

Dysphagia Management in Stroke

Acute Stroke Best Practices Workshop
“Advancing Best Practices in Acute Stroke Care”
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Objectives

- To offer a basic overview of swallowing management at TBRHSC
- To provide suggestions of when to include other professionals in the Patient's continuum of care



Why perform a swallowing screen?

- Incidence of dysphagia post-stroke is high (1/3 to 2/3 of acute stroke) with potential for life-threatening airway obstruction, aspiration pneumonia and malnutrition
- It is a best-practice for stroke care
- Ensures patients who can be fed, are fed
- Ensures that patients who are not safe for any oral intake can be flagged for an alternative means of nutrition or medication administration



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Swallowing Screening

- There is an automatic order to complete a swallowing screen as part of the Pre-Printed Direct Orders (PPDOs) for acute stroke
- Screening must be done within the first 24 hours of admission/presentation to hospital
- Re-screening should be done when there has been a change in your patient's neurological status



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STROKE STANDARDIZED SWALLOWING SCREEN

Guidelines:

- Complete for patients with stroke prior to initial oral intake (including medications) and with any change in condition
- do not use with patients who already receive thickened fluids -> maintain NPO, alert SLP
- see reverse for additional guidelines

Place Patient Label with Barcode Here

Pre-Swallow Screening Checklist: COMPLETE WITHIN 24 HOURS OF ADMISSION

		YES	NO
1. Is the patient awake and alert, or responding to speech?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient able to be positioned upright with some head control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your answer is NO to either of the above questions – STOP, GO NO FURTHER AND DO NOT SCREEN.

MAINTAIN PATIENT NPO, re-assess every 24 hours and if the patient remains inappropriate for screening or assessment by SLP, discuss hydration and nutrition with medical team and alert SLP.

3. Can the patient cough when asked to?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the patient able to maintain some control of their saliva?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the patient able to lick top and bottom lip?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the patient able to breathe freely? (i.e. no difficulty breathing or problems maintaining O ₂ saturation)	<input type="checkbox"/>	<input type="checkbox"/>

If answers to QUESTIONS 3-6 ARE YES – PROCEED WITH SCREEN

If ANY answer is NO – STOP, MAINTAIN PATIENT NPO, AND ALERT SLP (Ext 6273)

FINALLY:

7. Does the patient have a "WET" or HOARSE-sounding voice

NO PROCEED WITH SCREEN
YES STOP, MAINTAIN PATIENT NPO, ALERT SLP

If IN DOUBT, DISCUSS WITH SLP ON MEDICAL TEAM.

Pre-Screen Signature: _____ **DATE/TIME:** _____

SWALLOW SCREENING: CHECK SUCCESSFUL COMPLETION OF EACH TASK OR PROBLEMS IDENTIFIED IF APPLICABLE

WITH PATIENT ALERT & SAT UPRIGHT:

<p>Give first teaspoonful of water</p> <p><input type="checkbox"/> Pass, <input type="checkbox"/> Fail</p> <p>↓ Pass, No Problems</p> <p>Give 2nd teaspoonful of water</p> <p><input type="checkbox"/> Pass, <input type="checkbox"/> Fail</p> <p>↓ Pass, No Problems</p> <p>Give 3rd teaspoonful of water</p> <p><input type="checkbox"/> Pass, <input type="checkbox"/> Fail</p> <p>↓ Pass, No Problems</p> <p>Give ½ glassful of water</p> <p><input type="checkbox"/> Pass, <input type="checkbox"/> Fail</p> <p>↓ Pass, No Problems</p>	<p>PROBLEMS IDENTIFIED:</p> <p><input type="checkbox"/> No attempts to swallow</p> <p><input type="checkbox"/> Water leaks straight out of mouth</p> <p><input type="checkbox"/> Breathlessness</p> <p><input type="checkbox"/> Choking</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Wet or gurgly voice afterwards</p>
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STOP Screening

Patient NPO

Alert SLP



Form # Approved MAC

SIGNATURE REQUIRED IN 2 PLACES - AFTER PRE-SCREEN AND SCREEN (IF BOTH COMPLETED)

PLACE COMPLETED PAPER FORM IN CHART IN THE INTERDISCIPLINARY NOTES SECTION

WITH COPY CHART Page 1

The Tool: Stroke Standardized Swallowing Screen

Reverse side has information regarding:

