Basic Swallow Screening for Acute Stroke Patients

This protocol is a brief and simple bedside screening tool that may help identify a patient's risk of aspiration following acute stroke. It should be administered by nurses or other HCPs on all patients admitted with a diagnosis of stroke as soon as possible before starting oral foods, fluids, or medications. It aims to guide the appropriate medical nutrition feeding format and identify the possible need for more in depth assessment. Always review the patient's chart prior to screening and consult with the primary care team.

1 Exclusion Criteria

Answer the following questions regarding the patient to determine if the protocol should be administered:

- ☐ YES / ☐ NO Unable to remain alert for testing?
- ☐ YES / ☐ NO Pre-existing dysphagia with no thin liquids allowed?
- ☐ YES / ☐ NO Head of bed restrictions < 30°?
- ☐ YES / ☐ NO Tracheotomy tube present?
- ☐ YES / ☐ NO Nil per os order for medical/surgical reason?

If YES to ANY: : Defer screening for 24 hours and keep nil per os (tube feeding possible); consider clinical and/or instrumental assessment

If NO to ALL: Continue with Steps 2-4

2 Brief Cognitive Screen

Ask the patient the following, and indicate if they are able to answer correctly or perform the task:

- ☐ What is your name?
- ☐ Where are you right now?
- ☐ What year is it?
- ☐ Open your mouth
- ☐ Stick out your tongue
- ☐ Smile

3 Oral Mechanism Evaluation

Ask the patient the following, and indicate if they are able to perform the task:

- ☐ Close your lips
- ☐ Move your tongue from left to right
- ☐ Smile, then pucker your lips

- **Failure to answer/perform parts of Steps 2 & 3 may suggest increased aspiration risk**
- **Be attentive to signs of swallowing difficulty, such as coughing, choking, or difficulty initiating swallowing**
- **Use clinical judgment whether to continue. When in doubt, keep nil per os.**

4 Water Swallow Challenge

1. Prepare 90 mL of **DISTILLED** water in a cup, and sit patient upright at 80-90°(or as high as tolerated >30)
2. Ask patient to drink entire 90 mL of water from cup or with a straw, in sequential swallows, slowly/steadily without stopping
3. Emphasize to patient, "Slow and steady swallowing **WITHOUT STOPPING**"

Cup or straw can be held by staff or patient

If patient stops and starts due to misunderstanding instructions, restart and try again

PASS

Complete and uninterrupted drinking of all water, with no overt signs of aspiration (coughing/choking) during/immediately after completion – collaborate with medical doctor/dietitian to order an oral diet appropriate for the patient's health status

FAIL

Interrupted drinking, coughing, or choking during or immediately after completion of drinking – keep nil per os (tube feeding possible), and either rescreen in 24 hrs or refer for clinical / instrumental assessment

Monitor situation as patient recovers, and make diet changes accordingly, including consideration for medical nutrition support

This is not a diagnostic tool and is for the guidance of HCPs only. It does not substitute for the clinical judgment of qualified medical professionals.

Adapted from: Leder SB & Suiter DM. The Yale Swallow Protocol . Cham: Springer Intl. Publishing AG; 2014.

The Angels Initiative is a non promotional, healthcare project of Boehringer Ingelheim International GmbH to support the ESO and WSO in implementing their main goal: to improve stroke care around the world.

Nutricia's support of the Angels Initiative aims to help healthcare professionals and stroke centres improve screening, and nutritional management of dysphagia.

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