HACKETTSTOWN MEDICAL CENTER
NURSING POLICIES
DYSPHAGIA SCREENING

Effective Date: 08/2008	**Policy No: 8620.254**
Cross Referenced: 6010/6050.30c; 7010.109c	**Origin: Patient Care**
Reviewed Date: 11/2010; 8/2013	**Authority: Chief Nursing Officer**
Revised Date: 09/2016	**Page 1 of 5**

SCOPE:
Inpatient and Emergency Department Registered Nurses

PURPOSE:
To allow for patients nutritional needs to be safely met in an expeditious, efficient manner while identifying those at high risk for aspiration pneumonia.

DEFINITIONS:

I. Dysphagia: difficulty swallowing which may or may not be accompanied by pain.
II. Aspiration: a foreign material, usually food, entering into the respiratory system: the trachea or bronchus.

POLICY:

I. A Registered Nurse (RN) will complete a Bedside Nursing Dysphagia screening on all patients admitted with a diagnosis of stroke, TIA, stroke-like symptoms, neurological deficit, recurrent pneumonia and significant cognitive impairment.
II. The RN will complete the Nursing Dysphagia screen on all patients who have an order for Speech Therapy Bedside Assessment regardless of patient diagnosis. Patients should not have any oral intake until Nursing Dysphagia screen is completed. A negative nurse screening will not negate the physician's order for the STB assessment, it serves as a pre-assessment and communication tool for the Speech Therapist's STB.
III. Interventions related to diet and medication administration will be initiated based on the screening assessment findings in collaboration with the Provider.

PROCEDURE:

I. A Dysphagia screening assessment will be performed by an RN as long as the patient is awake, alert and responsive to verbal commands. (Appendix A)
   a. The Dysphagia screen will be completed prior to any oral intake, including medications.
   b. The patient should be rescreened in 4 hours if they fail the initial screen or when the patients' condition improves.
   c. Patients that fail the screening and are alert and responsive will be referred to Speech Therapy for a Swallowing evaluation.
   d. Complete screening with HOB elevated at least 45 degrees.

II. Use the Dysphagia screening tool to assess the patient and document findings in the Electronic medical Record. (Dysphagia Screen Downtime Form Appendix B)
   A. Assess the patient to be certain they are alert and responsive to verbal commands in order to continue assessment:
      a. If the patient is not alert and responsive, **STOP**, and do not proceed with the assessment. Keep the patient NPO.

b. Repeat Dysphagia Screening in four hours or when patient is alert and responsive. Communicate need for reassessment in report.
c. If the patient is alert, proceed to next step.

B. Step-one: Give the patient two teaspoons of applesauce.
1. If tolerated, then proceed to next step.
2. If not tolerated, **STOP** and do not proceed to next step if patient exhibits signs of failure (signs and symptoms listed on dysphagia screening tool)
3. Keep NPO
4. Order Swallowing Evaluation by Speech Therapy

C. Step-two**:** Give the patient two sips of water.
1. If tolerated, proceed to next step.
2. If not tolerated, **STOP** and do not proceed to next step if patient exhibits signs of failure.
   a. Order Swallowing Evaluation by Speech Therapy
   b. Applesauce for crushable medication PO administration
   c. Order Honey, Thick Liquids and Puree diet
   d. Order Dietary consult

D. Step-three: Give the patient two bites of graham crackers.
1. If tolerated, screening is completed.
   a. Contact Provider for therapeutic diet order based upon patient's current status.
2. If not tolerated, **STOP** and do not proceed to next step if patient exhibits signs of failure.
   a. Order Swallowing Evaluation by Speech Therapy
   b. Applesauce for crushable medication PO administration
   c. Order Honey, Thick Liquids and Puree diet
   d. Order Dietary consult

III. Signs and symptoms of failure include:
1. Food/drink spat out or coming out of nose
2. Food held in mouth
3. Food leaking from mouth
4. Suctioning is required
5. Breathing is labored/affected
6. Wet gurgled vocal quality
7. Choking/coughing or throat clearing during or immediately after swallow
8. Patient states that the swallow is painful.

