Screening for Dysphagia

An Interactive Training Package
SCREENING FOR DYSPHAGIA
An Interactive Training Package

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This booklet has been designed to accompany the Swallow Screening Training and forms part of the recommended programme leading to recognition of competency in the procedure within NHS Lothian. It was prepared by:

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Acknowledgements

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SECTION 1: INTRODUCTION

Dysphagia affects a large proportion of the elderly population. The incidence of dysphagia in acute care is around 33% (Layne et al 1998) rising to 66%(Seibens et al 1986) in long-term care.

Failure to identify dysphagia or inappropriate management can result in potentially life threatening pneumonia and problems receiving adequate nutrition and hydration.

Swallow screening is a procedure designed to detect signs or indicators of swallow dysfunction (dysphagia). It is not a full clinical assessment to inform the management of the patient with dysphagia or to make judgement on the type or degree of dysfunction. It does however allow the individual to identify those who can swallow safely and those who should be referred for a full clinical assessment by a Speech and Language Therapist (SLT).

1.1 Aims of training programme

This training package has been devised to provide the theoretical knowledge and practical skills to competently and safely perform a basic swallow screen.

This will lead to the individual having a documented statement of competency in swallow screening and will be able to perform the test independently.

1.2 Structure of the training programme

This programme consists of 4 inter-related sections, all of which should be completed:

1. Self directed learning using the training package and other sources.
2. Theoretical instruction using the CD ROM.
3. Performing supervised swallow screening.
4. A final practical competency assessment.

The supervision and assessment will be carried out by a member of the speech and language therapy team or an individual who is recognised as an assessor in swallow screening.

1.3 The competency assessment

• The assessment will be based on the criteria in appendix III.
• The individual undertakes as many supervised screens until he/she feels competent to carry out the screen independently.
• When the competency assessment has been successfully completed a record will be kept in his or her department. It will be dated and signed by the individual and the assessor.
• On signing the document, the individual accepts responsibility in widening the scope of his/her professional practice by screening for dysphagia.
• It is also recommended that the individual maintain a copy in his or her own personal records.
1.4 **Learning outcomes**
On completion of the training package the individual will be able to:

- Demonstrate sound theoretical knowledge of the principles and practices of swallow screening
- Demonstrate an awareness of local, national and risk management guidelines as they apply to swallow screening
- Correctly identify patients who require swallow screening
- Demonstrate correct procedure in planning and undertaking swallow screening
- Identify and demonstrate correct use of documentation
- Demonstrate the procedure and referral process for patients who have dysphagia

The speech and language therapist for your clinical area is:

_____________________________________

The Clinical supervisor for dysphagia screening for your area is:

_____________________________________

_____________________________________

_____________________________________
SECTION 2: PRINCIPLES OF SWALLOW SCREENING

2.1 The normal swallow

The stages

It is important to have an understanding of the normal swallowing process before attempting to screen for dysphagia. Much of the screening procedure is based on observed patient behaviour, which can alert one to alteration in the normal swallowing process.

Swallowing is a complex neuromuscular process, which is often described in 4 stages.

- Oral preparatory
- Oral
- Pharyngeal
- Oesophageal (Logemann 1998)

Difficulties in eating and drinking can develop for a variety of reasons and are more easily understood when the swallow can be broken down into the above stages.

These stages are described with annotated diagrams in the CD ROM.

Oral Preparatory Phase:

**Purpose:** Breaks down food prior to swallowing.

**Involves:** Saliva to moisten food. Function of jaws, lips, tongue, cheeks, teeth and soft palate to control and chew the food bolus. Sensory recognition of food approaching and in mouth.

Oral Stage:

**Purpose:** Gathers the bolus in the mouth and moves it back into the pharynx.

**Involves:** Co-ordinated tongue movements to clear the mouth and soft palate closure to prevent nasal regurgitation.

Pharyngeal Stage:

**Purpose:** Transports bolus through the pharynx protecting the airway.

**Involves:** Finely co-ordinated movements including:
- Soft palate closure
- Laryngeal closure and elevation to protect airway
- Pharyngeal contractions to squeeze bolus down and clear the pharynx
- Epiglottis tilting to protect the airway
- Relaxation and opening of the upper oesophageal sphincter to allow the food to proceed into the oesophagus
Oesophageal Stage:

**Purpose:** Transports the food to the stomach.

**Involves:** Muscles to assist transit. This ends the swallowing process and digestion can continue.

### 2.2 Respiration and swallowing

Normal swallowing should involve fine coordination with the respiratory system.

