



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Dysphagia Management – Acute Care

#### Site Applicability

**Acute Care:** St. Paul's Hospital, Mount Saint Joseph Hospital, Holy Family Hospital

#### Disciplines

Nursing, Nutrition, Occupational Therapy, Pharmacy, Speech-Language Pathology

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#### Policy Statement

- All patients with dysphagia belonging to at risk populations will be identified on admission.
- Patients who are at risk for dysphagia or experience an event that will change their swallowing ability will be screened.
- It is the responsibility of the interdisciplinary team to obtain consent for treatment or for eating at risk (See-[CPF0500](#) – Corporate Policy Consent).

#### Need to Know:

##### Introduction

Dysphagia can be defined as difficulty in swallowing, and includes difficulty in the oral preparation, oral, pharyngeal, and/or esophageal stages of swallowing. Swallowing difficulty can occur as a result of anatomic abnormalities, mechanical obstruction or neuromuscular dysfunction of the oral cavity, pharynx, larynx and esophagus. Dysphagia is often associated with neurological conditions such as stroke, Alzheimer's disease or other dementias, multiple sclerosis, and Parkinson's disease. It can also occur as a result of spinal cord injuries, head trauma, prolonged intubation or cancer and its treatment. Indicators of dysphagia include drooling, slurred speech, ineffective airway clearance, inability to manage secretions, wet or gurgly voice quality, coughing, choking while eating, and weak, absent, delayed or effortful swallow. The health risks associated with dysphagia include aspiration pneumonia, dehydration and malnutrition. The impact of dysphagia on quality of life is immeasurable.

##### Philosophy Statement

- All people will have access to evidence based dysphagia management.
- People have a right to make an informed choice as to how their dysphagia is managed.
- The needs of the patients are best met by an interdisciplinary approach.



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### Objectives

The Dysphagia Management Guidelines will address the identification, assessment, and management of patients with dysphagia using a consistent interdisciplinary approach at acute care sites in Providence Health Care.

The goals of dysphagia management are to reduce the incidence of complications of dysphagia, optimize nutrition, prevent dehydration, minimize the need for tube feeding, and improve quality of life, with consideration to patients' wishes.

### NPO Orders at Providence Health Care

NPO order at PHC does not include NPO for medications unless the physician specifies “NPO including medication.” Patients who are NPO require a physician's order prior to screening or assessment.

### Ethical/legal Decision-Making

In the event of any conflict or uncertainty regarding decisions about dysphagia management, Ethics may be consulted for assistance. If a patient chooses to eat-at-risk, the S-LP, OT and/or RD should liaise with the team, and clearly document the patient's decision in the interdisciplinary progress notes.

## PRACTICE GUIDELINES – Nursing

For Residential Care Dysphagia Management see [RCS6015](#)

### Initial Assessment

#### Screening/protocol initiation

1. Complete Dysphagia Screening Tool (PHC-NF208, [Appendix A](#)) on all of the following patients on admission and before any food or drink is given:
  - age of 70 or more
  - head or neck surgeries or injuries (this admission)
  - neurological diagnosis
  - history of COPD
  - intubation of more than 48 hours
  - signs or symptoms of dysphagia at any time during their hospitalization
  - identification on Patient Admission History and Screening (e.g. PHC-NF407)

Complete referral(s) and request appropriate diet orders or 'NPO including medications' and for 'swallowing assessment' as indicated on the screening tool.

2. In critical care areas follow the "Critical Care Nursing Dysphagia Pathways for Patients Intubated Greater Than 48 Hours" ([Appendix B](#)) and complete Dysphagia Screening Tool.
3. As soon as dysphagia has been confirmed:
  - Post "Swallowing Precautions" sign ([Appendix L](#)) at bedside.
  - Ensure that oropharyngeal suction and oxygen are available for emergency use

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- Write the prescribed diet type (e.g. Dysphagia minced honey thick fluids) on Kardex/Care Guide

### Ongoing Assessment

#### Ability to Swallow

Evaluate safety and effectiveness of swallow during intake of meals and snacks and medication administration. Observe for indications of swallowing problems including:

1. Gurgly voice
2. Weak or absent cough on command
3. Pocketing food in mouth
4. Delayed swallow

Evaluate ability to manage prescribed diet including appropriateness of:

1. Food consistency (e.g. minced, pureed)
2. Food temperature
3. Food texture
4. Thickness of liquid

#### Food and Fluid Intake

1. Obtain weekly weight. Report weight loss to the dietitian if more than 2 % (1 to 2 Kg) per week
2. Report meal intake of less than 50% for more than 3 days.
3. Record intake for calorie count as requested by Dietitian (RD)
4. Measure fluid intake for at least first 2 days if thickened fluids newly prescribed (Intake goal is 1200 to 1500 mL in 24 hours).
5. Monitor hydration status (intake & output etc.) as per usual standards.
6. Report findings outside parameters above to RD
7. Report any signs and symptoms of dysphagia as soon as possible to Speech-Language Pathologist (S-LP) and order diet as directed by screening protocol, or reinstitute previous diet if recently upgraded.

#### Respiratory Status

1. For newly diagnosed patient, complete a respiratory assessment, including breath sounds BID and PRN as soon as swallowing problem identified.
2. Do baseline respiratory assessment prior to upgrade in fluid consistency.
3. Thereafter, complete respiratory assessments BID and PRN until fluid upgrade has been determined to be safe.
4. Monitor temperature daily and as necessary, if patient has been identified as being at risk for aspiration or until upgrade in fluid consistency has been determined to be safe.
5. Report abnormal findings to physician and team.

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### Mouth Condition

1. Perform visual inspection of mouth following meals to check for pocketing food.

### Ability to Follow Instructions

1. Assess ability of patient/family to carry out instructions from S-LP, OT and RD and report need for further instruction to the disciplines.

### Patient Satisfaction

1. Assess patient satisfaction with meals.
2. Provide information regarding diet preferences, ethnic or religious requirements to RD.

### Patients at Risk: Related to Alternative Dietary Choice:

Patients who make an informed decision to take a diet that is not recommended will be educated by S-LP re: safer eating strategies. The nurse will:

1. Encourage the patient to use the recommended safer eating strategies
2. Do respiratory assessment and temperature as for diet upgrade.

### Interventions

#### Assisting with Food and Fluid Intake:

1. Incorporate recommendations of S-LP, OT and RD
  - a. Reinforce the use of recommended compensatory techniques: (e.g. chin tuck, turning head to one side, use of adaptive utensils, double swallow)
  - b. Assist patient to maintain position for meals as specified in plan.
  - c. Assist patient to use any special adaptive equipment (e.g. swivel spoons, cutlery with special handles, non-slip mats, special cups or plates) as provided by OT.
  - d. Ensure upright sitting position when eating, drinking or taking medications.

### Mouth Care

1. Brush with toothbrush and rinse mouth prior to meals to reduce risk of aspiration of bacteria in mouth, and to ensure moist mucous membranes to facilitate swallowing.
2. Perform visual inspection of mouth and provide mouth care following meals.
3. Instruct patient to perform finger sweep of mouth if necessary, and assist if necessary.

### Safety:

1. Supervise closely during food and fluid intake.
2. Ensure patient is upright for meals and remains upright for 15 to 30 minutes.
3. Adjust environment to maximize concentration and attention on eating and swallowing: minimize distractions (TV, radio, conversation).

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### **Obstructed Airway Management**

Follow usual procedures for intervening in choking situation including Heimlich maneuver and/or suctioning if necessary.

### **Patient Identification:**

May be required for patients who eat in shared dining room away from their own rooms.

Units to determine their own method of identification (e.g. coloured bracelet; name on white board) for:

- Patients who are unable to communicate dietary requirements (e.g. aphasia).
- Patients with identified lack of understanding of dietary requirements.