- Guidelines
- Diets
- Abbreviations
- Contact Information
- Reference

Selected TBHSC Adult Diet Definitions		
Order	Description	Clinical Indications or Considerations from Screening
NPO	Nothing by mouth, this includes PO medications	Problems identified on swallowing screen.
Full	Regular diet	No obvious chewing or swallowing difficulties. No cognitive concerns that may affect safety of swallowing (eg. taking too much at once, trying to take more when they are already coughing).
Pureed	All foods blended smooth	Significant difficulty chewing/swallowing
Mixed	Meat and vegetables ground, blended both soup and regular cream soup, canned fruit	Difficulty chewing/swallowing Easy fatigue
Mixed Dysphagia	Mixed Diet plus blended/strained soups, pureed fruit, no bread products	Difficulty chewing/swallowing
Chopped	Meat cut in bite sized pieces, canned fruit "Ready meals" - please order CHOPPED diet and write "ready meals" in comment section - this will ensure that packages/containers are opened on tray prior to tray delivery	For patients with difficulty cutting food. http://www.tbhsc.com include amount and function/restrictions/medications with managing team/manager. Cognitive issues/concerns that may affect safety during meals (eg. needs help to open packages/pieces that attempting to eat larger pieces of food isn't an option)
Soft	Full Diet except no raw fruits/vegetables	Difficulty chewing tougher textures (eg. poor dentition or loose dentures)
Finger Foods	Sandwiches, soup in mug, foods that do not require utensils	Difficulty using cutlery. Poor dexterity.

Refer to TBHSC Adult Diet Definitions Summary for more detail ([TBHSC Nutrition and Food Services > Patient Meals > Diet Definitions / Orders](#))

Contact SLP if any questions/concerns: Extension 6273

Abbreviation Legend: EMR - electronic medical record, NPO - nil per os (nothing by mouth), O₂ - oxygen, SLP = Speech-Language Pathologist

Standardized Swallowing Assessment. Adapted with permission: Perry, L. Journal of Clinical Nursing 2001; 10:4:463-73

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Bedside Swallowing Assessment

- Only allows the SLP to assess the oral stages
- Relies on clinical judgment and inferencing skills
- Takes into consideration the objective, subjective, and behavioural information from physicians, nurses, other therapists, family, and any other individuals interacting with the client.



Bedside Swallowing Assessment

- Objective information including
 - ***Diagnosis and onset of symptoms**
 - *Past and current medical history
 - *CT/MRI/CXR results
 - *Flow sheet information (input, output, temps)
 - *Current levels of nutritional intake and difficulties with intake
 - *Medications
 - *Respiratory status



Bedside Swallowing Assessment

■ Subjective information including:

- *Mentation/cognition
- *Level of alertness
- *Willingness of client to participate
- *Impression of client's swallowing from the client, the family, and other team members



Bedside Swallowing Assessment

■ Start the assessment with discussing what the client feels is a concern and what they typically eat at home.

■ Complete an oral peripheral exam prior to offering food or fluid to the client

- *How is the client's positioning
- *What do the oral structures look like (lips, tongue, teeth, palate)
- *What does the client's voice sound like
- *Does the client have an effective cough



Bedside Swallowing Assessment

- Begin swallowing trials with fluids or what the SLP feels appropriate.
- Teaspoon amounts are typically offered initially and the client may be asked to try on their own if they seem safe.
- Progression to various textures is dependent on how well the client managed the previous texture of food/fluid.
- Good information can also be gathered by watching the client or caregiver take/give the food/fluid as they normally do at home.



Bedside Swallowing Assessment

- Diet recommendations will depend on what is observed during the assessment.
- Ideally the client and SLP discuss and agree upon safe food and fluid textures for the client to have on their trays.
- Diet recommendations work best when the client, their family, and staff all agree and comply with the recommendations.



Videofluoroscopic Swallow Study

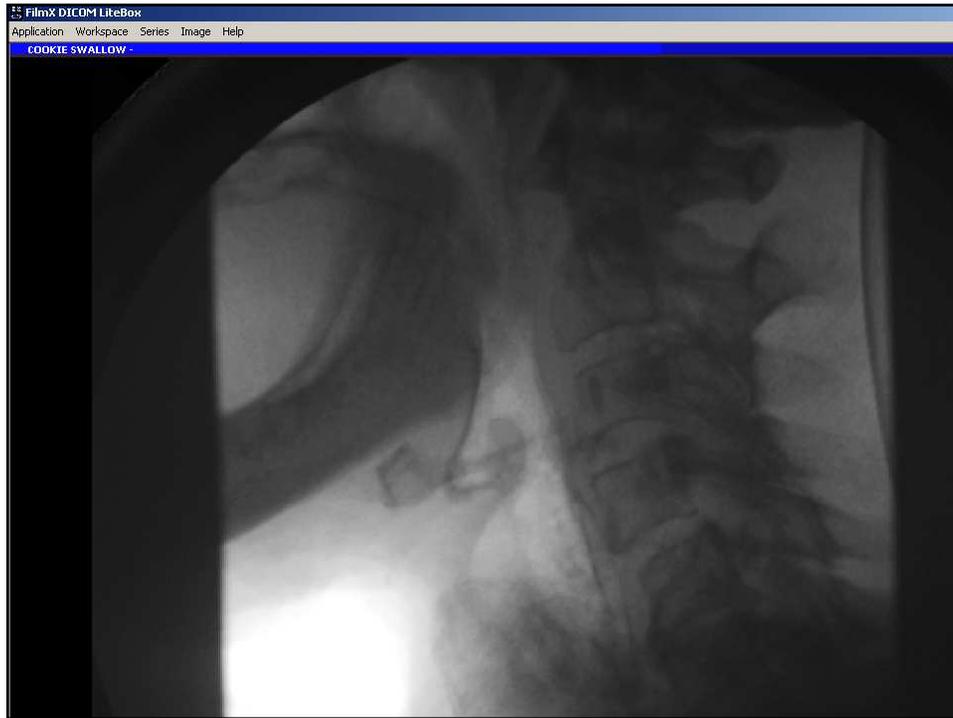
- When information from the bedside swallow assessment is inconclusive or if the client's performance is inconsistent, a Videofluoroscopic Swallow Study (VFSS) may be requested.
- The procedure is the same as at the bedside, but the client is assessed in Diagnostic Imaging and barium is added to the food and fluid.