IV. If at any time after a diet has been ordered and initiated and the patient develops coughing, sputtering, oxygen desaturation, throat clearing and change in breath sounds or vocal quality, the patient should be made NPO until further assessment and recommendations are made by the Speech Therapist.
1. Notify the Provider and Speech Therapy immediately for any change in patient's swallowing status.

REFERENCES:

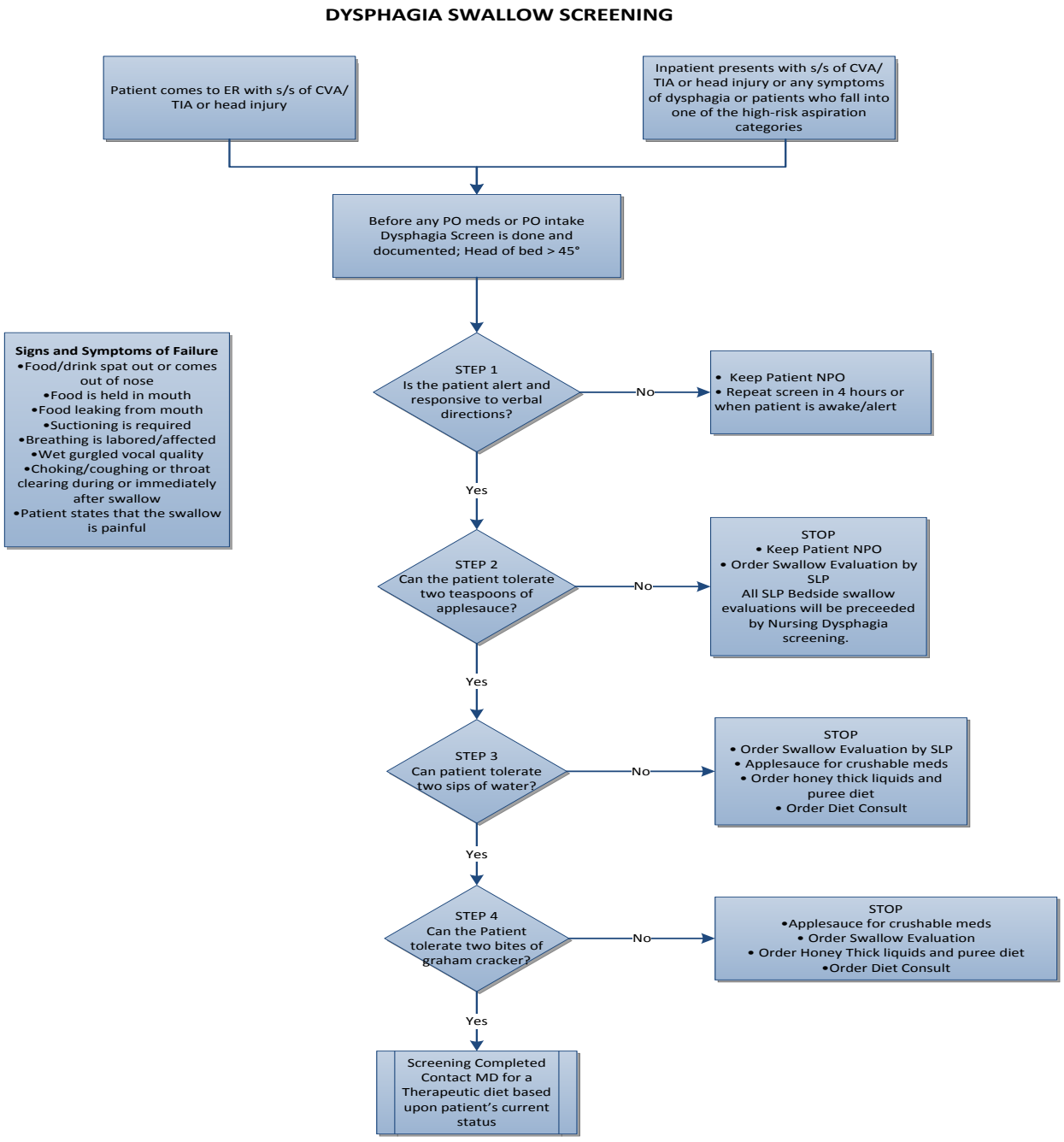
Weinhardt, J., Hazelett, S., Barrett, D., Lada, R., Enos, T., Keleman, R. (2008) Accuracy of a Bedside Dysphaghia Screening: A Comparison of Registered Nurse and Speech Therapists. *Rehabilitation Nursing*, November/December, 247-252.

