BEEBE HEALTHCARE

Patient Care Manual

Nursing Swallow Screen and Aspiration Precautions	Date Issued: 11/07
Issued By: Bobbi-Lynn Cole, BSN, RN, CCRN, Stroke Program Coordinator Approved By: Lynne Voskamp, DNP, RN, CEN, CNO and Vice President of Patient Care Services and Continuum of Care; Dr. William Chasanov, DO, Interim Stroke Program Medical Director; Stroke Committee	Revised: 4/11, 11/11, CPC 11/13, 10/16, 9/19, 11/21
[X] Condition of Participation [X] Joint Commission Standard [ ] Department Specific Regulation	Reviewed:

PURPOSE

To screen all patients at risk for dysphagia before any food, drink or oral medication are provided and to prevent aspiration in all patients.

SCOPE

Medical Staff, Nurses, and Speech and Language Pathologists who care for

- All patients with a diagnosis CVA or TIA (all confirmed or rule/out stroke patients)
- All patients with any neurological dysfunction (i.e., Traumatic Brain Injury (TBI), Parkinson's Disease (PD), Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Cerebral Palsy (CP) etc.)
- All patients with any alternation in level of consciousness (LOC)
- All patients with an enteral feeding tube

DEFINITIONS

The term 'dysphagia' refers to difficulty swallowing. This may refer to any disorder of swallowing across the oral-preparatory, oral, pharyngeal or esophageal phases of swallow.

POLICY

Nursing Swallow Screen will be administered to all 'at risk' patient populations prior to initiation of PO diet or administration of any oral medication.

PROCEDURE

Supplies: toothbrush, toothpaste, spoon, glass of ice water, suction equipment

Step 1: Exclusion Criteria

Any **YES** answer to the following risk factors will also defer administration of swallow screen and result in referral for Clinical Bedside Swallow Evaluation by Speech and Language Pathologist

Yes	No	Risk Factor
		Unable to remain alert for testing
		Eating a modified diet (thickened liquids) due to pre-existing dysphagia
		Existing enteral tube feeding via stomach or nose
		Head-of-bed restrictions <30 degrees
		Tracheostomy tube present
		NPO (nothing by mouth) per physician order

If the patient's clinical status changes resulting in a new risk for aspiration, the nursing swallow screen must be repeated before a PO diet or medications are ordered/provided to patient.

Step 2: Administration Instructions

If patient is deemed an aspiration risk and all exclusion criteria in Step 1 are checked "NO," proceed with nursing swallow screen as described below:

- **Brief Cognitive Screen:**
  - What is your name?
  - Where are you right now?
  - What year is it?
- **Ensure that patient is positioned upright at 90 degrees**
  - Ideally out of bed in chair if possible or upright with head of bed as high as tolerated > 30 degrees
- **Oral-Mechanism Examination**
  - Ensure that patient has adequate dentition for mastication

Domain Assessed	Verbal Prompt
Labial Closure	"Close your mouth" "Seal your lips together tightly"
Lingual Range	"Stick out your tongue and move it from side to side"
Facial Symmetry	"Smile" and "Pucker your lips"

*Provide a visual model as necessary

The brief cognitive screen and oral mechanism examination are intended to provide information on odds of aspiration risk and should not be used as exclusionary criteria for swallow screening.

- **Provide Oral care in accordance with Oral Hygiene Protocol**
- **Administer Single ice chip via teaspoon**
  - Present the patient with a small ice chip via teaspoon
    - If there is no attempt to swallow, water leaks out of the patient's mouth, the patient demonstrates coughing, choking, breathlessness, wet/gurgly voice, or any other symptom making them unsafe to swallow, make them NPO. Notify the patient's physician and request a swallowing evaluation by speech-language pathology.
- **Administer Teaspoon of water (x3)**
  - Present the patient with **one teaspoon of water**.
    - If there is no attempt to swallow, water leaks out of the patient's mouth, the patient demonstrates coughing, choking, breathlessness, wet/gurgly voice, or any other symptom making them unsafe to swallow, make them NPO. Notify the patient's physician and request a swallowing evaluation by speech-language pathology.
  - Present the patient with a **second teaspoon of water**.

        - If there is no attempt to swallow, water leaks out of the patients mouth, the patient demonstrates coughing, choking, breathlessness, wet/gurgly voice, or any other symptom making them unsafe to swallow, make them NPO. Notify the patient's physician and request a swallowing evaluation by speech-language pathology.
    - Present the patient with a **third teaspoon of water**.
        - If there is no attempt to swallow, water leaks out of the patients mouth, the patient demonstrates coughing, choking, breathlessness, wet/gurgly voice, or any other symptom making them unsafe to swallow, make them NPO. Notify the patient's physician and request a swallowing evaluation by speech-language pathology.
- **Perform 3-ounce water swallow challenge**
    - Ask patient to drink 3 ounces (90cc) of water from a cup or straw, in sequential swallows, slowly and steadily but without stopping. (Cup or straw may be held by either RN or patient).
    - Assess patient for interrupted drinking and coughing or choking during or immediately after completing drinking

PASS: Complete and uninterrupted drinking of all 3 ounces of water without overt signs or symptoms of aspiration (e.g., coughing, choking, wet vocal quality, persistent throat clearing) either during or immediately after completion.

- If patient passes, collaborate with MD/PA/NP to order appropriate PO diet.

FAIL: Inability to drink the entire 3 ounces in sequential swallows due to stopping/starting or patient exhibits overt signs or symptoms of aspiration (e.g., coughing, choking, wet vocal quality, persistent throat clearing) either during or immediately after completion.

- If patient fails, keep NPO (including medications) and discuss with the MD/PA/NP the need for a clinical bedside swallow evaluation by speech-language pathologist.
- Re-administer the protocol in 24 hours if patient shows clinical improvement.

DOCUMENTATION:

Document the date, time and results in the electronic medical record (EMR) as well as any notifications to the provider.

RELATED POLICIES

STROKE: Rapid Management of Patients who Develop Symptoms of Stroke

REFERENCES

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