in the ICU in the public sector at the sites from which permission to conduct the research was obtained. The study was conducted in two large tertiary public sector hospitals in Johannesburg, Gauteng Province. All participants signed consent prior to data collection. In total, 15 participants were included in the study while ensuring a variation of MDT professionals (Table 1).

Consent for research was obtained from the National and Provincial Health Research & Ethics Committee and the University of the Witwatersrand medical ethics committee (ref. no. M220126). The methods included site observations, focus groups and individual interviews where focus groups were not possible. This was to assist with data triangulation and improved reliability. The information gained from the observation tool was later used in the focus group and at interview stage to generate points of discussion. The site observations were conducted according to an observation schedule, developed by the researcher, with the use of reflective accounts and note-taking. The observation schedule included aspects regarding the setting, team dynamics, types of patient, and notes about feeding protocols and layout of the ICU. Site observation of each ICU was conducted before the researcher began with the focus groups and individual interviews.

The second phase of data collection involved the interviews and focus groups. Participants were either in a focus group or an individual interview if they were unable to attend the focus group. The same questions were asked for each set of interviews. These were conducted face-to-face on site. The questions were open-ended in nature to allow for discussion from the participants. The tool was developed by the researcher and piloted on one participant; no changes needed to be made. The data from the pilot study were included in the final analysis. Data collection stopped when saturation was obtained. Braun and Clarke's[9] six steps of thematic analysis, together with Campbell *et al.*'s[10] reflective thematic analysis, were used with a deductive approach.

Trustworthiness was ensured by the variety of professionals involved in the study; this provided adequate representation on the MDT. Reflections, post observations and note taking were conducted, a research assistant transcribed the recordings for reliability and to avoid bias, and member checking was also completed. Data triangulation was used to ensure that the data had depth. Investigator triangulation was used to ensure the reliability of the findings and interpretation of the data.

Results

From the larger study, six themes were identified; however, for the purposes of this article, only the strongest three themes will be discussed.

Theme 1. Factors involved in the CDM of feeding the critically ill patient in the ICU by the MDT

Subtheme 1. Clinical factors

There were specific factors that assisted professionals in making the clinical decision of how to feed the patient. Each professional listed common factors, which were patient specific and linked to their medical diagnosis and condition. These clinical factors were the foundation underpinning the CDM process of how to feed a critically ill patient. Fig. 1 provides a summary of the clinical factors considered.

Medical condition and oxygen dependency were raised as important deciding factors in the clinical decision by all members of the MDT. Different members of the MDT highlighted the factors that they specifically consider when selecting a mode of feeding for a patient in ICU. These are discussed below.

The STs consider the patient's abilities, their level of consciousness, anatomical obstructions, signs of aspiration and oxygen therapy.

> *So like from oral to NG [nasogastric], is the patient aspirating? And it's not just about them coughing. We look at silent aspirations. Are their eyes watery? Do they have a runny nose? Are they wheezing? Is their colour changing? So, we have to look at the silent aspiration as well. Are their SATs [oxygen saturation] coming down when they eat? Is their LOC [level of consciousness] changing when they eat? And if all those things are happening then it's probably best to go back to NG because they don't always cough. So that can be missed. You have to look at*

the silent aspiration, I think that's really important. (P9, ST)

The DT observes oxygen therapy, patient preferences and nutritional requirements.

Obviously, a lot of ICU patients are ventilated, sedated. So, then they would need alternate modes of feeding like NG or TPN [total parenteral nutrition] ... I think it's sometimes tough, because you are that ill, you just really don't want to eat. And then, I think that some of the time, why do we then ask for NGs... Also, if they are not eating enough orally. If they only have 2 spoonfuls of cereal or a spoonful of rice or yoghurt. It's really not enough, because they are usually so catabolic that their requirements are so much higher... Also, if the patient is previously malnourished then you would also want to feed them more intently and more aggressively than waiting longer. (P5, DT)

The doctors look at medical conditions, physiological issues, and anatomical obstructions, level of consciousness and nutritional requirements.

Assess a patient's needs but we don't actually calculate the caloric needs, the DT, we get collaboration from them for that. And we would also take things into account like electrolyte disturbances or needing a high protein or low protein diet, so we would advise on that. So, we get collaboration from the dietitian on things like that. Importantly it's about whether or not the patient is able to take feeds orally or if we need an NGT and to monitor tolerance of those feeds as well. (P15, doctor)

The OT indicates that the patient's physical abilities are an important factor to consider but a bit more subtle when related to dysphagia.

