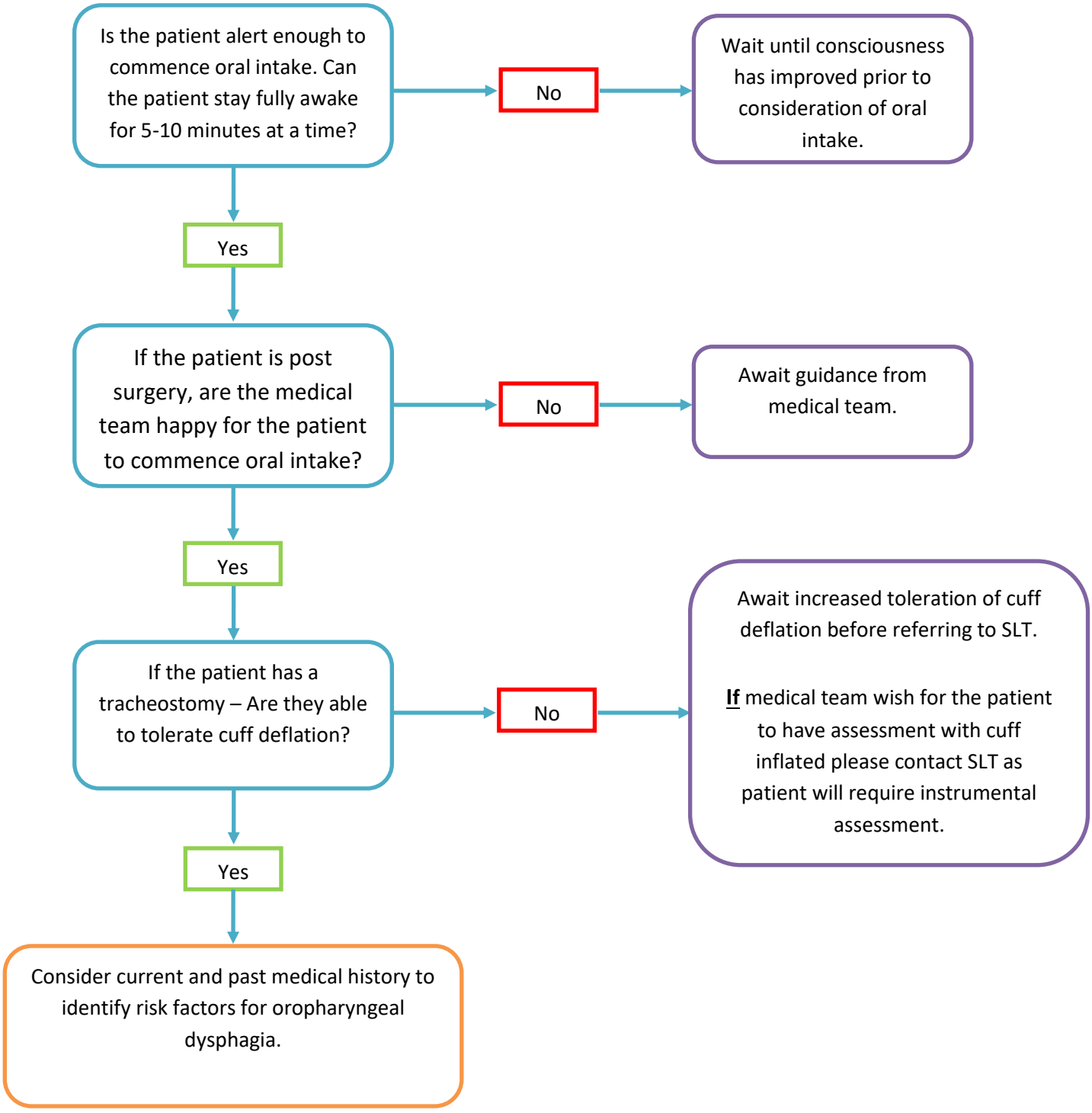
GUIDELINES FOR IDENTIFYING SIGNS/SYMPTOMS OF SWALLOWING DIFFICULTIES (DYSPHAGIA) in CRITICAL CARE

There are many potential risk factors that may lead to the development of dysphagia for patients in critical care. These guidelines are designed to help nurses follow some sensible steps to identify anyone with potential oropharyngeal dysphagia and to signpost when to refer to Speech and Language Therapy for full assessment. Please consider going through these steps with anyone who has had a period of NBM, especially anyone who has been intubated. If in doubt following any of these steps, please contact Speech and Language Therapy on 26915 – we are happy to advise or to directly assess the patient.

1. Identify if the patient is ready to eat and drink



2. Identify risk factors for oropharyngeal dysphagia

CONSIDER DIRECT REFERRAL TO SPEECH AND LANGUAGE THERAPY IF THE PATIENT HAS:

- ☐ A tracheostomy in situ.
- ☐ Any previous history of swallowing difficulties. Check with patient/family/carers/.
- ☐ A new or existing neurological disorder (particularly posterior fossa or brainstem lesions).
- ☐ A history of neurological disorders (e.g. previous stroke).
- ☐ A hypoxic brain injury.
- ☐ Any evidence of cranial nerve impairment.
- ☐ New or historical oropharyngeal/laryngeal cancer.
- ☐ Burns inhalations or anything causing swelling/structural changes to the oro-pharynx.
- ☐ Difficulty managing secretions and poor or weak cough reflex.

Refer directly for SLT assessment.

ARE ANY OF THE FOLLOWING PRESENT?

- ☐ Respiratory disease/disorders.
- ☐ Muscle atrophy, poor sensation or laryngeal trauma caused by prolonged intubation (>72 hours).
- ☐ Advanced age.
- ☐ Aphonia (no voicing) post extubation.
- ☐ High O2 requirements.
- ☐ Delirium/poor cognition.
- ☐ Critical illness neuropathy.

Discuss number of risk factors with medical team.

Refer directly for SLT assessment.

Proceed with nurse led observations.

3. Nurse Led Observations

BEFORE COMMENCING SWALLOW TRIALS:

- ☐ Ensure the patient is sitting upright at a 90° angle and not slumped in bed.
- ☐ Ensure the patient is fully awake and responsive.
- ☐ Check patient's oral hygiene, especially back of mouth.
- ☐ Ask the patient to swallow their own saliva.
- ☐ Ask the patient to cough.

MONITOR FOR THE FOLLOWING DIFFICULTIES DURING SWALLOW OBSERVATIONS:

Overt Signs of Penetration +/- Aspiration

- ☐ Immediate or delayed cough after swallowing.
- ☐ Patient going red or changing colour.
- ☐ Inability to control food or fluid in the mouth (e.g. dribbling, residue in the mouth).
- ☐ Patient reporting difficulties, e.g. "it's going the wrong way" or "it feels stuck in my throat". Ask the patient how swallowing feels.
- ☐ A visibly delayed swallow meaning food is sitting in the patient's mouth.

Signs of Silent Penetration +/- Aspiration

- ☐ Altered voice quality (where possible, check the patient's voice regularly.
- ☐ Consistent increased respiratory rate post swallow.
- ☐ Drop in SpO2 saturations.
- ☐ Wheeze post swallow (not previously present).
- ☐ Wet breath sounds post swallow.
- ☐ Increased secretion production after oral intake.
- ☐ Patient becoming more chesty after oral intake.

If the patient appears to be swallowing well but then either regurgitating or vomiting this may indicate a GI difficulty and SLT referral would not be appropriate.

4. COMMENCE SWALLOW TRIALS AND OBSERVATIONS