Assessment of communication and swallow screening in ICU

SICSAG Guidlines

Tracheotomy communication and swallowing needs assessed in Critical Care

This is a Quality Indicator.

*All patients with a tracheotomy should have communication and swallowing needs assessed by a **nurse, therapist** or a **Speech and Language Therapist** when the decision to wean from the ventilator has been made and the sedation hold has started.*

Level of compliance definition, please choose one of the following	**Please mark an 'X' against the level your unit is at for this indicator/standard**
Communication and swallowing needs are not assessed in critical care upon weaning from a ventilator; there are no plans to implement this practice in future.	
Not implemented but a plan is in place to implement in the next 6 months	
A process for assessment is in place; however compliance is inconsistent and does not happen in the majority of relevant cases.	X
A process for assessment is in place and complied with for the vast majority of relevant patients, however this is not always evidenced in the documentation.	
A process for assessment is in place and complied with for all patients, and this is evidenced in the patient documentation	

Post extubation dysphagia

- Laryngeal oedema/ muscular atrophy
- Age, duration of intubation, previous co-morbidites
- Silent/overt aspiration
- Increased length of hospital stay
- Inadequate nutrition

Aim

- Nurse-initiated bedside swallow screening tool
- When to seek SALT assessment
- Use of FEES to validate swallow tool

Modified swallowing screening tool to manage post extubation dysphagia

Stage 1

THIS ONLY APPLIES TO THOSE PATIENTS WHO HAVE BEEN INTBATED >72 HOURS	Yes	No
Extubated >24 hours	1	0
RASS: 0 - +1	1	0
CAM ICU: Negative	1	0
Intubated > 72 Hours	1	0
Nasogastric Tube Insitu (patency and position assured)	1	0
Stridor Present	0	1
Ask patient to cough and/or throat clear	1	0
Observe a saliva swallow: swallowing successful	1	0
Drooling	0	1
Voice change (hoarse, gurgly, weak)	0	1
SUM		(10)

If score <10, place patient NBM for 4 hours. If after 4 hours score <9 please seek medical advice

Can proceed If a score of 10 is achieved

Stage 2

Perform a Direct Swallowing test		
First administer 3mls of water	Pass	Fail
If patient is successful in swallowing the first amount, proceed with increasing amounts:		
Administer 5mls of water	Pass	Fail
Administer 10mls of water	Pass	Fail
Administer 20mls of water	Pass	Fail
Administer 50mls of water	Pass	Fail
If patient passes the 50mls of water may proceed to soft diet		
Observe the patient after each amount. Discontinue the trial is any 4 aspiration signs – deglutition, cough, drooling and voice change are positive, if so refer to Speech pathology for a formal review.		

If patient fails any one section of the direct swallow test, place NBM and please seek medical advice and/or a Speech Pathologist referral

Figure 2 GuSS-ICU bedside swallowing screening tool.

Guideline for Communication with Ventilated Patients