My role is a little bit more difficult because we obviously are doing the ADL [activity of daily living] itself of actually feeding. and the hand function of manipulating the utensils and stuff like that so they have to be of the right GCS [Glasgow coma scale] level, they have to be able to follow instructions, they have to try physically and that also depends on their condition and what level of functioning they on. (P11, OT)

Nurses list the medical condition, anatomical obstructions, and oxygen therapy as the factors for consideration.

There are certain indicators that show us if a patient is a candidate for TPN that excludes…, he cannot be fed nasogastrically, and he certainly cannot have sips of water. Often, they are intubated... I think we look at the clinical indicators. (P1, nurse)

While all professionals highlighted several factors, only the ST considered signs of aspiration when deciding on a mode of feeding, which was an interesting finding. It is evident that scope of practice does influence the clinical factors noted by each profession. These findings are summarised in Fig. 2.

The sites involved in the study appear to have protocols for progressing feeds, which is the process of increasing the volume of the feeds over time, while monitoring the tolerance of the patient, but they lack guidelines for deciding on a mode of feeding in the first place. The participants were asked if they knew of protocols for this purpose.

There is an enteral feeding protocol but there isn't one to decide on the route of feeding. I think we just use discretion. Ja, it's different for everybody. We just use our own discretion. (P5, DT) There are profession-specific protocols used in some departments, as mentioned by ST and DT participants: *No, we use our standard dysphagia protocol* (P12, ST); *I think it's more departmental*. (P10, DT) This is concerning as some professions are using evidence-based protocols and others are not. This will greatly influence CDM and when and how the team members refer to and communicate with each other. The impact of this needs to be further explored.

Table 1. Participant demographics

Participant	Age	Gender	Experience, years	Profession
P1	61	M	17	Nurse
P2	28	F	5	Doctor
P3	31	F	7	Doctor
P4	61	F	12	Speech therapist
P5	32	F	10	Dietitian
P6	41	F	15	Nurse
P7	25	F	3	Physiotherapist
P8	26	F	3	Physiotherapist
P9	29	F	7	Speech therapist
P10	32	F	9	Dietitian
P11	29	F	8	Occupational therapist
P12	28	F	5.5	Speech therapist
P13	32	F	5	Nurse
P14	31	F	8	Doctor
P15	32	F	-	Doctor

Theme 2. Non-patient-related impacting factors on CDM of the MDT

External factors – both personal and environmental – play a significant role in CDM when determining feeding methods for critically ill patients in public sector ICUs. While personal factors among professionals tended to support more positive decision-making, environmental challenges were more likely to negatively affect feeding outcomes. These non-patient-related considerations are just as important as clinical indicators when navigating CDM in this context.

Subtheme 1. Non-patient-related factors

Personal factors

MDT communication. Participants with work experience in private and public sectors made a positive comparison and noted that

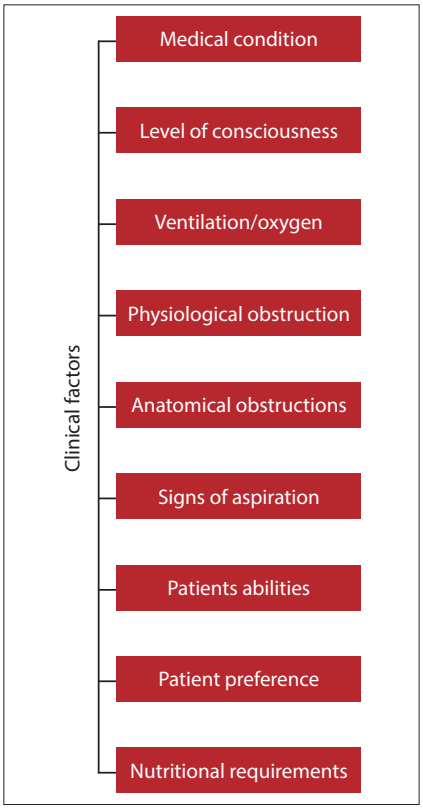

Fig. 1. Clinical factors that impact the decision-making of the multidisciplinary team.

interprofessional communication is easier in the public healthcare setting

.... Here in government, I have the opportunity to screen every patient in the ICU. I don't need a referral from a doctor to see a patient, just for NGs. A lot of the times that I screen patients in the ICU, not because I can see they have an NG in place but because I can see they are generally malnourished, and they will need the help in the future. (P10, DT)

This is a significant finding.

