Swallow Screening for the Stroke Patient Resource Guide

The ad hoc dysphagia group met for over a year discussing issues related dysphagia, swallow screening and the stroke patient. The following are results of their hard work:

1. Development of expert consensus (See sidebar)
2. Identification of swallow screens already published in the literature.
3. Comprehensive literature review.
4. Development of a swallow screen checklist and swallow screen process checklist enabling hospitals to compare their processes with best practices identified by the work group.
5. Recorded teleconferences with experts on swallow screening, dysphagia, The Joint Commission and the stroke patient. These can be reviewed, downloaded and listened to at: http://www.uic.edu/depts/glstrknet/events.html
6. An evaluation of this work group found:
   - Over 50% changed their training process
   - Almost 50% changed their swallow screen tool
   - 100% will still monitor dysphagia

Materials can be found at: http://www.uic.edu/depts/glstrknet/dysphagia.html
The Consensus Stroke Performance Measures recommended by CDC, AHA, and The Joint Commission includes a swallow screen completed by a health care professional prior to oral intake of food, fluid or medications. A screening test need not be a formal evaluation of swallowing by a speech language pathologist (SLP) but should be standardized. Those with abnormal results should be referred for a complete examination by SLP. Below you will find a listing of swallow screens discussed in the literature specific to stroke between 1992 and 2009. The GLRSN does not endorse any particular screen.

### Bedside Swallow Assessment
**Description:** Pre-assessment questions, clinical exam, teaspoons of water three times, followed by water in a cup. 

### Bedside Swallow Assessment EATS
**Description:** Uses 3 consistencies: semisolid, liquid and solid. Also contains pre-assessment criteria. 

### Burke Dysphagia Screening Test (BDST)
**Description:** 3 oz. water swallow test and clinical checklist. Developed for use within stroke rehabilitation settings. 

### Gugging Swallow Screen
**Description:** Uses three consistencies: Semisolid, liquid and solid. Also contains pre-assessment criteria. 

### Kidd Water Test
**Description:** Clinical examination includes pharyngeal sensation assessed by orange stick, tongue and facial movement, speech, sensory and perceptual function and muscle strength also assessed. Ability to swallow also assessed by patient swallowing 50 ml of water in 5 ml allotments. 

### Massey Bedside
**Description:** Water test designed for nurses. Uses 1 teaspoon of water followed by glass of water. Also contains pre-assessment criteria. 
**Nishiwaki et al.**


**Scottish Intercollegiate Guidelines Network (SIGN)**


**Standardized Swallowing Assessment (SSA)**

Description: Pre-swallowing check list if passed is followed by teaspoon sips of water 3 times, followed by half glassful of water. (Grade A, strong evidence Westergren, 2006). Source: Perry, L. Screening swallowing function of patients with acute stroke. Part one: Identification, implementation and initial evaluation of a screening tool for use by nurses. Journal of Clinical Nursing 2001; 10: 463±473.

**Timed Test**

Description: Pre-assessment criteria. Small amount of water given to patient with teaspoon. If tolerated, patient is given 100 – 150 ml of water and told to drink the water as quickly as possible. Residual water left over is measured. The number of swallows is counted by observing the movement of the thyroid cartilage. Stopwatch is started when the first drop of water touches the lip. Also includes a patient questionnaire. Source: Hinds NP, Wiles CM. Assessment of swallowing and referral to speech and language therapists in acute stroke. QJM. 1998 Dec;91(12):829-35.

**TORBSST®**

GLRSN Swallow Screen Checklist*

**PART ONE: Your swallow screen**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is evidence based (were external sources referenced when developed)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Is validated (were swallow <strong>screen</strong> results compared to SLP swallow <strong>eval</strong> results)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Published in the literature?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Begins with oral care?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Starts with behavioral observation? (cognition, postural control, speech/oral motor coordination and respiratory status)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Includes a progressive water swallow test?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>a. Controlled small sips of water (tsp)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Single sips from a cup</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Multiple sips from cup (Does <strong>not</strong> use straws)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Is conducted in the emergency department?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>a. is a part of your care pathway in the ED?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. If not done in ED, patients are kept NPO including meds until screened on the inpatient unit?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Criteria for completing screen clearly identified</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>a. Upon arrival in ED</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Change in neurostatus</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. After admission to floor</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Is included in standing orders?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. <strong>Completion</strong> clearly documented in the patient’s chart?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. <strong>Results</strong> are clearly documented in patient’s chart.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>a. If passed, diet is ordered.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. If failed, kept NPO and SLP order solicited.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. If unable to assess on admission the reason is documented and the task to screen continues before the patient can take po</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
PART TWO: Your swallow screen training

1. Is a collaboration between SLP and Nursing? □ □
2. Includes a teach back opportunity? (formal training for the person conducting the screen with competency validated includes provider feedback) □ □
3. Is covered in nursing orientation? □ □
4. Has an annual competency requirement? □ □
5. Is taught during unit orientation training? □ □
6. Includes behavioral observations (cognition, postural control, speech/oral motor coordination and respiratory status) □ □
7. Includes signs of dysphagia □ □
8. Observation of eating and drinking □ □

If you answered “yes” to all of these, congratulations! You are already using best practice strategies for swallow screening. Keep up the good work and share your successes!

If you answered “no” to any of these questions, you may need to consider revising your swallow screen tool, and/or training process to include these items that were identified as best practices. Follow up with your speech language pathology department and refer to the screens published in the literature as well as the literature review (which can be found at: http://www.uic.edu/depts/glstrknet/dysphagia.html).

* This swallow screen checklist was developed by through expert consensus of Great Lakes Regional Stroke
Dysphagia Bibliography/Last Updated 09/11/09


ASHA Division 13 (Swallowing and Swallowing Disorders) Steering Committee. Frequently Asked Questions (FAQ) on Swallowing Screening: Special Emphasis on Patients with Acute Stroke screening. 2006 Oct; 1-10.


Davies, S. Dysphagia in acute strokes. (4-20 April 1999) Nursing Standard, 13 (30), 49-54.


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Johnson, K. Developing an RN dysphagia screening program for stroke patients. (Edith Matesic)


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Swigert presentation.