### **Suction:**

Ensure suction available in shared dining areas as well as in patient rooms

### **Medication Administration:**

- Follow recommendations from S-LP regarding delivery of medications in a form that is consistent with prescribed dysphagia diet (e.g. liquid form, with thickened liquids, crushed).
- Follow pharmacy guidelines regarding whether or not medication may be crushed.
- Be aware that some medications may contribute to dysphagia (e.g. anticholinergic medications such as antidepressants, antihistamines, antihyperlipidemics and psychotropics that reduce secretions).
- Monitor patient for safe swallowing of medication

### **Evaluation**

Re-refer to S-LP if condition changes (either improves or deteriorates). For concerns regarding nutritional intake, refer to RD. For concerns regarding feeding or positioning, refer to OT.

### **Patient Education & Resources:**

Provide instruction to patient/family in safe medication administration prior to discharge (e.g. crushed medications, medications mixed in pudding or applesauce).

### **Documentation:**

Document all assessments and interventions using the appropriate tool:

- PHC-NF208, Dysphagia Screening Tool
- Flow sheet (Nursing or ADL flow sheet)
- Interdisciplinary Progress Notes



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### PRACTICE GUIDELINES - Clinical Nutrition

#### Related Documents and Resources

1. [B-00-07-10009](#) – Enteral (Tube) Feeding Guidelines: Practice Guidelines Nutrition
2. Dysphagia Diets - [VCH/PHC Diet Writing Guidelines](#)
3. [Appendix D](#) – Nutrition Protocol for the Management of Dysphagia (Algorithm)
4. National Dysphagia Diet Task Force. *National Dysphagia Diet: Standardization for Optimal Care*. Chicago, IL: American Dietetic Association; 2002

#### Screening/Identification of Dysphagia

Identify patients with potential swallowing problems by:

- Referrals received from RN, S-LP, OT, or MD for patients/residents with confirmed/potential swallowing problems.
- Evidence of previously unnoted swallowing difficulties during meal rounds, chart reviews, interdisciplinary rounds, or while doing an assessment for another medical condition.

Refer such patients/residents to RN to initiate dysphagia protocol.

#### Assessment

Conduct nutritional assessments within one working day of referral for patients/residents identified as having dysphagia. Determine nutrition diagnosis.

Nutritional assessments include:

- Assessment of overall nutritional status,
- Pertinent laboratory results,
- Adequacy of food and fluid intake,
- Identification of other specific nutritional and texture modification needs,
- Weight history, and
- Barriers to adequate food intake such as pertinent psycho-social factors.

The assessment may identify the need for nutritional support by means other than the oral route e.g. enteral feedings (see *Dietitian Practice Guidelines for Enteral Feeding*).

Confer with the S-LP to determine the appropriate texture/fluid viscosity for the patient/resident (see [VCH/PHC Diet Writing Guidelines](#)).

#### Intervention: Nutritional Care Plan, Implementation, and Coordination of Care

1. Formulate the nutritional care plan based upon the nutrition diagnosis and discussion with the MD, RN, S-LP and/or OT, using the nutrition assessment to identify key nutritional issues. Factors to consider include: patient/resident/caregiver's desires; nutritional, fluid, consistency and texture modification needs; food preferences; other dietary modifications required; and pertinent psychosocial factors.
2. Confer with MD, RN, S-LP and/or OT when necessary the need to provide nutritional support by means other than the oral route (See *Dietitian Practice Guidelines for Enteral Feeding*)



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3. Ensure implementation of appropriate nutritional care plan.
4. In the event of any conflict or uncertainty regarding ethical/legal decisions about dysphagia management, consult Ethics for help if necessary.
5. If the patient, in consultation with the S-LP and the interdisciplinary team, makes an informed decision to take a diet that is not recommended, clearly document the patient's decision in the progress notes.

### Monitoring and Evaluation

1. Monitor and assess tolerance of diet and/or nutritional support and recommend changes to nutritional care plan as necessary. Use Calorie Count Worksheet, if necessary. (See [Appendix C](#))
2. Monitor and assess hydration and nutritional adequacy of intake and recommend changes to nutritional care plan as necessary.

### Discharge Planning, Patient Education and Resources

1. Discuss discharge dietary plans with RN, S-LP, SW and/or OT.
2. Provide education to patient and/or caregiver for appropriate diet at home.
3. Ensure appropriate community follow-up as necessary following discharge.
4. Provide pertinent dietary information to receiving facilities for patients/residents who are transferred to other facilities. (See [Appendix P](#)— PHC-PM159 Dysphagia Transfer Information)

### Documentation

Document assessment and Nutrition Care Plan on appropriate Nutrition Assessment form: e.g. Acute Care Nutrition Care Plan (PHC-D1281), Elder Care Nutrition Assessment (PHC-EL015), and/or in the Interdisciplinary Progress Notes.



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### PRACTICE GUIDELINES - Occupational Therapy

All dysphagia (swallowing) referrals are referred to Speech-Language Pathology (S-LP) and managed by S-LP. Meal management/ADL referrals related to eating/feeding are referred to Occupational Therapy (OT).

#### Practice Level

Grade 1 Occupational Therapist

#### Assessment and Interventions

##### Meal Management/Activities of Daily Living (ADLs)

1. If patient demonstrates difficulty with self-feeding ability at admission or during the course of the patient's stay, OT will perform a meal management/ADL assessment.
2. OT will provide recommendations and set up modifications to improve self-feeding as appropriate. These may include:
  - a. Setting up an appropriate seating and positioning system
  - b. Providing adapted utensils or equipment
  - c. Providing recommendations to address cognitive, perceptual, behavioural, environmental or cultural factors associated with eating and feeding.
3. OT will liaise with S-LP and nursing to ensure equipment use is encouraged and monitored.
4. OT will re-assess within 2 working days after intervention and as needed.
5. OT will liaise with the interdisciplinary team re: management plan and education (see [Appendix R](#))
6. OT will provide patient/family/caregiver education for discharge.
7. OT will liaise with the team to arrange appropriate follow-up and provide information to the discharge destination ([Appendix P](#)- Dysphagia Transfer Information).



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### PRACTICE GUIDELINES - Speech-Language Pathology (S-LP)

All swallowing referrals are made directly to S-LP and managed by S-LP.

#### Practice Level

Basic: Grade 1 Speech-Language Pathologist.

Advanced: S-LP's who provide instrumental assessments and/or service to patients with tracheostomies require advanced certificates from the College of Speech & Hearing Health Professionals of BC

- Communication and Swallowing Assessment and Management for Tracheostomy (Advanced Certificate H)
- Fiberoptic Endoscopic Evaluation and Management of Swallowing Disorders (Advanced Certificate F)
- Videofluoroscopic Assessment of Swallowing Disorders in Adults (Advanced Certificate I)

#### A. Clinical Swallowing Assessment

1. Perform a clinical swallowing assessment (at bedside or mealtime) following:
  - The receipt of a written physician's referral for patients who are NPO or
  - A completed dysphagia screen that indicates the need for a swallowing assessment, or
  - If S-LP identifies dysphagia issues
2. Initiate a dysphagia assessment within one working day of receiving the referral. If the S-LP is unable to assess the patient within the established time frame, the reasons and the planned time frame for the assessment will be noted in the progress notes of the health record.
3. Patients who have had endotracheal intubation should be extubated for at least 24 hours (preferably 48 hours) prior to the introduction of food or fluid trials.
4. Assess patients with tracheostomies according to the Dysphagia Assessment Guidelines for Tracheostomized and Ventilator Dependent Patients ([Appendix H](#)).
5. After obtaining patient consent, conduct bedside or mealtime evaluation.
6. Consult other team members, as needed, e.g. RD for nutrition, OT for self-feeding and seating.
7. Discuss findings with the patient and patient's family.
8. Educate patient, family and team members on outcome of swallowing assessment, including ways to improve swallowing safety if appropriate.
9. Collaborate with patient/family to establish a dysphagia management care plan which aligns with the patient and families goals; this may include eating at risk.
10. SLP may make recommendations about strategies to minimize risk of aspiration for those patients who choose to eat at risk.
11. Document the results of the assessment and dysphagia management recommendations on long or short versions of the Dysphagia Assessment Form or Mealtime Observation/Assessment (Forms PHC-PM243 - [Appendix E](#), [Appendix F](#), [Appendix G](#), [Appendix I](#))

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- Document a summary of results, including recommendations, in the Interdisciplinary Progress Notes of the health record.
12. Document recommended diet textures or NPO in the Prescribers' Orders of the health record. If patient is NPO, write order as "NPO for dysphagia. Nurse to call physician for medication orders."
  13. Order diet via SCM.
  14. Post-swallowing precautions sign ([Appendix L](#)) above bed or in the dining room and in the Kardex / Care Guide.
  15. In consultation with attending physician, determine if further medical investigations are required, e.g. otolaryngology, gastroenterology, and neurology. Liaise with team to organize referral/follow-up.
  16. Request RN to monitor patient's status following assessment, and re-refer as necessary.