Environmental factors

Training of healthcare professionals and levels of experience. The participants were probed on the factors relating to working in a teaching environment.

...the negative thing is that some of these doctors are still training. So, they still have a lack of experience, so they will go over and above your scope of practice and change things that they don't understand. (P10, DT)

Resource constraints including staff and equipment. The issues related to the lack of equipment have a direct impact on the CDM process. A lack of equipment was raised by three of the participants and appears to be the most significant challenge when it comes to CDM regarding feeding the critically ill patient. It requires additional decision-making once the issues have been identified.

We don't have a blender for puree … our diet options were only liquids, thickened liquids, like mixed fluids diet with or without porridge, soft ward diet and full ward diet … if your patient was aspirating on liquids but couldn't cope with solids, then you had to keep the patient on an NGT. Or if the patient was on a mixed fluid diet but they wanted to eat food but weren't at the level to eat a SWD [soft ward diet], then they were stuck on that mixed fluid diet for weeks until we could make a plan. (P10, DT)

The only problem is that sometimes we don't have enough food in the kitchen … we don't always have yoghurt and custard available. We don't always have a certain type of vegetable or meat available to accommodate all the different types of diets. For example, if there is no soft porridge then the patients on the SWD will get spaghetti or macaroni. Sometimes they will even get bread if there is no other starch option available. (P10, DT)

The only problem here is sometimes we do not have the giving sets for the NG bags. I have found that to be a weakness, that sometimes we don't have that. It will impact on the decision to give NG feeds, because if we don't have the giving set for the NG feeds then we can't give the NG feeds. (P1, nurse)

So I think sometimes our environment definitely plays a big part of that decision-making... even just availability of equipment to confirm things. So, if we are putting in an NGT and you need an X-ray so you can start feeds, it's actually so hard to get that X-ray, and if it's not them struggling to come on time, it's actually PACS [the system the hospital uses to view results] not being online. So, there are a lot of factors that affect timeous feeding and initiation of feeding. (P2, doctor)

The main concern was the availability of equipment; participants explained that they often lack access and impact on decisions that need to be made in this setting.

One participant highlighted the challenges of accommodating patients with special dietary requirements.

I think in terms of resources that does constrain your ability to accommodate a patient. I think also time resources, if we could be in ICU all the time … doing proper in-service training. But in terms of staff complement and the amount of pts it's just not possible. … Just to add to the STs frustration about the SWD not being that soft, if you think about how the kitchen operates. They have to feed 600 patients, so they can't make specific accommodations for a certain patient. They try and do the best they can with the resources that they have.... (P10, DT)

These factors affect multiple professions and need to be discussed as a team.

Interestingly, one staff member believes that there is enough staff (nursing) but that perhaps the staff is not efficient.

There is more than enough staff. I think it's a misconception that there is no hands. The government hospitals are very well staffed, very well staffed. It's 1:1. You don't get those ratios in private, in private the ratio is 1:2 and they accept that because it's private and its profit making... There are more than enough hands. Our hands are sometimes not on our patients; they are on our phones. (*P1,* nurse)

This factor impacts CDM as it does not involve medical aspects but rather how the decisions can be executed. This shows that medical decisions cannot be made in isolation.

Subtheme 2. Overcoming environmental factors

Two participants described a scenario where they had to make a plan because of the lack of specific equipment. They also reflected on how this issue impacted the decision-making process and how they managed to overcome it.

That kind of affects what kind of a diet you putting a patient on…Then she [the DT] has the struggle of going to the kitchen to see what she can put on the plate for this patient… There was a period of time that we didn't have a puree diet in the hospital. (P12, ST) Yes, we didn't have a blender. (P10, DT) Yes, so that's why we came up with the Purity hack. (P12, ST)

In the absence of ideal conditions, creativity becomes essential. A key positive personal factor is the determination of healthcare professionals to find solutions, ensuring that patients receive the necessary care despite environmental challenges.

