

Approaches to Swallow Screening: Part 1

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Objectives

- Describe evidence behind assessment for dysphagia
- List TJC guidelines for dysphagia
- Describe ongoing assessment and process of care related to care of stroke patients
- Disclosure: Nothing to disclose.

Stroke complications

- Pneumonia is present in 6-22% of hospitalized patients with stroke.
- There is a 3 fold increase in 30 day all cause mortality for those with pneumonia
- Most post-stroke pneumonia is preventable with proper screening, evaluation, and diet modifications.

Significance of dysphagia in pneumonia

- Oro-pharyngeal dysphagia associated with aspiration leading to pneumonia
- Dysphagia is present in large percentage of stroke patients – sources vary from 38-72%, of these 19% require PEG tube
- Approximately half of stroke patients with dysphagia will experience aspiration

Known risks of pneumonia in stroke patients

- Age (older)
- Men greater incidence than women
- Prior at ECF
- Abnormalities of head and neck
- More severe stroke (as measured by NIHSS)

Significance of pneumonia in stroke

- Increased mortality
- Longer LOS
- Increased admissions to ECF
- Increased readmission (all cause) within 30 days

Preventing complications

- Objective: identify those at risk for swallowing difficulties
- Plan: clear swallow screen process at admission and with neurologic changes
- Modify oral intake
- Therapy to improve swallow, educate regarding safety, and for diet modifications

Joint Commission

- TJC includes dysphagia screening in acute stroke (PSC) as one of the performance measures AND as part of Delivering and Facilitating Care standards.
 - “A swallow screen for dysphagia should be performed on all ischemic and hemorrhagic stroke patients before given food, fluids, or medication by mouth”

– Joint Commission, 2004

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Standards

- DF 2, EP 4, 5:
 - Assessment and intervention activities are consistent with CPG's
- DF 3, EP 2,3, 4:
 - Assessments are within timeframe defined, plan of care, and prioritizing needs of participants

Evidence for swallow screen

- 27-50% of stroke patients develop dysphagia
- 43-54% of those with dysphagia will aspirate
- Of these, 37% will develop pneumonia
- Pneumonia increases mortality (3.8% in those untreated)
- Pneumonia associated with increase LOS, malnutrition, difficulty discharge

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Standards

- VHA – Nurses must administer initial assessment within 24 hours
- What is your policy for head to toe assessment and time frame?
- ASHA Practice Pattern on Swallow Screens: pass/fail procedure. Process is “hands-off” assessment to identify overt signs of aspiration.

ASHA

- No screening procedure will match accuracy of comprehensive clinical and instrumental swallow examination in identification of dysphagia.
- Swallow screen
- Bedside swallow examination

Swallow screen tool

- A number exist. Must be evidence based, have psychometric properties established
 - Validity – are you assessing what you intend to?
 - Sensitivity and specificity – how accurate and precise is your tool?
- Hinchey, Shephard, Furie, Smith, Wang, & Tonn – formal protocol decreases incidence of pneumonia in AIS.

Dysphagia process

- Must use valid tool
- Must have comprehensive education to those who administer screen
- Need to have high level of confidence that those that pass screen will not have dysphagia
- Ongoing education and review of your data is critical

Tool

- TOR-BSST – Toronto Bedside Swallowing Screening Test
 - Bedside test
 - Only uses items known to have high predictive value based on evidence
 - High sensitivity and specificity. Also feasible.
 - One page (front and back)
 - Pass/fail option

Elements of tool

- Initial assessment
 - Alert, able to speak clearly, swallow?
 - Any observed weakness?
- Oral exam
 - Tongue midline, palate elevates, no deviation
 - Able to swallow
- Motor tasks
 - Speech, oral and pharyngeal

Who administers screen

- A number of models present
 - Swallow team
 - RN's in key units
 - All RN
 - SLP only
 - SLP or MD only
- Key is education and training, ongoing data evaluation and skill level

Education

- Ideal is SLP providing education to those who will administer screen
 - What is your practice, availability and volume?
 - 24/7 availability?
 - What determines re-screen?
- 2-4 hour education session common
- How often do you re-educate or re-evaluate competencies

Data

- Monitor your data
 - Who is educated
 - How often do they screen
 - What are the results of your bedside swallow screen compared to formal dysphagia evaluation
- How often do you monitor quality of bedside swallow screen?

Data

- TJC Performance measure –
 - Dysphagia screening
 - What percentage are missed?
 - What was process improvement?
 - What was changed?
 - What was included in your process of care to improve care?
- CMS did not include dysphagia in 2010 measures. TJC will follow this guideline

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Dysphagia

- If not a required measure, how do you monitor?
 - Review of pass/fail screen vs. dysphagia evaluation
 - Review of re-assessment based on clinical indicators

Strategies for success

- Dedicated SLP trainer
 - Scheduled courses, re-fresher course, and inclusion in skills updates. Need realistic timelines
- Dedicated team of RN's who will assess swallow
 - Review your practice. Should all RN's be trained or a core group?
- Communication
 - Use of newsletter, staff minutes, posters, etc to update staff on performance, tips, successful strategies, and pitfalls.

Strategies for success

- Administrative
 - Clear support from leadership as resources of personnel and time are needed
- Physician
 - Stroke champions will be involved in evidence and data.
- Clinical
 - Excellent interdisciplinary communication
 - Include swallow in hand off of care

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Process of care

- Stroke Patient NPO
- Swallow screen by designated, educated personnel
- Pass: ok for food/meds and continued monitoring.
- Fail – SLP evaluation and possible aid for nutrition. Ongoing assessment

Process improvement

- Must know what data shows in your practice
 - How many missed
 - How many false passed?
 - Reassessed as appropriate
- Communication of gaps
- Changes implemented into daily process of care and hand off of care.

Take home message

- Swallow screen
 - Part of initial and ongoing assessment
 - Identify key personnel to train
 - Assessment bases interventions
 - Evaluate outcomes as indicated
- Process and data reviewed and evaluated by stroke leadership – administrative, clinical, and physician