### **B. Further Investigation, Including Instrumental Assessments**

Further investigation (e.g. VFSS, FEES, ENT, upper GI series) is recommended if the cause of dysphagia is unclear and/or to guide treatment/management plan. A physician's order is required for instrumental assessments. See Videofluoroscopic Swallow Study ([Appendix M](#)) for procedural information. Use Form PHC-PM157, PHC-PM212 or PHC- PM 186 ([Appendix N](#), [Q](#) and [U](#)) to document results.

**HFH** - On-site access to specialized services is limited to FEE's; S-LP liaises with the team to refer the patient to another PHC site for other investigations (e.g., GI, VFSS).

A formal Free Water Protocol is used at HFH ([Appendix S](#)). Document results on form PHC-PM185 ([Appendix T](#))

### **C. Interventions**

#### **Patient/Family/Team Education**

- Update swallowing precautions signage as needed.
- Educate patient, team and family members as indicated to ensure swallowing safety.
- Follow facility specific guidelines to ensure dysphagic clients are identified to care providers.
- **HFH** – In conjunction with RD, educate family on specific diet textures and restrictions for overnight and weekend passes.

**Treatment** - Provide treatment exercises (e.g. oral-motor strengthening, Shaker exercise, etc.) as indicated, including therapeutic feeding sessions on patients who are otherwise NPO. Physician approval is required for therapeutic feeding and for any exercises that impact medical condition of the patient (e.g., Shaker, Supraglottic Swallow, Super-Supraglottic Swallow, Respiratory Muscle Strength Training, etc.).

#### **Ongoing Monitoring (Upgrading/Downgrading the Diet)**

- Monitor all patients who are NPO and without an alternative method of nutrition/hydration on a daily basis (on working days).

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- Upgrade/downgrade diet based on a clinical swallowing re-assessment (see Section A above).
- Patients with recent diet changes should be monitored frequently, e.g. if patient's diet has been upgraded, re-evaluate on next working day.
- Reassess patient as frequently as is appropriate for that patient until optimal diet is obtained or patient plateaus.
- Reassess patients at request of patient, family, or staff members if a significant change in abilities is noted, e.g. patient complains of difficulty with current diet.

**Mouth Care** - Make recommendations to patient and care team on method and equipment for mouth care pre and post meals such as brushing teeth, cleaning of dentures etc.

**Note:** Bacteria in the mouth have been found to be the most significant contributing factor in aspiration pneumonia

### D. Discharge from S-LP:

Discharge patients with dysphagia from S-LP when the:

- Patient is stable on the optimum diet.
- Patient cannot tolerate assessment/intervention for physical or cognitive reasons.
- Patient does not comply with recommendations.
- Dysphagia is stable, and/or further assessment and intervention is not warranted.
- Patient is discharged from hospital.

If further assessment or therapy is required when a patient is discharged from hospital, S-LP will liaise with the team to arrange appropriate follow-up. S-LP will provide information to the discharge destination as required (e.g., [Appendix P](#) - PHC- PM159 - Dysphagia Transfer Information).

## PRACTICE GUIDELINES - Pharmacy

### Related Documents and Resources:

See [Appendix K](#) – *Dysphagia as an Adverse Effect of Drugs*

### Screening/Identification of Problem:

Patients with swallowing problems will be identified by:

- Initial evaluation of patient medication regimen (e.g. medication history or medications prescribed on admission). Refer such patients/residents to Nursing or MD.
- Referrals received from Nursing or MD for patients/residents with confirmed/potential swallowing problems. Nursing or Speech-Language Pathologist will indicate on order sheet: **“Patient dysphagic – pharmacist to review for appropriate method of medication administration.”**

### Assessment:

**RD: November 2017**

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Questions, concerns, comments about PHC guidelines can be emailed to: [nursingstds@providencehealth.bc.ca](mailto:nursingstds@providencehealth.bc.ca)

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- The pharmacist will review the patient's medication profile and extent of dysphagia to identify:
  - Appropriate indications for each medication that is prescribed.
  - Medications which may be given in alternative formulations
  - Medications that may cause dysphagia or aggravate pre-existing dysphagia as an adverse effect.
  - Oral medications that can be discontinued short-term.

### **Interventions:**

- The pharmacist will, if necessary, suggest therapeutically equivalent medications, or alternative routes of administration of medication (e.g. transdermal, rectal or parenteral) to the physician
- Where a choice of several formulations exists, the pharmacist will, as appropriate, contact other members of the dysphagia team, or discuss with the patient, which formulations would be better tolerated.
- The pharmacist will suggest for discontinuation of unnecessary medications and/or medications that may cause or aggravate dysphagia.
- The pharmacist will be available to assist nursing staff with any further problems encountered with administration of medications to the patient, consulting further with the physician when required.

### **Discharge**

- **From dysphagia program:** The pharmacist will assist the physician and nursing staff with conversion of the patient's medication regimen back to regular formulations, if appropriate for the patient's current status.
- **From hospital:** the pharmacist will counsel the patient on his/her medications, with emphasis on any special instructions in using alternative dosage formulations (e.g. measuring liquids, crushing/dispersing tablets, rectal administration).

### **Follow-Up:**

- The pharmacist will encourage the patient to consult his/her community pharmacist for information on alternative formulations for newly prescribed or non-prescription medications required after discharge.

### **Documentation:**

- The pharmacist will document his/her findings and recommendations in writing in the History and Progress Notes/Interdisciplinary Notes section of the patient's chart.

### **Education:**

- The pharmacist maintains competence in evaluating medication regimens and dosage forms for patients with dysphagia.



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- The pharmacist provides relevant drug information to dysphagia team members and health professional colleagues, and updates such information included in the interdisciplinary dysphagia guidelines on an annual basis.

### All Disciplines - Evaluation

The measurable desired outcomes are:

- All patients will be screened by nursing using the Dysphagia Screening Tool – Acute (PHC-NF208) form and [criteria](#).
- Referrals will be assessed by S-LP within one working day.
- All patients/residents with dysphagia will receive nutrition within 4 days of identification of dysphagia.
- Weight loss will be less than 2% per week or 5% per month for patients/ with dysphagia.



