DYSPHAGIA SCREENING TOOL

☐ 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°, 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?
   ☐ YES
   ☐ NO  Keep patient NPO and alert SLP, Clinical Nutritionist and MD.

4. Give 1 tsp. of tap water, feeling for laryngeal elevation.
   ☐ NO PROBLEMS
   ☐ Problems

5. Repeat 1 tsp. of tap water 3 times. Ask patient to say “aaahhh” after each swallow.
   ☐ NO PROBLEMS
   ☐ Problems

6. Continuously drink 50 mL of water. (May take short breaks between sips)
   ☐ NO PROBLEMS

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.