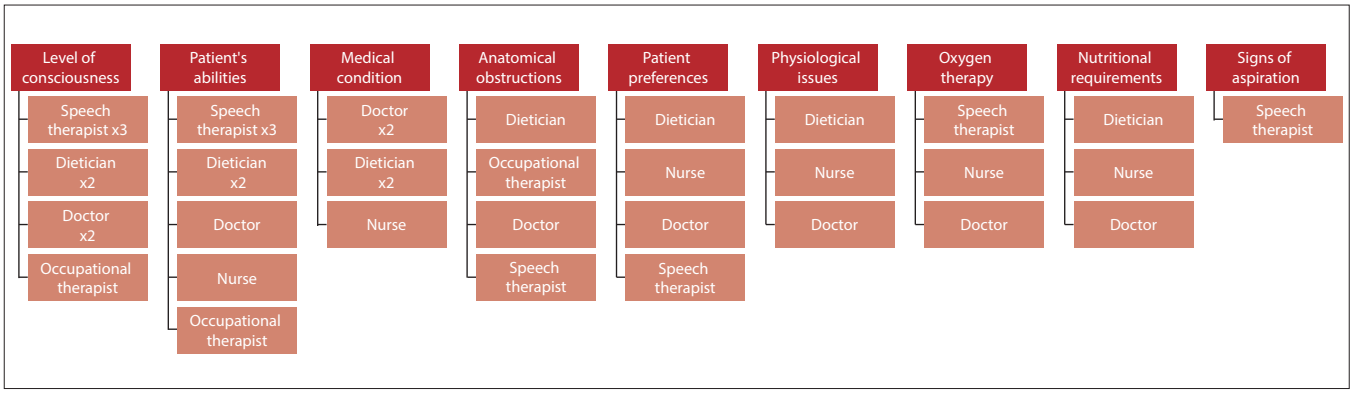

Fig. 2. Clinical factors by profession.

Theme 3: The ambiguity of 'tolerance' for different professions

This was a novel theme that emerged, which is of significance. Medical jargon is crucial, with one participant highlighting how the meaning of a word can vary significantly between individuals, and this can have serious consequences for patient management. The word 'tolerance' emerged as a word that STs, DTs, nurses and doctors use differently. This theme was brought up by the ST.

I feel like 'tolerance' could be interpreted in two ways, tolerating in terms of being able to swallow vs tolerating in terms of a nutritional point of view. (P12, ST)

Meaning 1. Tolerance (absorption)

When assessing tolerance concerning absorption it pertains to the body's ability to digest the food prescribed. This concept is relevant in the ICU as many critically ill patients present with gut-involving conditions that could lead to an inability to digest food.[11]

The nurses, doctors and DTs refer to absorption as an understanding of tolerance.

First of all, there is no nausea or vomiting, he takes it with enthusiasm, you can see that he is really… and it's a natural way of eating. (P1, nurse)

Here it is evident that nurses focus primarily on absorption, assessing tolerance from a gastrointestinal perspective.

... If I have a patient on NG feeds, for me tolerance has a different meaning in terms of nutrition. When it's an enteral feed, we look at different clinical signs, for example vomiting, diarrhoea, gastric residual volumes, so when they aspirate, the content that's been sitting there in the stomach that's not moving, whether or not the patient is passing stools would also be one of the signs. Then we also look at external factors, understanding of predicting possible intolerances in the future that could cause them to not absorb the food properly, that's what our tolerance means, its actually absorption of the food...Then if the patient can't tolerate any of the modes of feeds that we've given them, then our last resort would be TPN, but we don't give it to patients with a poor prognosis. Because it's very expensive. That's my tolerance. (P10, DT)

First of all, we would monitor if there were any vomits after the feed. Any associated complaints of shortness of breath or aspiration of fluids from the meal, from their trachy [tracheostomy]. That's it. (P3, doctor*)*

Tolerance of the selected mode of feeding refers to the patient coping physically and medically and assessing symptoms such as vomiting and aspirates.

Meaning 2. Tolerance (not aspiration)

The STs in this study refer to tolerance as the ability to tolerate food safely, i.e. the swallowing function and if the patient is aspirating or not.

From our side we rely a lot on the patient report, if they are awake, alert and responsive, to ask how it's going. If they're reporting that they are still hungry, I will communicate with the DT to see if she can supplement or grade up a diet to see if we can meet those appetite requirements … I will ask how easy it was to feed the patient? Did they finish their food? … I think when you assess a patient for the 1st time, it's important to assess them realistically. You can't give them a small amount of water or Purity or custard and make a decision off of that, you need to give them a good amount to see if they will be able to sustain themselves, if they are able to not fatigue throughout, or to see if the muscles become weaker as they go, if there is tons of anterior spillage, or if the patient is not actually tolerating the feed. (P12, ST)

This tolerance also refers to the patient being able to complete meals safely and obtain sufficient nutrition. The use of the word tolerance in medical notes needs to be interrogated based on the context of its use and which professional is using it. This needs to be explored and discussed on a larger platform and warrants future research.