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### Appendices

- [Appendix A](#) PHC-NF208: Acute Care Dysphagia Screening Tool
- [Appendix B](#) Critical Care Dysphagia Pathway for Patients Intubated Greater than 48 Hours
- [Appendix C](#) PHC-NF018: Calorie Count Worksheet
- [Appendix D](#) Nutrition Protocol for Management of Dysphagia
- [Appendix E](#) PHC-PM243 Dysphagia Assessment / Reassessment Short Form
- [Appendix F](#) PHC-PM166: Dysphagia Assessment / Reassessment
- [Appendix G](#) PHC-PM213: S-LP Dysphagia Meal Time Observation/Assessment
- [Appendix H](#) Dysphagia Assessment Guidelines for Tracheostomy/Ventilator Dependent Patients
- [Appendix I](#) PHC-NF214: Dysphagia Sign
- [Appendix J](#) Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- [Appendix K](#) Dysphagia as an Adverse Effect of Drugs
- [Appendix L](#) PHC-PM179: Swallowing Precautions Sign
- [Appendix M](#) Videofluoroscopic Swallow Study Procedure
- [Appendix N](#) PHC-PM157: Videofluoroscopic Swallow Study Report
- [Appendix O](#) PHC-PM212: Modified Barium Swallow MBSImP Assessment
- [Appendix P](#) PHC-PM159: Dysphagia Transfer Information
- [Appendix Q](#) Holy Family Hospital Preparation for Discharge; Includes FM11 Rehabilitation Dysphagia Management Plan
- [Appendix R](#) Patient Education Handout – Swallowing Problems
- [Appendix S](#) Free Water Procedure Rehabilitation
- [Appendix T](#) PHC-PM185: Speech Language Pathology Free Water Assessment
- [Appendix U](#) PHC-PM186: Fiberoptic Endoscopic Evaluation of Swallowing
- [Appendix V](#) PHC-PH698: FEES Prescriber Orders
- [Appendix W](#) PHC-PM249: FEES Assessment Report – Short Form



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix A

### PHC-NF208 Acute Care Dysphagia Screening Tool



#### DYSPHAGIA SCREENING TOOL - ACUTE

Dysphagia screening is completed before any food or drink is offered to patients with:

- age of 70 or more
- head or neck surgeries or injuries (current admission)
- neurological diagnosis
- history of COPD
- intubation of more than 48 hours
- signs or symptoms of dysphagia at any time during their hospitalization
- identification on Patient Admission History and Screening (PHC-NF407)

N/A – Screening not required – patient doesn't meet above criteria

#### \*Signs and symptoms of dysphagia:

- drooling, slurred speech, ineffective airway clearance
- inability to manage secretions
- coughing and/or choking while eating or drinking
- wet and/or gurgly voice quality
- weak, absent, delayed and/or effortful swallow

#### 1. Is the patient:

- awake and alert enough to be screened AND able to sit up with head control?
- AND has the patient been extubated for more than 24 hours (when intubation is more than 48 hours)

Yes Go to question 1a

No Request physician order for "NPO including medications", notify dietitian and RESCREEN as soon as patient is awake and alert.

**Screen is complete** – Date and sign the bottom of the form

#### 1a. Has the patient had:

- head or neck surgery (current admission) OR
- a recently inserted tracheostomy

Yes Request physician orders for "NPO including medications" and for "swallowing assessment", refer to SLP for swallowing assessment and notify dietitian

**Screen is complete** – Date and sign the bottom of the form

No Go to question 2

#### 2. Prior to admission was patient on a modified textured food or fluid diet?

Yes Obtain physician order for pre-admission diet, notify dietician, monitor at meals and refer to SLP for swallowing assessment if signs/symptoms of dysphagia noted

No Go to question 3

**Screen is complete** – Date and sign the bottom of the form

#### 3. Does the patient or others report swallowing problems? OR Does the nurse observe signs and symptoms of dysphagia? \*

Yes Request physician orders for "NPO including medications" and for "swallowing assessment", refer to SLP and notify dietitian Swallowing problem or sign/symptoms of dysphagia: \_\_\_\_\_

On weekends or statutory holidays, RESCREEN if swallowing problems or sign/symptoms of dysphagia resolve

No Go to question 4

**Screen is complete** – Date and sign the bottom of the form

#### 4. Administer 90 mL water test:

Sit the patient upright at 90 degrees with head in midline position, glasses on, dentures clean and in place, and hearing aids in. Perform oral care, then give patient 90 mL of water and ask him/her to drink entire amount from a cup or with a straw in sequential swallows without stopping. (cup(straw can be held by staff or patient.)

Pass No signs and symptoms of dysphagia\* exhibited

Initiate admission diet order and continue to observe for dysphagia signs and symptoms\*

Fail Signs and symptoms of dysphagia\* exhibited

Request physician orders for "NPO including medications" and for "swallowing assessment", refer to SLP and notify dietitian

**Screen is complete** – Date and sign the bottom of the form

Signature

Printed name

Date

Form No. PHC-NF208 (R. Jun 12-17)

## INTERDISCIPLINARY GUIDELINES

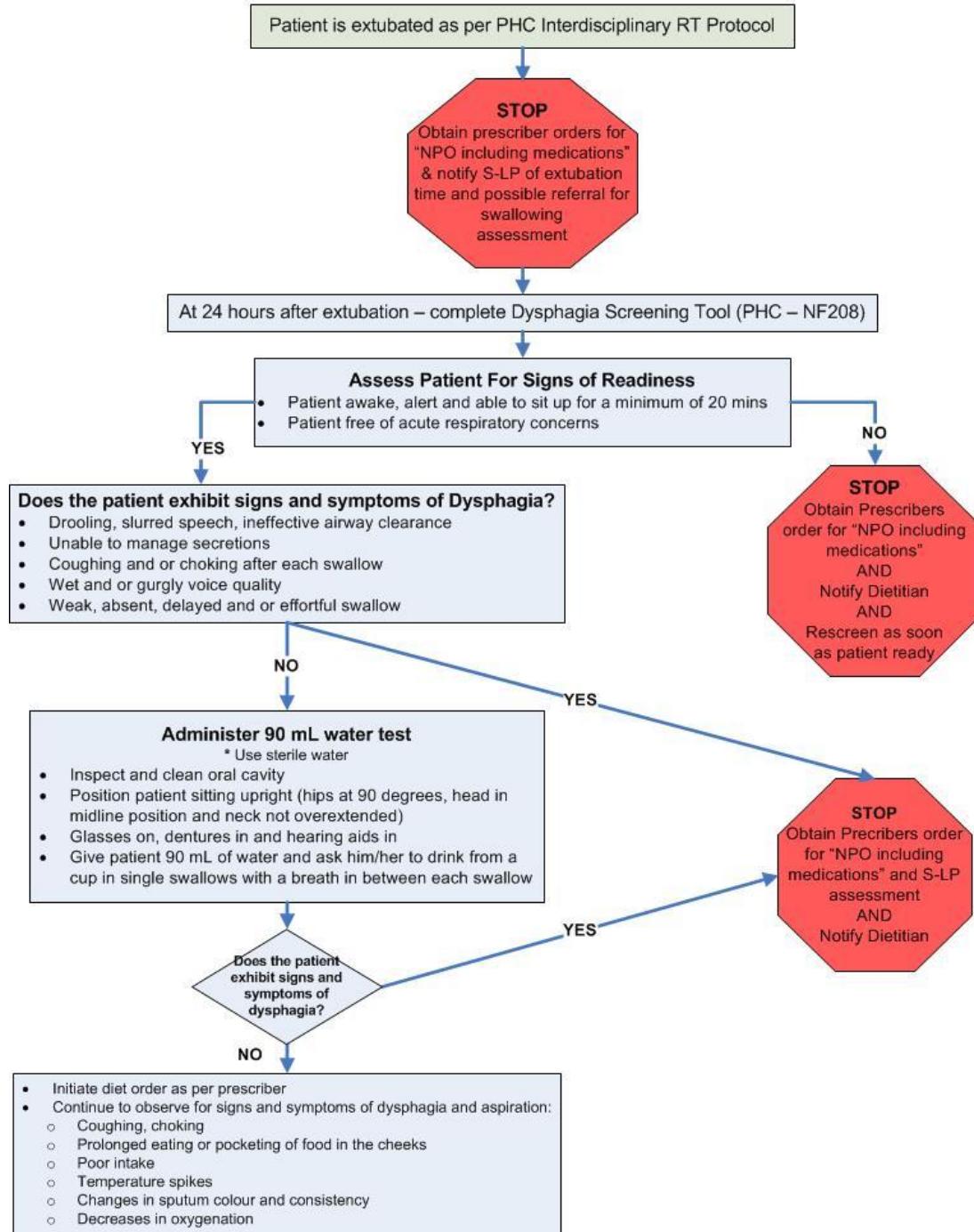
B-00-07-10010– Dysphagia

### Appendix B

#### Critical Care Nursing Dysphagia Pathway for Patients Intubated Greater than 48 Hours

\*Not for tracheostomy patients\*

\*Patients should be NPO for first 24 hours post extubation\*





## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix C

### Calorie Count Worksheet



- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Holy Family Hospital        | St. Vincent's Hospitals               |
| <input type="checkbox"/> Mount Saint Joseph Hospital | <input type="checkbox"/> Brock Fahrni |
| <input type="checkbox"/> St. Paul's Hospital         | <input type="checkbox"/> Langara      |
| <input type="checkbox"/> Youville Residence          |                                       |

