

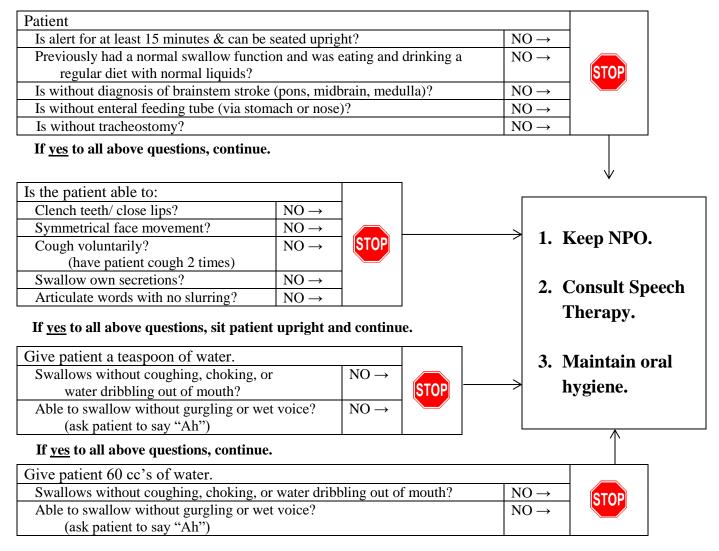
Nursing Dysphagia Screen

*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 ves or no.



If <u>ves</u> 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



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.