- A longer than normal inspiration followed by a breath hold period, should precede the pharyngeal stage of the swallow reducing the risk of aspiration
- This stage should then be followed by a large expiration to prevent any residual bolus being ‘sucked’ into the trachea, thus potentially playing a protective role
- The cough reflex also provides a protective mechanism

Patterns of breathing become more irregular during eating and drinking.

A problem with breathing may contribute to swallowing dysfunction for example:

- High respiratory rate may not allow sufficient breath hold
- Altered pattern of breathing may result in poor coordination of breathing with swallowing.

### 2.3 The abnormal swallow

The consequences of dysphagia are:

- Reduced nutritional intake, potentially leading to malnutrition and dehydration
- Inability to take oral medication
- Aspiration potentially leading to aspiration pneumonia.

An example of an abnormal swallow and aspiration is described with annotated diagrams in the CD ROM.
The following table lists some examples of disorders and details the possible consequences and presenting symptoms to consider:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced lip closure</td>
<td>Likely drooling with inability to keep food in mouth and build up intra oral pressure for swallowing.</td>
</tr>
<tr>
<td>Unilateral oral weakness</td>
<td>Inability to clear food from weak side.</td>
</tr>
<tr>
<td>Reduced tongue movement</td>
<td>Problems delivering food onto the teeth for chewing. Inability to clear mouth and push bolus back into the pharynx, triggering the swallow reflex.</td>
</tr>
<tr>
<td>Delayed swallow reflex</td>
<td>Food enters the airway before swallow triggered causing aspiration before the swallow.</td>
</tr>
<tr>
<td>Reduced laryngeal closure</td>
<td>Bolus can enter the airway during the swallow.</td>
</tr>
<tr>
<td>Reduced laryngeal elevation</td>
<td>Bolus can get caught above the airway during the swallow and then be aspirated once swallow mechanism returned to rest.</td>
</tr>
<tr>
<td>Pharyngeal weakness</td>
<td>Incomplete clearance of the throat, which can result in aspiration after the swallow.</td>
</tr>
<tr>
<td>Reduced laryngeal sensation</td>
<td>If there is no sensation, the trigger and coordination of the swallow can be affected and the protective cough response may be absent. This is silent aspiration.</td>
</tr>
</tbody>
</table>

These are just a selection of problems and some of these will be easier to observe than others. Generally oral problems are easier to see whereas pharyngeal stage problems are much more difficult to identify and are more likely to lead to aspiration.

It is therefore essential to follow an approved screening protocol carefully and accurately to ensure sensitivity of the test.
SECTION 3: IDENTIFYING THE PATIENT AT RISK

There are national guidelines and standards to ensure swallow screening, to identify the presence or absence of dysphagia, is carried out for all patients with suspected stroke.

A further important skill is identifying those other patients who should be screened for dysphagia.

3.1 National Guidelines

SIGN (Scottish Intercollegiate Guidelines Network):

78 Management of Patients with Stroke: Identification and Management of Dysphagia

‘All stroke patients should be screened for dysphagia before being given food or drink’ 2004.

Should include checks on:

- Conscious level
- Postural control
- Oral hygiene
- Control of oral secretions
- If appropriate, a water swallow test


“All patients have an initial swallow screen test performed on day of admission, unless there is a documented contraindication.”

3.2 Other patient groups who may require swallow screening

Many other medical conditions are associated with dysphagia for example head injury, Parkinson’s Disease, cerebral palsy, dementia, and degenerative neurological conditions.

This screening test is appropriate to use with patients with suspected neurological swallowing problems. However, it is not appropriate for patients with mechanical swallowing problems such as those with head and neck tumours, or with the presence of a tracheostomy, where further assessment is required.

It is therefore appropriate to screen patients with a suspected neurological cause of dysphagia when:
• They present with a history of swallowing problems – although not all patients will be aware of their swallowing safety.
• There are guidelines or standards in place, for example SIGN 78.
• There has been deterioration in condition or new neurological event.
• Signs and symptoms of possible dysphagia have been observed (see checklist below).
SECTION 4: SIGNS AND SYMPTOMS OF DYSPHAGIA

Very often suspected dysphagia is picked up during history taking or later after observation. The following checklist is a guide to improve the identification of patients at risk.