#### CLINICAL NUTRITION SERVICES 24 HOUR CALORIE COUNT WORKSHEET

Date \_\_\_\_\_ [Dietitian's Initials \_\_\_\_\_]

	Circle Food Eaten	Qty.	Describe	Amount Eaten
<b>Breakfast</b>				
Juice				0 1/4 1/2 3/4 ALL
Cereal ( hot / cold )				0 1/4 1/2 3/4 ALL
Egg / Cheese				0 1/4 1/2 3/4 ALL
Muffin / Scone / Bread				0 1/4 1/2 3/4 ALL
Jelly / Jam				0 1/4 1/2 3/4 ALL
Milk ( skim / 1% / 2% / homo )				0 1/4 1/2 3/4 ALL
Coffee / Tea / Sugar / Milker				0 1/4 1/2 3/4 ALL
<b>Other Items</b>	[incl. Resource, milkshake, etc.]			0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
<b>Lunch</b>				
Soup ( cream / broth )				0 1/4 1/2 3/4 ALL
Crackers				0 1/4 1/2 3/4 ALL
Salad ( reg. dress. / other [specify] )				0 1/4 1/2 3/4 ALL
Hot Entrée / Cold Entrée				0 1/4 1/2 3/4 ALL
Roll / Bread ( plain / margarine )				0 1/4 1/2 3/4 ALL
Dessert ( fruit / baked item )				0 1/4 1/2 3/4 ALL
Milk ( skim / 1% / 2% / homo )				0 1/4 1/2 3/4 ALL
Coffee / Tea / Sugar / Milker				0 1/4 1/2 3/4 ALL
<b>Other Items</b>	[incl. Resource, milkshake, etc.]			0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
<b>PM Snack</b>				
				0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
<b>Dinner</b>				
Soup ( cream / broth )				0 1/4 1/2 3/4 ALL
Salad ( reg. dress. / other [specify] )				0 1/4 1/2 3/4 ALL
Entrée				0 1/4 1/2 3/4 ALL
Gravy / Sauce				0 1/4 1/2 3/4 ALL
Potato / Rice / Noodles				0 1/4 1/2 3/4 ALL
Vegetable				0 1/4 1/2 3/4 ALL
Roll / Bread ( plain / margarine )				0 1/4 1/2 3/4 ALL
Dessert ( fruit / baked item )				0 1/4 1/2 3/4 ALL
Milk ( skim / 1% / 2% / homo )				0 1/4 1/2 3/4 ALL
Coffee / Tea / Sugar / Milker				0 1/4 1/2 3/4 ALL
<b>Other Items</b>	[incl. Resource, milkshake, etc.]			0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL
<b>HS Snack</b>				
				0 1/4 1/2 3/4 ALL
				0 1/4 1/2 3/4 ALL

#### Directions:

1. Circle all foods & fluids taken 0700h – 0700h. Record quantity of item if more than one.
2. Specify exactly what food item is in 'Describe' column. [ Refer to patient's menu to correctly identify foods ]
3. Specify any food items eaten other than those listed. [ Include foods from home, restaurants, etc. ]
4. Circle amount eaten. Write other amount if necessary.
5. Completed forms: [ SPH: tube to #40 at 0700h ] [ ALL OTHER SITES: leave with chart for dietitian to pick up ]
6. Dietitian to document results in patient's clinical record.

Form No. PHC-NF018 (R. Nov-04)

**RD: November 2017**

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Published by: Providence Health Care, Vancouver, BC

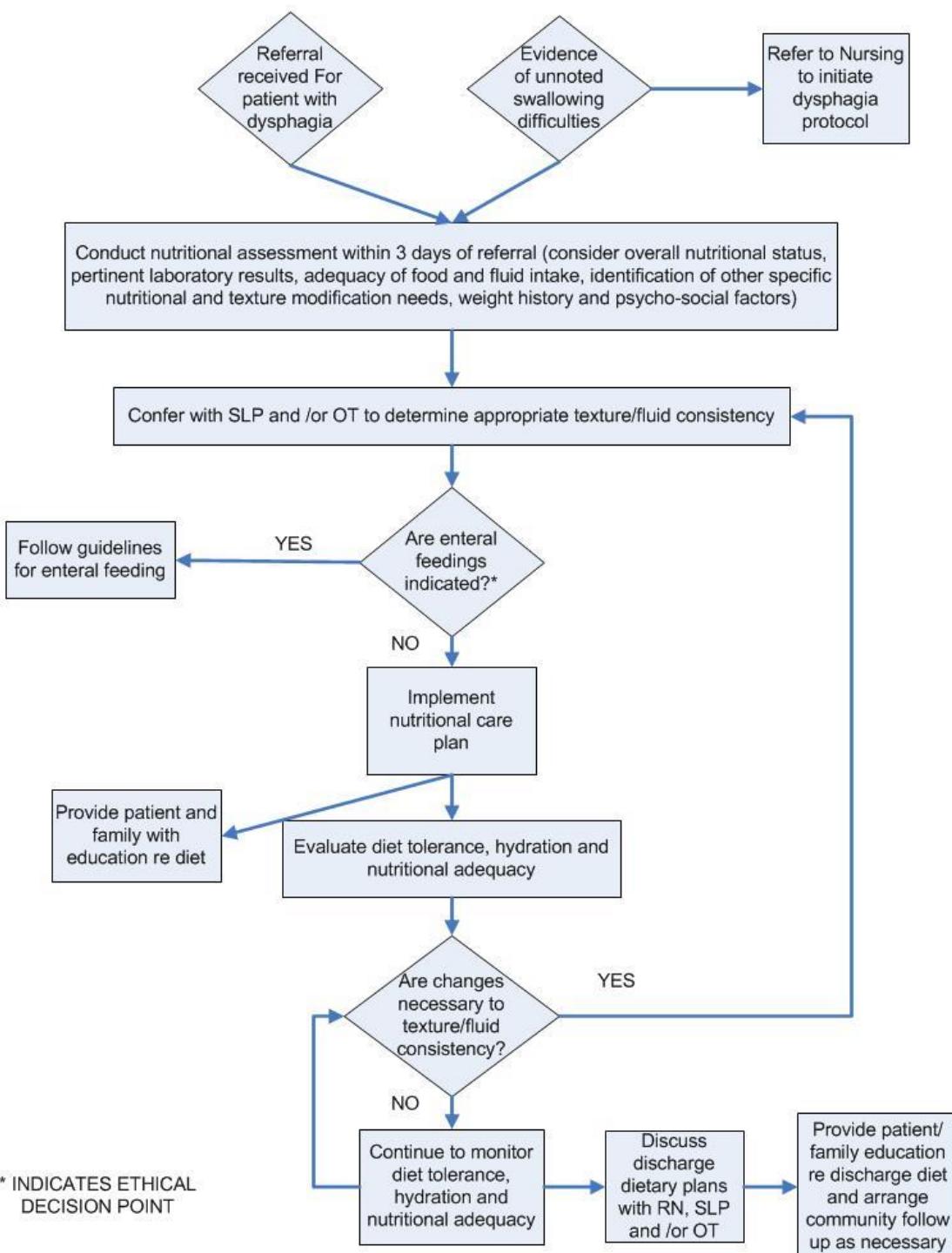
Questions, concerns, comments about PHC guidelines can be emailed to: [nursingstds@providencehealth.bc.ca](mailto:nursingstds@providencehealth.bc.ca)