Discussion

CDM by the MDT

Members of the MDT often focus on different aspects when making decisions about a patient. Given the heterogeneous nature of dysphagia and the varying factors considered, it is evident that CDM in ICU dysphagia management must be MDT-driven.[2] The most commonly considered factors are clinical and patient-related, such as medical conditions, level of consciousness, oxygen therapy, anatomical or physiological obstructions, signs of aspiration, patient preferences, abilities, and nutritional needs. However, non-clinical factors, such as limitations within the public healthcare sector, resource constraints, equipment shortages, staff availability, and teaching facility demands, also influence CDM.

The absence of local, contextually responsive guidelines for feeding critically ill patients in ICUs highlights a critical gap that requires further discussion and development.[12] Current evidence suggests that professionals often work within their own scope of practice, indicating that decisions, when made, tend to reflect MDT input rather than a fully interdisciplinary approach.[13] Nevertheless, the MDT approach remains valuable, as each professional contributes their unique expertise, fostering a more holistic understanding of the patient.[14] Given the evident lack of communication among team members, greater emphasis is needed, both in research and practice, on enhancing MDT collaboration within ICUs, particularly in the SA context.

Owing to the absence of established guidelines, it was challenging to clearly outline the current processes involved in CDM related to feeding critically ill patients. However, based on the findings and the defined roles of various professionals in the ICU, the researchers propose a potential CDM protocol for public sector ICUs. Ideally, this process begins with the doctor, nurse, and possibly the DT, depending on the patient's diagnosis, identifying a patient who is either at risk of or already exhibiting signs of dysphagia. Once identified, a timely referral should be made to an ST to assess the patient. The ST would then evaluate patient-related factors such as readiness for feeding and determine the appropriate mode of feeding to initiate or continue.

Referrals should include comprehensive details on the patient's diagnosis, medical condition, prognosis, and feeding history to support the ST's focus on patient safety during the initiation of oral intake.[6,15] According to international best practices, patients should be referred to an ST within 24 hours or less of extubation, as post-extubation dysphagia is often transient and requires early identification and management.[16]

Following the ST's clinical assessment, environmental and contextual factors must be taken into account to ensure that management decisions are relevant to both the healthcare setting and the individual patient.[11] This step should involve input from the entire MDT. Communication of recommendations to all relevant team members, including DTs, nurses, doctors, PTs, and OTs, should be clear and open to discussion. Importantly, CDM is a dynamic and continuous process that must evolve in response to the patient's changing condition.

For each participant in the current study, it was evident that the CDM process involved a systematic mental checklist, where indications and contraindications of each route of feeding are examined before making a final decision. Again, this was mostly an individual decision and not based on guidelines. Kozlowski *et al.*[17] explained this phenomenon as the process where the professional integrates all the relevant information

to arrive at a logical decision. The current study supports this, with all participants discussing the various factors they consider before deciding how to manage their patients. It shows that medical factors alone are not enough to make effective clinical decisions in a complex setting, and that each member of the team needs to be aware of the role of the others when making decisions around feeding in ICU. This supports the need for improved communication among team members when making decisions regarding feeding. This is supported by international literature, such as Brodsky *et al.*,[2] but more research is needed in the SA context.

The impact of environmental and personal factors on CDM

While existing research has noted resource scarcity in SA ICUs, this study reveals additional concerns not covered in the current literature.[18] Issues reported include insufficient stock and equipment for tube feeding and dietary requirements, such as a lack of pumps for NG feeds, and no access to certain modified diets such as soft or puree. These factors are crucial in determining the appropriate mode for a patient based on their abilities. For example, the ST may have to rely on tube feeding rather than offering the patient a risky form of oral feeding, which could have avoidable consequences.

Challenges with procurement, storage, and distribution of adequate resources in the SA public health are an increasing obstacle.[19] Current research highlights similar difficulties relating to scarce resources and poor resource allocation.[18-20] However, a positive outcome from this study among these challenges is that participants reported developing their own strategies to address these challenges, such as using baby food in the absence of a blender for pureed diets or adapting feeding pumps for NG feeds. These findings align with those of Kozlowski *et al.*,[17] who describe CDM as both rational and humane. Another positive aspect is that the study emphasises the positive role of MDT collaboration in the ICU of the SA public sector and its beneficial impact on the CDM process. This links to the other positive aspect mentioned, which was the ability of the MDT to communicate effectively.

