MONTANA Stroke Initiative

Nursing Dysphagia Screen

*Adapted from the Yale, Massey Bedside Swallowing Screen and the Scottish Intercollegiate Guidelines Network Screen.

Complete prior to oral intake for all ischemic stroke, hemorrhagic stroke and TIA patients.

Date of admission/event:_____

Date of Screen:_____ Time of Screen:_____

Follow Algorithm and circle yes or no.

Patient	
Is alert for at least 15 minutes & can be seated upright?	NO →
Previously had a normal swallow function and was eating and drinking a regular diet with normal liquids?	NO →
Is without diagnosis of brainstem stroke (pons, midbrain, medulla)?	NO →
Is without enteral feeding tube (via stomach or nose)?	NO →
Is without tracheostomy?	NO →

STOP

If yes to all above questions, continue.

Is the patient able to:	
Clench teeth/ close lips?	NO →
Symmetrical face movement?	NO →
Cough voluntarily? (have patient cough 2 times)	NO →
Swallow own secretions?	NO →
Articulate words with no slurring?	NO →

STOP

If yes to all above questions, sit patient upright and continue.

Give patient a teaspoon of water.	
Swallows without coughing, choking, or water dribbling out of mouth?	NO →
Able to swallow without gurgling or wet voice? (ask patient to say "Ah")	NO →

STOP

If yes to all above questions, continue.

Give patient 60 cc's of water.	
Swallows without coughing, choking, or water dribbling out of mouth?	NO →
Able to swallow without gurgling or wet voice? (ask patient to say "Ah")	NO →

STOP

1. **Keep NPO.**
2. **Consult Speech Therapy.**
3. **Maintain oral hygiene.**

If yes to all above questions, patient passes dysphagia screen. Follow instructions below.

Consider starting patient on a regular diet. Keep in mind patient's diet prior to admission and dentition. Continue to observe for immediate or delayed coughing, change in vocal quality, lung sounds and temperature spikes. If any occur, consult speech therapy.

Nurse Signature _____ Printed Surname_____

 See reverse for aspiration signs & precautions.

Signs of Aspiration:
For all patients, even those who pass a nursing swallow screen, monitor for signs of aspiration.

- Watery eyes
- Fever of unknown origin
- Slow oral intake
- Increased work of breathing
- Increased oxygen needs

Aspiration Precautions:

- Position patients to reduce risk of aspiration.
- HOB at 90 degrees
- Encourage small bites
- Head in midline
- Pillow at back for upright posture
- Chin tuck with swallowing. (Patients who chronically struggle with pills getting "stuck" may be able to close the vallecular space by tucking their chin when they swallow.)
- Cheek check after meds and meals. (Teach patient and family as well.)
- Set up tray to compensate for visual field cut. If the patient has a left visual field cut, position items further to their right and vice versa. Left strokes usually have right field cut and vice versa.
- Family education on all of the above.