## INTERDISCIPLINARY GUIDELINES

B-00-07-10010– Dysphagia

### Appendix D: Nutrition Protocol for the Management of Dysphagia

#### NUTRITION PROTOCOL FOR THE MANAGEMENT OF DYSPHAGIA





## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix E: PHC PM243 Dysphagia Assessment Form



#### DYSPHAGIA ASSESSMENT / REASSESSMENT SHORT FORM

Patient consent obtained

##### Current Status:

(diagnoses, respiration, dysphagia history, diet/nutrition, cognition/behaviour, endurance, physical status)

---

---

##### Oral Motor Examination:

(condition, dentition, sensation, lingual/labial/jaw function, palate/velum, voice, cough, laryngeal excursion, praxis)

---

---

##### Food Trials / Meal Observation

	Within Normal Limits	ORAL STAGE PROBLEMS				PHARYNGEAL STAGE PROBLEMS			
		Retrieval Retention	Oral Manipulation	Oral Transit	Oral Residue	Delayed Trigger	Reduced Hyolaryngeal Excursion	Throat-Clearing or Coughing	Altered Voice Quality
Ice Chips									
Thick _____									
Thin Fluid									
Pureed									
Pudding									
Minced/Soft									
Regular									

##### Summary of findings:

---

---

##### Recommendations:

Diet

Medication Administration

Positioning

Level of Assistance

Strategies / Precautions

Treatment Plan

---

---

Therapist printed name

Signature

Date

Form No. PHC-PM243 (R. Feb 3-16)



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix F PHC-PM166 Dysphagia Assessment/Reassessment Short Form



#### SPEECH - LANGUAGE PATHOLOGY DYSPHAGIA ASSESSMENT / REASSESSMENT

Patient consent obtained

Reason for Referral: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Relevant Medical and Dysphagia History: \_\_\_\_\_  
\_\_\_\_\_

History of Chest Infections / Aspiration:  Yes  No \_\_\_\_\_

Food Allergies:  Yes  No \_\_\_\_\_

Previous Clinical/Instrumental Assessments: \_\_\_\_\_  
\_\_\_\_\_

Current Nutrition:  Dysphagia diet  Regular diet  

Solids	<input type="checkbox"/> Regular	<input type="checkbox"/> Dental soft	<input type="checkbox"/> Minced	<input type="checkbox"/> Pureed	
Liquids	<input type="checkbox"/> Thin	<input type="checkbox"/> Nectar	<input type="checkbox"/> Honey	<input type="checkbox"/> Pudding	
Non oral	<input type="checkbox"/> NPO	<input type="checkbox"/> NG	<input type="checkbox"/> G or J-tube	<input type="checkbox"/> TPN	<input type="checkbox"/> IV

Baseline Diet: (prior to admission) \_\_\_\_\_

Cognition/Behaviour: \_\_\_\_\_

Communication: \_\_\_\_\_

Respiratory Status: \_\_\_\_\_

Physical Status / Endurance: \_\_\_\_\_

Other: (e.g. free water) \_\_\_\_\_

Oral Motor Examination: WNL Impaired  

Oral Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Face/Oral Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lip Strength/ROM	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tongue Strength/ROM	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dentition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaw/Mandible	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocal Quality	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palate/Velum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spontaneous Swallow	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____

Food Trials / Meal Observation:

Able to Self-feed:  Yes  No \_\_\_\_\_ Positioning for trials: \_\_\_\_\_



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix G PHC-PM213 Dysphagia Mealtime Observation / Assessment



#### SPEECH-LANGUAGE-PATHOLOGY DYSPHAGIA MEALTIME OBSERVATION/ ASSESSMENT

Date: \_\_\_\_\_

Relevant history: \_\_\_\_\_  
\_\_\_\_\_

Speech/communication/cognition: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

#### CURRENT DIET

**Solid:**  Regular  Dental soft  Minced  Pureed \_\_\_\_\_  
**Fluid:**  Thin  Nectar  Honey  Pudding \_\_\_\_\_

#### ORAL MOTOR CONDITION/FUNCTION

Dentition/oral condition: \_\_\_\_\_

No oral motor difficulties reported/observed  
 Difficulties noted: \_\_\_\_\_  
\_\_\_\_\_

#### MEALTIME OBSERVATION/ASSESSMENT

Positioning	<input type="checkbox"/> Upright in bed	<input type="checkbox"/> Upright in chair _____	
Level of alertness	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Level of assistance	<input type="checkbox"/> Independent	<input type="checkbox"/> Partial assistance required	<input type="checkbox"/> Full assistance required
Retrieval/retention	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Oral manipulation	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Oral transit	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Pharyngeal trigger	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Holaryngeal excursion	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired _____	
Throat clearing/coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	
Altered voice quality	<input type="checkbox"/> Yes	<input type="checkbox"/> No _____	

Other: \_\_\_\_\_  
\_\_\_\_\_

**SAMPLE ONLY - Do Not Use**

**SUMMARY OF FINDINGS** \_\_\_\_\_  
\_\_\_\_\_

**PATIENT/FAMILY GOALS:** \_\_\_\_\_

#### RECOMMENDATIONS

Diet: \_\_\_\_\_  
Medication administration: \_\_\_\_\_  
Positioning: \_\_\_\_\_  
Level of assistance: \_\_\_\_\_  
Strategies / precautions: \_\_\_\_\_  
Treatment plan: \_\_\_\_\_

Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_

Form No. PHC-PM213 (Oct 24-12)



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010– Dysphagia

### Appendix H Dysphagia Assessment Guideline for Tracheostomy/Ventilator Dependent Patients

#### Skill Level:

Speech-Language Pathologist (S-LP) must have Advanced Certificate H (Communication and Swallowing Assessment and management for Tracheostomy) from the College of Speech and Hearing Health Professionals of BC when working with patients with tracheostomies.

#### Need to Know:

- Swallowing is optimized when there is no cuff or when the cuff is deflated and the outer cannula is small enough to allow sufficient air flow past the trach for phonation.
- Occlusion of the tracheostomy or use of a speaking valve improves swallowing. Tracheostomy tube cuffs must be deflated when occluding the tracheostomy.
- The Modified Evans Blue Dye Test (MEBDT) is a screening tool only. It is effective in identifying aspiration in those who test positive, but is poor at ruling out aspiration in those who test negative. Findings from the MEBDT should never be used exclusively to determine candidacy for oral feeding. An instrumental exam is recommended for those who test negative on MEBDT.
- Instrumental examination (e.g. FEES, and VFSS) may be needed to properly assess dysphagia. VFSS and FEES are conducted per guidelines ([Appendix M](#) VFSS and [Appendix J](#): FEES), except RT or RN (who can deep suction) with must be present.
- Dysphagia assessment is generally not recommended if the trach is open (i.e., when patient is unable to tolerate cuff deflation, has the cuff permanently inflated or cannot tolerate tracheostomy occlusion). Occasionally an assessment may be necessary (e.g. tracheomalacia or palliation); in this case an instrumental exam is strongly advised.
- If any changes to the tracheostomy (e.g. downsize, corking, or decannulation) are imminent, consider delaying the swallowing assessment until they are completed.

