DYSPHAGIA SCREENING TOOL

Patient Sticker/Addressograph

❒ Initial Screening ❒ Repeat/reassess screen #___
Staff Name:_____
Date:_____
Repeat screening tool as needed.

Ensure the following is available prior to screening:
- Oral care **before and after** trials
- Suction equipment
- Head of bed elevated 90^0, assess in chair, if possible

1. Is the patient able to maintain adequate arousal and attention for feeding?
   - ❒NO → **Keep patient NPO** and try one more time within next 24h. If remains NPO after next attempt, alert SLP, MD/NP, Clinical Nutritionist for alternative feeding.
   - ❒YES ↓
2. Is the patient able to manage oral secretions (i.e. No excess drooling, no wet/ gurgly voice quality or respiration?) **FEEL FOR LARYNGEAL ELEVATION**
   - ❒NO → Have patient attempt dry swallow. If unable to swallow own secretions, STOP here. **Keep patient NPO** and alert SLP, MD/NP, Clinical Nutritionist for alternative feeding
   - ❒YES ↓
3. Does the patient have a clear, strong voice and strong cough?
   - ❒NO → **Keep patient NPO** and alert SLP, Clinical Nutritionist and MD.
   - ❒YES ↓
4. Give 1 tsp. of tap water, feeling for laryngeal elevation.
   - Problems → ❒ No laryngeal elevation ❒ No attempt to swallow ❒ Water leaks straight from mouth ❒ Any other reason you feel swallow is unsafe (Please document below) **NPO** Alert MD/NP, Clinical Nutritionist and SLP
   - NO PROBLEMS ↓
5. Repeat 1 tsp. of tap water 3 times. Ask patient to say "aaahhh" after each swallow.
   - Problems → ❒ Coughing ❒ Choking ❒ Wet/gurgly voice quality ❒ Breathlessness ❒ Any other reason → **ACTION: REPEAT STEP 5 WITH THICKENED FLUID/PUDDING**
     - Problems → ❒ Coughing ❒ Choking ❒ Wet/gurgly voice quality ❒ Breathlessness ❒ Any other reason — **NPO** Alert MD/NP, Clinical Nutrtionist and SLP ❒ **Consider** NG tube if SLP assessment is delayed for > 24h.
     - NO PROBLEMS → ❒ Dysphagia Pureed Diet ❒ SLP Swallowing Consult ❒ Clinical Nutrition Consult
   - NO PROBLEMS ↓
6. Continuously drink 50 mL of water. (May take short breaks between sips)
   - Problems → ❒ Dysphagia Pureed Diet ❒ SLP Swallowing Consult ❒ Clinical Nutrition Consult
   - NO PROBLEMS ↓

❒ Regular Texture Diet

***For Dysphagia* diets::**
- **No** straws or tbsp
- **Thicken** liquid medications
- **Crush** meds

DOCUMENTATION/OBSERVATIONS:

GUIDELINES FOR DYSPHAGIA SCREENING TOOL

This tool is to be used only by a physician or a dysphagia-trained nurse.
DO NOT use this tool if you have not received basic training in dysphagia identification and management.
(Guidelines on reverse.)

ACUTE STROKE:

- All patients with acute stroke should be assessed on admission prior to any oral intake. Place screening form on chart.
- Notify MD, SLP and Dietitian of dysphagic patients. (Order swallowing consultation.)
- Complex / persisting problems (>1 week) will receive complete swallowing assessment by SLP.
- If patient deteriorates, re-assess using the same tool.
- Referral to other health professionals (Physiotherapy, Occupational Therapy) as appropriate.
- Patients requiring a modified barium swallow study must be assessed by SLP clinically first (order swallowing consultation)
- Notify SLP and Dietitian of all patients being discharged on a modified diet.
- All initial diet orders require physician order.
- Other therapeutic diets required an MD or RD order.

NON-STROKE PATIENTS / PROGRESSIVE NEUROLOGICAL DISEASES:

- Not all patients need to be screened.
- Where swallowing is thought to be a problem (e.g. slurred speech, recent weight loss, coughing with meals, etc.) use this screening tool.
- You can always lower the diet **texture** to make it safer!
- If a patient at another site is coming to Owen Sound for diagnostic assessment, she/he may be seen by a SLP. Please contact SLP directly with date and time: (519) 376-2121, Ext. 2895

ALWAYS...

- Ensure the patient is upright 90° before feeding.
- Ensure good oral care after all PO intake.
- Remain upright 10 - 15 minutes following meals.
- Sit at eye level when feeding and avoid neck extension.
- Allow time for extra swallows.
- Discourage laughing or talking while eating.
- Monitor the first few meals after screening.