A local study by Coutts and Pillay[12] showed that STs use a variety of factors when making clinical decisions at the bedside when assessing dysphagia in adult patients. These factors included patient factors, as well as environmental and personal factors. These included the types of assessment measures and recommendations made based on the availability of staff, resources and experience. These results were echoed at an MDT level, which shows congruency between different professions. It can, therefore, be assumed that the environment in which we practise has a significant impact on our CDM about patients and their feeding in ICUs. This further supports the need for the development of contextually relevant protocols. The impact of contextual factors on CDM with patient care in ICUs needs to be explored in more detail, as we need to ensure that our practices are contextually responsive. This should be a focus for all MDT members.

The ambiguity of the meaning of the word 'tolerance'

A novel outcome of this study was the distinction between the different meanings of the term 'tolerance'. It was discovered that STs, doctors and DTs have different understanding and use of the term, which was highlighted in focus groups and interviews. This ambiguity can lead to misunderstandings when implementing management plans, particularly in MDT settings. STs use 'tolerance' to describe the absence of dysphagia, or that the patient is able to eat or drink orally without signs of aspiration,[21] and when the patient can eat without fatigue and can consume a meal to completion.[14] In contrast, DTs and doctors generally use 'tolerance' to refer to a patient's ability to absorb food, noting that it passes through the gastrointestinal tract without signs of intolerance such as vomiting or diarrhoea.[22] This is important to consider when understanding and interpreting clinical notes for each profession when assessing a patient. The literature shows similarities to this study's findings as multiple articles discuss tolerance, but this is dependent on each profession.[14,21-23] These findings are novel and significant for clinical practice, especially in SA. The use of the word 'tolerance' needs to be discussed at the level of the MDT on a national scale, and clear definitions need to be set through research and discussion for our context. This finding also supports the need for the development of guidelines and improved communication between team members to ensure increased understanding when implementing management plans.

This study is not without limitations, including the small number of participants and the number of sites. This study needs to be replicated in more settings and in different contexts, such as the private sector.

Conclusion

CDM in feeding critically ill patients is complex owing to the heterogeneous nature of swallowing. Factors such as the patient's diagnosis, the ICU setting, and the effectiveness of communication within the MDT all significantly influence CDM. In ICU contexts, the MDT draws on both clinical expertise and experiential knowledge to guide feeding decisions, taking into account personal and environmental factors. This underscores the multifaceted nature of CDM in these settings. Decisions should not be made in isolation; therefore, strong communication and problem-solving skills among healthcare professionals are crucial. The absence of clear, standardised guidelines for feeding critically ill patients in ICUs remains a key challenge. Moreover, inconsistent use of terminology, particularly the term 'tolerance', among professionals can cause confusion, highlighting the need for a unified language in dysphagia management within MDTs.

Data availability. The data used for this study are available from the authors on request.

Declaration. None

Acknowledgements. None.

Author contributions. KC conceptualised the study and supervised data collection and article write-up. KE collected data and assisted with article write-up.

Funding. None.

Conflicts of interest. None.

1. Zuercher P, Moret CS, Dziewas R, Schefold JC. Dysphagia in the intensive care unit: Epidemiology, mechanisms, and clinical management. Crit Care 2019;23(1):103. https://doi.org/10.1186/s13054-019-2400-2
2. Brodsky MB, Pandian V, Needham DM. Post-extubation dysphagia: A problem needing multidisciplinary efforts. Intensive Care Med 2020;46(1):93–96. https://doi.org/10.1007/s00134-019-05865-x
3. Brodsky MB, Mayfield EB, Gross RD. Clinical decision making in the ICU: Dysphagia screening, assessment, and treatment. Semin Speech Lang 2019;40(3):170–187. https://doi.org/10.1055/s-0039-1688980
4. Ntoumenopoulos G. Rehabilitation during mechanical ventilation: Review of the recent literature. Intensive Crit Care Nurs 2015;31(3):125–132. https://doi.org/10.1016/j.iccn.2015.02.001
5. Curci C, Pisano F, Bonacci E, et al. Early rehabilitation in post-acute COVID-19 patients: Data from an Italian COVID-19 rehabilitation unit and proposal of a treatment protocol. Eur J Phys Rehabil Med 2020;56(5):633–641. https://doi.org/10.23736/S1973-9087.20.06339-X
6. McRae J, Montgomery E. Garstang Z, Cleary E. The role of speech and language therapists in the intensive care unit. J Intensive Care Soc 2020;21(4):344-348. https://doi.org/10.1177/1751143719875687