#### Procedure:

##### A. Non-Ventilator Dependent Tracheostomy

1. Follow safety precautions including: wearing protective goggles and mask and avoiding positioning yourself directly in front of tracheostomy site wherever possible.
2. For patients who usually maintain inflated cuffs, RT determines if the cuff can be deflated and for what period of time. RT deflates cuff and follows suctioning protocol.
3. When the cuff is deflated or if the trach is cuffless, the RT will help to determine if the tracheostomy can be occluded or if a speaking valve can be placed.
4. If the trach is open and cannot be occluded, consider delaying the assessment until the trach can be occluded. If the trach must be left open for the assessment, schedule an instrumental assessment.
5. Conduct bedside assessment per the dysphagia protocol up to food trials, with the following exceptions:
  - Monitor vitals including use of pulse oximetry

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010- Dysphagia**

- With speaking valve in place or trach occluded, assess vocal fold status (phonation, coughing, throat clearing) and hyolaryngeal excursion.
6. Proceed to:
- a. food trials using MEBDT (see instruction at end of protocol) **and /or**
  - b. instrumental assessment based on: evidence of aspiration/penetration, vital signs, and patient's subjective comfort.
7. Make recommendations, complete appropriate documentation and liaise with patient and team as needed.

### **B. Ventilator-dependent patients with inflated cuffs:**

- 1 RT will institute ventilator modifications as tolerated, such as deflating the cuff and allowing the patient time to adjust to settings.
- 2 Continue with procedure A for non-ventilator dependent patients.

### **C. Patients who cannot tolerate cuff deflation:**

Proceed directly to instrumental assessment

#### ***Optional: Screening using the Modified Evans Blue Dye Test (MEBDT) - Instructions for Food Trials***

MEBDT is effective in identifying aspiration in those who test positive, but is poor at ruling out aspiration in those who test negative. Findings from the MEBDT should never be used exclusively to determine candidacy for oral feeding. An instrumental exam is recommended for those who test negative on MEBDT.

- 1 Notify RT or RN of any food trials. RT (or RN in Critical Care areas, comfortable with deep suctioning) will be in attendance during the administration of food/fluids.
  - 2 Add blue food colouring to water or whatever consistency the S-LP feels would be more successful (e.g. water, thickened water, etc.).
  - 3 Ensure oral and pharyngeal areas are clean and free of secretions prior to introducing food or fluid. RT to suction as needed per suctioning protocol.
  - 4 Trial swallows with one consistency of food/fluid at a time using the MEBDT.
  - 5 Observe for oral and pharyngeal stage difficulties.
  - 6 Check vocal quality and encourage cough/throat clear.
  - 7 At the discretion of the S-LP\*, RT to suction/re-suction per suctioning protocol.
    - Negative (no blue in tracheal secretions): schedule instrumental exam
    - Positive (blue in tracheal secretions): NPO, alternative method of feeding.
  - 8 If test results are negative and at the discretion of the S-LP, add blue food colouring to larger amounts or different consistencies and perform test swallow as above.
- Note:** Results of the blue dye test may be less valid if you are trialing more than one food or fluid consistency within a single session.



## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010- Dysphagia**

\*Need for suctioning during food trials with blue dye is based on clinical judgment of the S-LP. For more viscous foods (e.g., pudding) there is more potential for pharyngeal retention, and patients may require several suctions, at intervals, with a single bolus.

### References:

- Adapted from: Dikeman, K.J. and Kazandjian, M.S. (2003). Communication and Swallowing Management of Tracheostomized and Ventilator – Dependent Adults. Singular Publishing Group.
- Goldsmith, Tessa. (2000). Evaluation and Treatment of Swallowing Disorders Following Endotracheal Intubation and Tracheostomy. *International Anesthesiology Clinics Journal*, 38(3), 219-242.
- Tippet, Donna C. (2000). Management of Breathing, Speaking and Swallowing

**Appendix I**

**Dysphagia Sign (PHC-NF214)**



## **Swallowing Precautions**

- ⌚ Speak to the nurse before offering any food or drink.
- ⌚ **DO NOT** leave food or fluid at the bedside.

Form No. PHC-NF214 (Jan-05) Stock # 00070754

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010– Dysphagia**

### **Appendix J Fiberoptic Endoscopic Evaluation of Swallowing (FEES)**

#### **Skill Level:**

Speech-Language Pathologist (S-LP) with *Advanced Certificate F: Fiberoptic Endoscopic Evaluation and Management of Swallowing Disorders* from the College of Speech and Hearing Health Professionals of BC

#### **Need to know:**

- Full clinical examination must be performed prior to instrumental evaluation of the swallow
- S-LPs can perform FEES independently or in collaboration with ENT

#### **A. Prior to FEES**

##### S-LP who request FEES:

1. A referring S-LP without advanced certificate must discuss the patient with an S-LP with advanced certificate, before referring the patient to ensure referral is appropriate.
2. Explain procedure to patient and ensure patient has no allergies.
3. Explain potential risks (e.g., nose bleeds, fainting) to patient and obtain patient consent.
4. Request order/referrals from physician for S-LP to perform FEES and use of topical anaesthetic and decongestant as needed, using FEES pre-printed order set: PHC-PH 698 ([Appendix V](#))
5. Make referral to S-LP performing FEES and provide case history.
6. Ensure ability to call a code or access medical staff in case of emergency

\*At HFH, there may be no physician on-site when FEES is done. The physician should be informed.

##### S-LP performing FEES:

1. Gather necessary supplies, including food.
2. Ensure patient understands procedure.
3. Answer any patient questions/concerns and obtain additional information as necessary.
4. Confirm patient consent.
5. Administer topical anesthetic and or decongestant prior to exam (optional).
6. Position patient/client for good visualization and to limit patient distraction.
7. The power for the digital processor and light source must be OFF when you plug in or remove the scope.
8. Follow precautions to prevent and control infection, including avoiding touching the equipment with the gloves worn during scoping.

#### **B. During FEES**

1. Liaise with ENT as needed
2. Conduct anatomic-physiologic assessment of:
  - a. Velopharyngeal Closure
  - b. Appearance of Hypopharynx and Larynx at Rest
  - c. Handling of Secretions and Swallow Frequency
  - d. Respiration
  - e. Phonation

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010- Dysphagia**

- f. Airway Protection
  - g. Base of Tongue
  - h. Pharyngeal Musculature
  - i. Sensation
3. Administer a variety food textures as appropriate and observe for:
- Premature Spillage/Location/Point of Swallowing Trigger
  - White-out during height of swallow
  - Laryngeal Penetration/Location
  - Aspiration/Silent/Able to Clear
  - Pharyngeal Residue/Location/Able to Clear
  - Reflux/Able to Clear

Optional: Add food colouring to textures if you need a better view.

4. Trial strategies as appropriate and note effect

### C. Following FEES

1. Liaise with family/patient/team as needed to formulate recommendations.
2. Educate patient/family/referring S-LP on findings and recommendations, including a review of the FEES video.
3. Clean equipment per site specific cleaning instructions from Infection Prevention and Control and Sterile Processing Department.
4. Document findings, including patient consent, on PHC-PM 249 ([Appendix W](#)) or PHC-PM186 ([Appendix U](#)).
5. Liaise with other referral sources to ensure communication of information.

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010- Dysphagia**

### Appendix K: Dysphagia as an Adverse Effect of Drugs

The following is a (partial) list of medication classes and examples of medications that have been associated with the development of dysphagia in some patients:

- a. Medications that affect the tone of the esophageal muscles
  - i. Anticholinergic medications/Antimuscarinic medications
    - 1. Benztropine
    - 2. Oxybutynin
    - 3. Tolterodine
- b. Medications that can cause dry mouth (xerostomia) which may impair swallowing ability
  - i. ACE inhibitors
    - 1. Ramipril
    - 2. Trandolapril
    - 3. Perindopril
  - ii. Antiemetics
    - 1. Prochlorperazine
    - 2. Metoclopramide
    - 3. Dimenhydrinate
  - iii. Antihistamines
    - 1. Diphenhydramine
    - 2. Chlorpheniramine
    - 3. Loratadine
  - iv. Selective serotonin reuptake inhibitors
    - 1. Citalopram
    - 2. Fluoxetine
    - 3. Paroxetine
    - 4. Sertraline
  - v. Antipsychotics/Neuroleptics (see list below)
- c. Antipsychotics/neuroleptics can cause movement disorders (i.e. EPS) which can impact muscles of the face and tongue
  - 1. Clozapine
  - 2. Risperidone
  - 3. Quetiapine
  - 4. Loxapine
  - 5. Olanzapine
  - 6. Haloperidol
- d. Medications that can cause decreased level of consciousness and voluntary muscle control that may affect swallowing
  - i. Antiepileptic drugs
    - 1. Phenytoin
    - 2. Phenobarbital

