Glendive Medical Center **Policy Owner: Speech**
Policies & Procedures Applies To: Nursing AC

SUBJECT: DYSPHAGIA EVALUATIONPROTOCOL FOR ACUTE CARE AND SWINGBED SETTING

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Effective Date: 02/20

Approved By: ____ 
Parker Powell, CEO

POLICY:

Appropriate protocol will be implemented for the evaluation and assessment of chewing and/or swallowing disorders in an effort to identify patients at risk for aspiration. Glendive Medical Center (GMC) Speech Therapy (SLP)) department evaluates the functioning level of patient's ability in feeding-swallowing process and recommends levels of diet modification in texture and viscosity and treatment plan following provider referral.

To screen patient for the presence of DYSPHAGIA

DYSPHAGIA:

Defined as, difficulty or pain in swallowing, caused by lesions or structure if the upper digestive tract, obstruction of the upper tract by tumors or foreign bodies, or disturbances in the nervous or muscular control of swallowing. Dysphagia can also be caused by an acute change in the central nervous system such as a cerebrovascular accident, transient ischemic attack, traumatic brain injury, or neurological disease processes such as dementia or amyotrophic lateral sclerosis. People with dysphagia may experience a sensation that food or liquid is lodged in the upper digestive tract.

PURPOSE:

1. To screen and determine if dysphagia is present.
2. To allow patients that pass the screen to consume a regular diet.
3. To provide optimal patient care and safety with a referral to Speech Therapy for patients that fail the initial nursing Swallow Screen.
4. To provide a standardized method of instruction to nursing staff completing the swallow screen

PROCEDURE:

1. Upon admit for a cerebrovascular accident (CVA), traumatic brain injury (TBI) or at any time that nursing suspects dysphagia or an acute change in neurological condition such as a TIA; Nursing will conduct the Bedside Swallow Screen within Cerner (Burke Dysphagia Screen)
2. In addition a provider may place an order for nursing to perform a swallow screen on any patient.
3. Patients that **PASS** the Swallow Screen will be cleared to consume a diet based on provider order and nursing judgment with the first meal being observed by Nursing watching for a) coughing b) choking c) loss of food or liquid from the mouth.

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4. Patient that **FAIL will be referred to Speech Therapy with a Physicians order** for speech evaluation and treatment to assess of the proper food textures, and liquid consistencies recommended. Nursing will enter a nursing note regarding what phase of the algorithm the patient failed the screen.
5. In the interim until they can be evaluated by speech therapy, patients should be nothing by mouth (NPO) status. During this time the patient may have ice chips, by spoon only, if they are alert and able to sit up at 90 degrees in bed/chair. Oral care is to be performed before and after each administration of ice chips. Ice chips should only be administered by nursing.
6. When appropriate the Speech Therapist will request a provider order for a Barium Swallow Evaluation and will assist the Radiologist during the testing.
7. Based on the findings from Speech Therapy and/or the barium swallow screen, an appropriate diet consistency will be ordered following consult with the Provider. The Speech Therapist may implement compensatory strategies or exercises following the speech evaluation and/or the Barium Swallow Study.