VFSS

- The oral, pharyngeal, and part of the esophageal phases are able to be visualized and gives the SLP a clearer picture of what is happening before, during, and after the swallow.





Safe Swallowing Suggestions

- Offer mouth care before and after each meal
- Make sure the client is alert and responsive
- Position the client to facilitate good swallowing
- Feed the client at eye level (Sit if the client is in a chair or in bed, if you want to stand, raise the client's bed to your height)
- Use teaspoons, not tablespoons
- Go slowly and wait for the client to swallow

Safe Swallowing Suggestions

- Offer fluids slowly from a wide nosed cup or from a teaspoon (minimize flexing the neck back). No big gulps or continuous drinking.
- Not everyone can manage a straw, check with the SLP or the chart for recommendations.
- Encourage more than one swallow per bite/sip if necessary.
- Minimize distractions – turn off the TV or minimize talking during the meal. Focus on intake.



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When Oral Intake is Not an Option

- There are times when oral intake is not safe for the client and is not recommended by the S-LP
- It is important to include all the team members in the discussion about oral and non-oral feeding, which may include the patient, the physician, nurse, speech-language pathologist, registered dietician along with any family or friends the patient may want there.
- Different feeding options may be discussed (NG tube feeds vs. PEG feeds) and the reasoning why either may be appropriate for the Patient



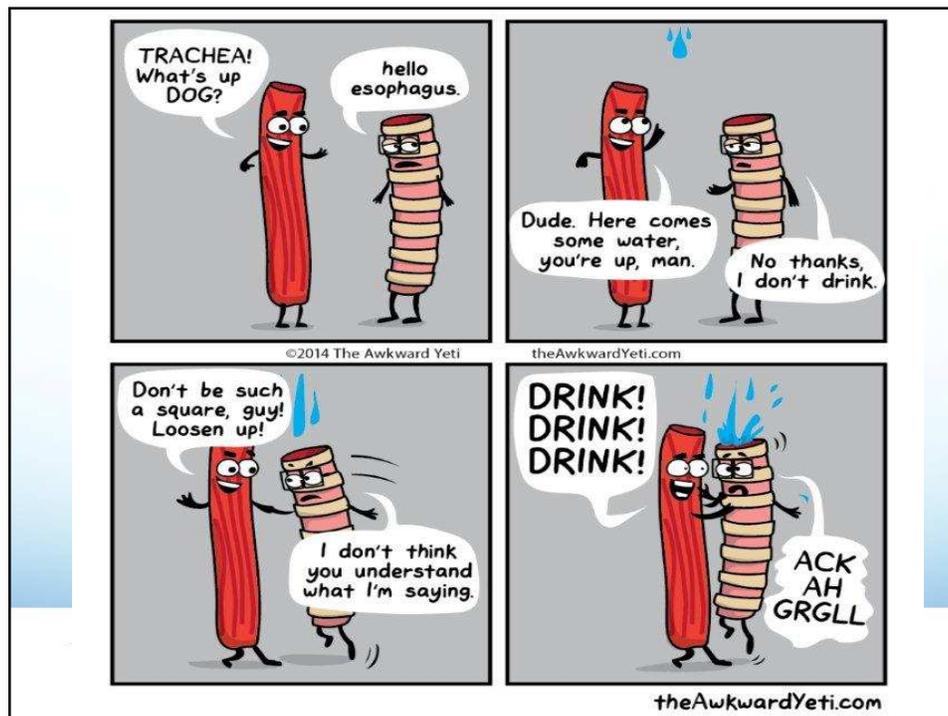
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S-LP vs. Registered Dietitian (RD)

- It is important to keep in mind the individual who will be able to manage different aspects of nutrition
- The S-LP will determine the patient's appropriateness for oral intake, taking into consideration safety and the patient's goals
- The RD will manage the patient's nutrition with either oral or non-oral intake
- Both try to provide the patient with food and fluid options that satisfy the patient's preferences



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QUESTIONS?

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