**Signs and Symptoms of Dysphagia Checklist**

<table>
<thead>
<tr>
<th>Feature</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduced conscious level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Recurring pneumonia (unexplained)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Weak voluntary cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gurgly voice quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Presence of dysarthria (speech disturbance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Patient complaining of swallowing difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Inability to control food/fluid in the mouth e.g. dribbling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Coughing before, during or after a meal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Pocketing of food in mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Impaired breathing during mealtimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Repeat swallowing on most mouthfuls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Difficulty initiating a swallow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Weight loss where no other reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Inability to recognise food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Avoidance of food consistencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Increased production of secretions after meal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 5: IMPLICATIONS OF DYSPHAGIA

Two main problems that occur as a result of dysphagia:

- Malnutrition
- Aspiration pneumonia

5.1 Malnutrition

It is estimated that 20-40% of hospital patients are undernourished (Clinical Standards Board, 2003). This means their bodies are in a state where they are not receiving enough energy, protein and other nutrients. This has adverse effects on the body’s structure, function and clinical outcomes. For example patients may experience:

- Increased risk of pressure sores
- Delayed wound healing
- Increased incidence of infections
- Longer hospital admissions
- Depression and lethargy
- Death

Patients with dysphagia are at increased risk of malnutrition. They have many of the risk factors commonly experienced by hospital patients such as anxiety, pain, lack of appetite and restricted access to food, but they have further problems to contend with, as outlined below.

5.2 Causes of malnutrition in dysphagia

- Difficulties with chewing and swallowing usually lead to decreased dietary intake
- Modified consistency diets can mean a dilution of nutrients e.g. pureed meat courses can contain less protein as the meat is diluted with gravy
- Unfamiliar hospital diets can lead to a decreased intake (modified consistency can mean foods are not recognisable or appetising)
- Modified consistency diet means restriction of food choices e.g. no bread
- Unsafe swallow sometimes requires patient to be made nil by mouth

It is therefore important to identify patients who are malnourished or who are at risk of malnutrition and take appropriate action to improve nutritional status.

A simple method of identifying at risk patients is to use a nutritional screening tool.

All patients should have nutritional screening completed on admission and repeated as necessary during their hospital stay.
5.3 What is nutritional screening and why do it?
Nutritional screening identifies patients at risk of malnutrition. This means a nutritional care plan can be implemented to improve nutritional intake and the patient’s progress monitored.

Nutritional screening uses a simple tool which scores risk factors that can lead to increased risk of malnutrition. **Check the policy in your area** but a sample of the type of questions usually included is given below.

Example of nutritional screening using 5 question approach

- Have you unintentionally lost weight recently?
- Have you been eating less than usual?
- What is your normal weight?
- How tall are you?
- Have you noticed clothing or jewellery has become loose?

**Calculate body mass index (BMI)**

\[
\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)}^2}
\]

Body mass index is a useful score calculated using height and weight as above.

A score of 20-25 indicates a healthy body weight, 19 or less indicates underweight and more than 26 indicates overweight.

A full objective assessment may not always be achievable e.g. patient may be unable to communicate or taking accurate weight may be difficult. This group of patients are more likely to be at risk of poor nutritional intake. Observing these patients carefully can be useful. Do they look thin? Does clothing look too big? Document these observations and actual food intake to provide information to assist the formulation of an appropriate care plan.

5.4 Treatment of Malnutrition
Malnutrition often goes unrecognised and untreated. A few simple steps can prevent and treat this problem.

- **Identify patients at risk:** use validated nutritional screening tool as previously described. Consider referral to the dietitian.
- **Monitor dietary intake at mealtimes:** keep accurate food charts and review the quality and quantity of food eaten. Your dietitian can make accurate assessments of nutritional intake from complete record charts.
- **Assist with menu choices:** encourage appropriate food selection in terms of consistency and nutritional value. Liaise with the dietitian.
• **Assist with feeding:** liaise with the occupational therapist if aids for feeding are required.

• **Offer snacks between meals:** little and often is probably the best way to increase dietary intake. It may be possible to obtain preferred foods from the dietitian.

• **Monitor progress:** repeat nutritional screening and take action according to local policy, record weekly weights etc.

**Nutritional support**

Patients with dysphagia, at risk of malnutrition, may not be able to meet their nutritional requirements with normal foods. In these cases the dietitian may recommend nutritional supplements. Nutritionally complete drinks or puddings are most commonly used to provide nutrients in a concentrated easy to take form.