Guidelines for Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke 44:870-947, 2013.

ATTACHMENTS:

Appendix A: Flowchart
Appendix B: Dysphagia Screening Downtime Form

APPENDIX A


DYSPHAGIA SWALLOW SCREENING
Patient comes to ER with s/s of CVA/ TIA or head injury
Inpatient presents with s/s of CVA/ TIA or head injury or any symptoms of dysphagia or patients who fall into one of the high-risk aspiration categories
Before any PO meds or PO intake Dysphagia Screen is done and documented; Head of bed > 45°
Signs and Symptoms of Failure
•Food/drink spat out or comes out of nose
•Food is held in mouth
•Food leaking from mouth
•Suctioning is required
•Breathing is labored/affected
•Wet gurgled vocal quality
•Choking/coughing or throat clearing during or immediately after swallow
•Patient states that the swallow is painful
STEP 1
Is the patient alert and responsive to verbal directions?
No
• Keep Patient NPO
• Repeat screen in 4 hours or when patient is awake/alert
Yes
STEP 2
Can the patient tolerate two teaspoons of applesauce?
No
STOP
• Keep Patient NPO
• Order Swallow Evaluation by SLP
All SLP Bedside swallow evaluations will be preceeded by Nursing Dysphagia screening.
Yes
STEP 3
Can patient tolerate two sips of water?
No
STOP
• Order Swallow Evaluation by SLP
• Applesauce for crushable meds
• Order honey thick liquids and puree diet
• Order Diet Consult
Yes
STEP 4
Can the Patient tolerate two bites of graham cracker?
No
STOP
•Applesauce for crushable meds
• Order Swallow Evaluation
• Order Honey Thick liquids and puree diet
•Order Diet Consult
Yes
Screening Completed Contact MD for a Therapeutic diet based upon patient's current status

APPENDIX B

DYSPHAGIA SCREENING by NURSING

For all ED and Inpatients with signs/symptoms of Stroke or TIA

Complete and document Screening before any PO intake including medications
Screening to be completed with patient's HOB elevated at least 45°
Re-Screen 2nd time in 4 hours if initial screen failed. If failed again, repeat when Patient is alert and responsive.
Failed screening interventions per Dysphagia Policy

Patient is alert and responsive to verbal commands	[ ] YES CONTINUE SCREENING	[ ] NO STOP SCREENING • KEEP NPO per policy • REPEAT this SCREEN IN 4 HOURS OR when patient is awake and alert
Can patient tolerate two (2) teaspoons of applesauce? ***(Observe for signs and Symptoms of Failure)***	[ ] YES CONTINUE SCREENING	[ ] NO STOP SCREENING Per Stroke Policy • KEEP NPO per policy • Order SWALLOW EVAL by Speech
Can the patient tolerate two (2) sips of water? ***(Observe for signs and Symptoms of Failure)***	[ ] YES CONTINUE SCREENING	[ ] NO STOP SCREENING Per Policy • Order SWALLOW EVAL by Speech • Applesauce for CRUSHable meds • Diet order: Honey Thick Liquids and Puree Diet • Order Diet Consult
Can the patient tolerate two (2) bites of graham Cracker? ***(Observe for signs and Symptoms of Failure)***	[ ] YES SCREENING COMPLETED Contact MD for a Therapeutic diet based upon patient's current status	[ ] NO STOP SCREENING Per Policy • Order SWALLOW EVAL by Speech • Applesauce for CRUSHable meds • Diet order: Honey Thick Liquids and Puree Diet • Order Diet Consult

Signs and Symptoms of Failure

- **Food/drink spat out or comes out of nose**
- **Food is held in mouth**
- **Food leaking from mouth**
- **Suctioning is required**
- **Breathing is labored/affected**
- **Wet gurgled vocal quality**
- **Choking/coughing or throat clearing during or immediately after swallow**
- **Patient states that the swallow is painful**

Screening Result: [ ] Passed [ ] Failed

Screening Performed By: _____ Date: _____ Time;_____ Unit: _____

Patient Label

Dysphagia Screening
10993 (8/2013)