Swallowing Screening Information for (organization name) Staff

Why is it important to consider dysphagia?

Dysphagia (difficulty swallowing occurring at the oral, pharyngeal and/or esophageal phases of swallowing) can occur in up to 65% of patients who have a stroke. When present, dysphagia is associated with increased mortality and medical complications, including pneumonia, malnutrition and dehydration. It is therefore important to complete a swallowing screen for all patients who have experienced a stroke to identify whether they are at risk for dysphagia.

Screening vs Assessment of Swallowing

Swallowing screening and swallowing assessment are very different.

Swallowing screening is a pass/fail process that identifies which patients need to receive a comprehensive swallowing assessment. Results of swallowing screening cannot be used to plan treatment and management of swallowing difficulties.

If a patient **passes** a swallowing screening an appropriate diet can be ordered; if a patient **fails** a swallowing screening, he/she must be referred for a swallowing assessment and be **kept NPO** while awaiting the swallowing assessment completion.

A swallowing assessment is conducted by a Speech-Language Pathologist (SLP). A swallowing assessment uses formal and/or informal measures to evaluate the structure and function of the patient's oropharyngeal swallowing mechanism. A swallowing assessment results in specific treatment recommendations for the patient.

What does NPO mean?

NPO means "nil per os". When a patient's status is NPO this means the patient **must not** receive any food, drink or medications by mouth. For stroke survivors, swallowing screening, or as required, a full swallowing assessment by SLP should be completed prior to provision of any food, drink or medications.

What does "within 24 hours" mean?

Canadian Stroke Best Practice Recommendations indicate that swallowing screening should occur within 24 hours of hospital arrival but **the earlier the better**, including patients who receive acute stroke treatments (tPA, EVT). This means that screening

should be completed **without any prolonged time delay**. It should be completed as early as possible after symptom onset, on the day of admission.

Which patients must have a swallowing screening?

All patients with a confirmed or suspected diagnosis of stroke or TIA must have their swallowing screened as early as possible using a validated swallowing screening tool.

What is best practice for dysphagia management following stroke?

Canadian best practice guidelines tell us that the swallowing status of patients with a stroke should be screened as early as possible on the day of admission using a validated screening tool. Swallowing screening should also be completed as early as possible for patients that suffer a stroke while in hospital for other reasons (i.e., post cardiac surgery, pneumonia, etc.) and patients who present to the emergency department with stroke-like symptoms that are not admitted. The stroke does not need to be confirmed by a CT to do a swallowing screen.

Patients that have an abnormal result from an initial or ongoing swallowing screening should have a prompt referral to a SLP. After a swallowing assessment is completed by SLP, an individualized management plan should be developed to address therapy for dysphagia, nutrition needs and specialized nutrition plans.

When observing or monitoring patients' meals, what are you looking for?

When observing patients' meals, you are looking for specific signs of swallowing difficulty and you are ensuring use of safe swallowing strategies.

Specific Signs of Difficulty

- drooling of saliva
- drooling or spilling of food from the mouth
- food or liquid coming out the nose
- pain with swallowing
- extra time or effort to chew or swallow
- being unable to swallow
- hesitating before swallowing
- reports of sensation of food stuck in throat
- need to "wash down" solid food with liquid
- coughing or choking during or after oral intake
- wet/gurgly voice during or after swallowing
- swallowing multiple times for each mouthful
- increased respiratory rate (to greater than 30bpm)

Ensuring Safe Strategies

- patient is awake and alert
- patient is in optimal position (upright or as specified by recommendations)
- patient's dentures are in place (if applicable)
- patient is receiving appropriate diet texture for solids and liquids (if recommended by SLP swallowing assessment)
- patient is using adaptive feeding utensils if recommended patient or feeder is following specific recommended swallowing strategies
- patient is fed or supervised if required
- patient is not talking while eating or drinking

Organization specific information:

At (name of facility) swallowing screening is carried out by appropriately trained staff using (name of screening tool), which is a validated swallowing screening tool.

To contact an appropriately trained swallowing screener in our facility (enter your organization's specific information about how to connect with a swallowing screener).

If you have any questions about swallowing screening you can contact:
(Name of local contact; email; phone)

References

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