In patients where the swallow is so compromised that the patient cannot safely take adequate oral diet then enteral tube feeding via nasogastric or gastrostomy tube should be considered.
SECTION 6: RELIABILITY OF SWALLOW SCREENING

Swallow screening is a procedure to identify any potential indication of dysphagia and therefore risk from aspiration. It is not a clinical assessment to inform the management of the patient with dysphagia or make judgement on the type or degree of dysfunction. It should however, reliably identify those patients who have potential problems and should be referred for full assessment from speech and language therapy.

A reliable screening procedure should:

- Be sensitive, i.e. identify risk when present.
- Be specific, i.e. clearly identify those patients not at risk.
- Be consistent, i.e. can be used by different people to give the same result.
- Be relatively quick and easy to carry out.

To meet these criteria the swallowing screening has three key components, all of equal importance to maintain reliability.

- Training component to establish competence and therefore accuracy in screening.
- Checklist on clinical features, which can identify those patients who are at risk and should not be screened but referred for full clinical assessment. The clinical features include conscious level, postural control, saliva control, and ability to cough and phonate.
- The graduated water swallow test with observation for signs and symptoms presented in a flow chart format (appendix I).

All the above components should ensure that the screening procedure will also identify those patients who are at risk including the patients who are most at risk of silent aspiration.
SECTION 7: PATIENT SAFETY
Safe swallow screening is demonstrated in the CD ROM. What follows is an outline of key points to remember.

7.1 Effects of Posture/Positioning on Swallowing
A good seating posture is essential for an effective swallow. Posture can have a significant effect on breathing, swallowing and digestion. Head posture is influenced by the position at the pelvis and trunk. Hyper extension or hyper flexion of the neck can seriously affect the swallowing process. Patients with unilateral weakness are prone to falling to their weaker side with the result that the weaker muscles are more involved when controlling the food/fluid.

Achieving optimum positioning of patients in bed is demonstrated in the CD ROM.

7.2 Respiratory Care
If patients have prescribed oxygen, additional care should be taken during the swallow screening procedure.

• If oxygen is being delivered via an oxygen mask – consider changing to nasal cannulae.
• If oxygen is removed, ensure patient is maintaining adequate oxygen saturations.
• Any recommendations to proceed with eating/ drinking should include reference to oxygen requirements
• Know where suction is available
## SECTION 8: DECISION MAKING

The outcome of the swallowing screening procedure is detailed in the table below:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Safe to commence diet and fluids</th>
<th>Not suitable to screen</th>
<th>Referral for full clinical assessment required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions</td>
<td>Complete documentation</td>
<td>Document NBM with reasons in notes</td>
<td>Complete documentation</td>
</tr>
<tr>
<td></td>
<td>Ensure initial supervision of feeding</td>
<td>Review within 24 hours</td>
<td>Ensure referral to SLT</td>
</tr>
<tr>
<td></td>
<td>Consider the stability of the patient’s condition</td>
<td>Review source of hydration</td>
<td>Notify medical staff</td>
</tr>
<tr>
<td></td>
<td>Review as required, looking out for any deterioration</td>
<td>Consider appropriate route for medication</td>
<td>Arrange non oral hydration</td>
</tr>
<tr>
<td></td>
<td>Complete nutritional screening</td>
<td>Consider referral to dietitian</td>
<td>Review medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral for full SLT assessment required</td>
<td>Consider referral to dietitian</td>
</tr>
</tbody>
</table>
References


Allison SP. Hospital Food as Treatment (2000); a report of the working party of the British Association of Parenteral and Enteral Nutrition (BAPEN).


## Appendix I: NHS Lothian Swallow Screening Protocol

### SWALLOWING SCREENING TEST – An Interdisciplinary Tool

<table>
<thead>
<tr>
<th>Pre-Assessment Criteria:</th>
<th>Site:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the patient is drowsy and unable to sit upright, then it is <strong>NOT SAFE</strong> to complete this assessment. They should remain Nil By Mouth (NBM). Monitor conscious level: attempt to screen daily until completed.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Addressograph, or Name</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<th>DoB</th>
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<table>
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<tr>
<th>Unit number</th>
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</table>

### Record of screening reviews

<table>
<thead>
<tr>
<th>date</th>
<th>Initials / signature / ward</th>
<th>Screened?</th>
<th>Reason if ‘No’ and actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