7. Bendavid I, Singer P, Theill M, et al. NutritionDay ICU: A 7 year worldwide prevalence study of nutrition practice in intensive care. Clin Nutr 2017;36(4):1122–1129. https://doi.org/10.1016/j.clnu.2016.07.012
8. Prohask CC, Sottile PD, Nordon-Craft A, et al. Patterns of utilisation and effects of hospital-specific factors on physical, occupational, and speech therapy for critically ill patients with acute respiratory failure in the USA: Results of a 5-year sample. Crit Care 2019;23(1):1–8. https://doi.org/10.1186/S13054-019-2467-9/TABLES/3
9. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3(2):77–101. https://doi.org/10.1191/1478088706qp063oa
10. Campbell KA, Orr E, Durepos P,. et al. Reflexive thematic analysis for applied qualitative health research. Qual Rep 2021;26(6):2011–2028. https://doi.org/10.46743/2160-3715/2021.5010
11. Tatsumi H. Enteral tolerance in critically ill patients. J Intensive Care 2019;7(1):30. https://doi.org/10.1186/s40560-019-0378-0
12. Coutts K, Pillay M. Decision making and the bedside assessment: The speech language therapists' thinking when making a diagnosis at the bed. S Afr J Commun Disord 2021;68(1):e1-e8. https://doi.org/10.4102/SAJCD.V68I1.790
13. Van Bewer V. Transdisciplinarity in health care: A concept analysis. Nurs Forum 2017;52(4):339-347. https://doi.org/10.1111/nuf.12200
14. Mah JW, Staff II, Fisher SR, Butler KL. Improving decannulation and swallowing function: A comprehensive, multidisciplinary approach to post-tracheostomy care. Respir Care 2017;62(2):137-143. https://doi.org/10.4187/respcare.04878
15. Perren A, Zürcher P, Schefold JC. Clinical approaches to assess post-extubation dysphagia (PED) in the critically ill. 2019;34:475-486. https://doi.org/10.1007/s00455-019-09977-w
16. Leder S, Warner HL, Suiter DM, et al. Evaluation of swallow function post-extubation: Is it necessary to wait 24 hours? Ann Otol Rhinol Laryngol 2019;128(7):619-624. https://doi.org/10.1177/0003489419836115
17. Kozlowski D, Hutchinson M, Hurley J, Rowley J, Sutherland J. The role of emotion in clinical decision making: An integrative literature review. BMC Med Educ 2017;17(1):255. https://doi.org/10.1186/s12909-017-1089-7
18. Naidoo R, Naidoo K. Prioritising 'already-scarce' intensive care unit resources in the midst of COVID-19: A call for regional triage committees in South Africa. BMC Med Ethics 2021;22(1):28. https://doi.org/10.1186/s12910-021-00596-5
19. Maphumulo WT, Bhengu BR. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. Curationis 2019;42(1):e1–e9. https://doi.org/10.4102/curationis.v42i1.1901
20. Malakoane B, Heunis JC, Chikobvu P, Kigozi NG, Kruger WH. Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. BMC Health Serv Res 2020;20(1):58. https://doi.org/10.1186/s12913-019-4862-y
21. Chen DE, Goh SW, Chan HN, et al. K. Rehabilitation of intubated COVID-19 patients in a Singapore regional hospital with early intensive care unit and sustained post-intensive care unit rehabilitation. Proc Singapore Healthc 2022;31:1-7. https://doi.org/10.1177/20101058211035195
22. Arab YM, Reintam Blaser A, Preiser JC. When and how to manage enteral feeding intolerance? Intensive Care Med 2019;45(7):1029–1031. https://doi.org/10.1007/s00134-019-05635-9
23. Ridley EJ, Parke RL, Davies AR, et al. What happens to nutrition intake in the post-intensive care unit hospitalisation period? An observational cohort study in critically ill adults. J Parenter Enteral Nutr 2019;43(1):88-95. https://doi.org/10.1002/jpen.1196

Received 17 October 2024. Accepted 21 July 2025.