### Risk Factors checklist:

<table>
<thead>
<tr>
<th>Unable to cough</th>
<th>Wet / hoarse voice</th>
<th>Excessive / copious oral secretions</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

If any noted

<table>
<thead>
<tr>
<th>If any noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>→ Consider direct referral to SLT.</td>
</tr>
<tr>
<td>→ Continue with oral hygiene.</td>
</tr>
</tbody>
</table>

### Prepare patient:

- Sit patient upright at 90° [ ]
- Ensure head not extended [ ]
- Check oral hygiene [ ]

### Give 1 teaspoon of water

- No attempt to swallow [ ]
- Some attempt to swallow [ ]

### Give 2nd teaspoon of water

- Problems [ ]
- No problems [ ]

### Give 3rd teaspoon of water

- Problems [ ]
- No problems [ ]

### Sips of water

- Problems [ ]
- No problems [ ]

### Give ½ glass of water

- Problems [ ]
- No problems [ ]

### Problems:

- [ ] Absent swallow
- [ ] Coughing
- [ ] Choking
- [ ] Breathlessness
- [ ] Wet / Gurgly voice
- [ ] Delayed swallowing
- [ ] Any other problems:

### Problems

- [ ] Absent swallow
- [ ] Coughing
- [ ] Choking
- [ ] Breathlessness
- [ ] Wet / Gurgly voice
- [ ] Delayed swallowing
- [ ] Any other problems:

### Problems

- [ ] Absent swallow
- [ ] Coughing
- [ ] Choking
- [ ] Breathlessness
- [ ] Wet / Gurgly voice
- [ ] Delayed swallowing
- [ ] Any other problems:

### SUMMARY

- Patient NBM
- Refer to SLT
- Hydration – Treat needs “Urgent for Action”
- Medication – Staff to confirm route with Pharmacist
- Nutrition – Complete Nutritian Tool and discuss with team
- Continue rigorous oral hygiene

### For re-screen tomorrow [ ]

- Safe for oral intake [ ]
- Referral to SLT [ ]
- Referral to Dietitian [ ]

Signed: .................................................................  Design: .................................................................
Appendix II:  Glossary of Terms

**Aspiration:** The entry of food or liquid into the airway.

**Bolus:** The portion of food or fluid placed into the mouth formed into a cohesive ball after chewing.

**Dysarthria:** A neuromuscular disorder of speech

**Dysphagia:** Difficulty moving food from the mouth to the stomach.

**Epiglottis:** A thin cartilaginous flap that covers the entrance to the larynx during swallowing preventing food/ fluid entering the trachea.

**Gastrostomy tube:** A non oral feeding method. The tube is placed surgically to create an external opening in the abdomen leading into the stomach.

**Larynx:** A cartilaginous and muscular organ forming part of the airway and containing the vocal cords.

**Nasogastric tube:** A non oral feeding method, the tube is surgically placed through the nose, pharynx and oesophagus to reach the stomach.

**Regurgitation:** The back-flow of food/ fluid in the opposite direction to the normal swallow.

**Oesophagus:** Part of the digestive tract from the pharynx to the stomach.

**Pharynx:** Part of the digestive tract from the mouth to the oesophagus.

**Silent aspiration:** Aspiration occurs without any outward signs such as coughing. Studies have shown up to half of the patients who aspirate, do so silently.
Appendix III: Competency Documentation

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward:</td>
<td></td>
</tr>
<tr>
<td>Title:</td>
<td></td>
</tr>
</tbody>
</table>

**Competency**

<table>
<thead>
<tr>
<th>Theoretical component:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical component:</td>
<td></td>
</tr>
</tbody>
</table>

Date commenced:  
Date completed:  
Assessor(s):  

Date competency achieved:  

**Date for review of competency (1 year):**  

Please Copy this sheet twice and give one to your line manager, send one to:
## Swallow Screening Competency

<table>
<thead>
<tr>
<th>Elements of competency</th>
<th>Supervised Session 1</th>
<th>Supervised Session 2</th>
<th>Competency Achieved Trainer/Trainees signature</th>
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</tbody>
</table>

I have received appropriate teaching and have attained a reasonable level of understanding of the nursing care and medical management of the patient requiring swallowing screening.

Signed (trainee) ……………………… Date……………………

Signed (assessor) ……………………… Date……………………
### Swallow Screening Competency – Performance Criteria

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Knowledge and Skill</th>
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</thead>
</table>
| Legal and ethical obligation to practice swallow screening safely is discussed | Shows awareness of  
• NMC code of conduct  
• Trust guidelines on competencies  
• SIGN guidelines  
• Risk management guidelines  
• Training package on swallow screening |
| Elements of a normal swallow are discussed | Normal swallow  
• Oral  
• Pharyngeal  
• Oesophageal  
The relationship between swallowing and respiration is outlined |
| Definition of dysphagia is outlined | Dysphagia – difficulty in swallowing food or liquid without aspiration  
Problems can occur  
• With the patient’s response to food  
• In the oral phase  
• During the pharyngeal phase  
• During the oesophageal phase |
| Patients who may require screening are correctly identified. | Common conditions are  
• Stroke  
• Traumatic head injury  
• Degenerative neurological conditions  
• Head and neck cancers  
• Dementia |
| Demonstrate knowledge of the risks associated with swallowing dysfunction | • Aspiration and possible pneumonia  
• Malnutrition  
• Dehydration  
• Inability to take prescribed oral medication |
| Correct assessment of the patient is carried out prior to screening | Patients who are:  
• Fully conscious aware and alert  
• Able to produce a normal voice and a voluntary cough  
• Swallowing saliva spontaneously  
• Nutritional screen using recognised tool is carried out |
### Swallow Screening Competency – Performance Criteria (continued)

<table>
<thead>
<tr>
<th>Elements of competency</th>
<th>Knowledge and Skill</th>
</tr>
</thead>
</table>
| Safety measures are put in place prior to carrying out a swallow assessment              | • Patient in upright position and assessed for ability to maintain position and control head and neck  
• If on oxygen therapy via face mask, ensure nasal cannulae and saturation probe in place prior to carrying out assessment  
• Suction is in close proximity  
• Mouthcare is carried out                                                                                                                                 |
| Swallow screening is carried out appropriately                                           | • Correct paperwork is identified  
• Consideration to patients dignity and confidentiality is demonstrated  
• Procedure is followed according to local protocol                                                                                                                                                           |
| Knowledge of reliable predictors of aspiration and silent aspiration and is demonstrated | Reliable Predictors  
• Wet voice  
• Weak cough  
• Cough on swallowing                                                                                                                                                                                       |
| Management of patients with suspected aspiration is described                           | Management  
• Patient nil by mouth  
• Supplementary IV/SC fluids prescribed  
• Referral to SLT/ and medical staff  
• Screening and reasons for suspected aspiration are documented in notes  
• Daily reassessment is carried out if appropriate                                                                                                                                                        |
| Demonstrate appropriate decision-making based on outcome of swallow screening           | • Refer to local policies for procedures for referral                                                                                                                                                                 |

**Notes:**
### SWALLOWING SCREENING TEST – An Interdisciplinary Tool

**Pre-Assessment Criteria:**
If the patient is drowsy and unable to sit upright, then it is **NOT SAFE** to complete this assessment. They should remain Nil By Mouth (NBM). Monitor conscious level: attempt to screen daily until completed.

**Site:**
- Addressograph, or
- Name
- DoB
- Unit number

**NB:** Nutritional screening required <48h for **ALL** patients

<table>
<thead>
<tr>
<th>Record of screening reviews</th>
<th>Screened?</th>
<th>Reason if ‘No’ and actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td>date</td>
<td>Initials / signature / ward</td>
<td>Y . N</td>
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</tr>
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</table>

**Risk Factors checklist:**
- Unable to cough
- Wet / hoarse voice
- Excessive / copious oral secretions

If any noted

- Consider direct referral to SLT.
- Continue with oral hygiene.

**Prepare patient:**
- Sit patient upright at 90°
- Ensure head not extended
- Check oral hygiene

**Give 1 teaspoon of water**
- No attempt to swallow
- Some attempt to swallow

**Give 2nd teaspoon of water**
- Problems
- No problems

**Give 3rd teaspoon of water**
- Problems
- No problems

**Sips of water**
- Problems
- No problems

**Give ½ glass of water**
- Problems
- No problems

**Problems:**
- Absent swallow
- Coughing
- Choking
- Breathlessness
- Wet / Gurgly voice
- Delayed swallowing
- Any other problems:

**SUMMARY**
- For re-screen tomorrow
- Safe for oral intake
- Referral to SLT
- Referral to Dietitian

Signed: ..................................................................................  Design: ..............................................................................
Screening for Dysphagia – An Interactive Training Package