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010- Dysphagia**

3. Gabapentin
4. Carbamazepine
5. Valproic Acid
- ii. Benzodiazepines
  1. Lorazepam
  2. Clonazepam
  3. Temazepam
  4. Diazepam
- iii. Narcotics
  1. Codeine
  2. Morphine
  3. Hydromorphone
  4. Fentanyl
- iv. Muscle relaxants
  1. Baclofen
  2. Cyclobenzaprine
  3. Tizanidine
- e. Medications that can cause esophageal injury
  - i. Acid containing products
    1. Clindamycin
    2. Doxycycline
    3. Erythromycin
    4. Tetracycline
  - ii. NSAIDs
    1. ASA
    2. Indomethacin
    3. Ibuprofen
    4. Naproxen
  - iii. Bisphosphonates
    1. Alendronate
    2. Etidronate
  - iv. Iron-containing products
    1. Ferrous gluconate
    2. Ferrous sulfate
1. Achem SR, DeVault KR. Dysphagia in Aging. *J Clin Gastroenterol* 2005;39:357-371
2. Balzer KM, PharmD. Drug Induced Dysphagia. *International Journal of MS Care* 2000;2(1):6. Retrieved February 5, 2014, from:  
[http://www.ct.gov/dds/lib/dds/health/attacha\\_med\\_dysphagia\\_swallowing\\_risks.pdf](http://www.ct.gov/dds/lib/dds/health/attacha_med_dysphagia_swallowing_risks.pdf)
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## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix L - PHC PM179 Swallowing Precautions



# SWALLOWING PRECAUTIONS

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Foods: \_\_\_\_\_

Fluids: \_\_\_\_\_

Supervision: \_\_\_\_\_

- Ensure patient is **ALENT**
- Position **UPRIGHT** in bed or chair
- **MOUTH CARE** with toothbrush before meals
- Remain **UPRIGHT** at least \_\_\_\_\_ minutes after meals

### SPECIAL INSTRUCTIONS:

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### Report concerns to Speech-Language Pathologist

Name: \_\_\_\_\_ Pager/Local: \_\_\_\_\_

Form No. PHC-PM179 (R. Jun 12-17)



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix M: Videofluoroscopic Swallow Study (VFSS)

#### Skill Level:

VFSS at PHC is performed by Speech-Language Pathologists (S-LPs). S-LPs require Advanced Certificate I: Videofluoroscopic Assessment of Swallowing Disorders in Adults) from the College of Speech and Hearing Health Professionals of BC.

#### Need to Know

- A VFSS should only occur after a recent clinical bedside assessment has been completed.
- S-LPs must be familiar with the purpose, indication and contraindications for VFSS. (For more information, please refer to ASHA's Clinical Indicators for Instrumental Assessment of Dysphagia <http://www.asha.org/docs/html/GL2000-00047.html>)
- A physician's order is required to conduct a VFSS.
- Safe radiation exposure training should be completed and safe radiation exposure procedures (e.g., protective garments) must be employed during VFSS.

#### Team Roles

- The VFSS will be performed jointly by S-LP and Radiology.
- The S-LP will interpret all phases of the swallowing in conjunction with the Radiologist, and progress the exam with respect to food trials/consistencies, compensatory strategies and swallowing maneuvers.
- The Radiologist is present to diagnose anatomical abnormalities and refer the patient for further medical investigations as needed.
- RT will attend VFSS of patients with tracheostomy or compromised respiratory status as necessary, with emergency equipment on hand.
- Team (e.g., S-LP, Radiologist) will reach a consensus regarding recommendations.

#### Procedure

##### S-LP:

1. Conducts clinical bedside assessment.
2. Recommends VFSS and documents purpose of VFSS in interdisciplinary progress notes.
3. Obtains Physician's order, educates patient and obtains consent from patient. Physician's order is taken verbally or by requesting physician to complete and sign the X-Ray requisition.
4. Contacts Radiology to schedule VFSS and orders food items for VFSS. S-LP informs patient and nursing of appointment time, and ensures appropriate transport is arranged.
5. Prepares food items in a standardized way (i.e., mixes specified amounts of barium with food).
6. Instructs and supervises Speech-Language Pathology Assistant (SLPA) if SLPA assisting with procedure.
7. Provides background information to the Radiologist.

RD: November 2017

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Published by: Providence Health Care, Vancouver, BC

Questions, concerns, comments about PHC guidelines can be emailed to: [nursingstds@providencehealth.bc.ca](mailto:nursingstds@providencehealth.bc.ca)

## INTERDISCIPLINARY GUIDELINES

**B-00-07-10010– Dysphagia**

8. Records VFSS using site-specific procedures.
9. Performs VFSS based on current best practice (e.g., MBSImP).
10. Documents findings and recommendations on VFSS Assessment report PHC-PM157 ([Appendix N](#)) or PM 212 ([Appendix O](#)), and summarizes information in the interdisciplinary progress notes.
11. Provides education on results of VFSS to patient, family and team members.
12. Writes diet order in physician's order section of the chart.
13. Enters order into SCM.
14. Places appropriate signage at bedside
15. Provides:
  - Ongoing documentation
  - Appropriate follow-up
  - Ongoing education to the health care team, patient, and family/caregivers



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix N: PHC-PM157 Videofluoroscopic Swallow Study Report



#### SPEECH-LANGUAGE PATHOLOGY VIDEOFLUOROSCOPIC SWALLOWING STUDY (VFSS) REPORT

Consent Obtained:  Yes  No

Date of VFSS: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

History of Aspiration or Chest Infection: \_\_\_\_\_

Previous Assessment/Treatment: \_\_\_\_\_

Current Diet: \_\_\_\_\_

Current Respiratory Status: \_\_\_\_\_

Purpose of VFSS: \_\_\_\_\_

Positioning for Assessment: \_\_\_\_\_

Views:  Anterior (A-P)  Lateral

#### Textures Trialed

Fluid Consistency:  thin  nectar  honey thick  pudding thick

Food Consistency:  regular  dental soft  minced  pureed

mixed  other: \_\_\_\_\_

FACTORS INFLUENCING RESULTS: (behaviour, attention, fatigue, etc.) \_\_\_\_\_

ANATOMY:  Unremarkable  Remarkable for \_\_\_\_\_

#### RESULTS:

Oral Stage  Within Normal Limits  Impaired

(e.g., lip closure, tongue control, bolus preparation/mastication/transport, oral residue, initiation of pharyngeal swallow)

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## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix O: PHC-PM212 Modified Barium Swallow MBSImp Assessment



#### SPEECH-LANGUAGE PATHOLOGY MODIFIED BARIUM SWALLOW (MBS) MBSImp ASSESSMENT

Date of MBS: \_\_\_\_\_

Consent Obtained:  Yes  No

Diagnosis: \_\_\_\_\_

History of aspiration or chest infection: \_\_\_\_\_

Previous assessment/treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current diet: \_\_\_\_\_

Current respiratory status: \_\_\_\_\_

Purpose of MBS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Positioning for assessment: \_\_\_\_\_

Views:  Anterior-Posterior (A-P)  Lateral

#### TEXTURES TRIALLED

Fluid:  thin  nectar  honey thick  pudding thick

Food:  regular  dental soft  minced  pureed  mixed \_\_\_\_\_  other \_\_\_\_\_

FACTORS INFLUENCING RESULTS: (behaviour, attention, fatigue, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### RESULTS:

##### A. Oral Stage

Lip closure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tongue control during bolus hold: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bolus preparation and mastication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bolus transport/lingual motion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Oral residue: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix P: PHC-PM159 Dysphagia Transfer Information



- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Holy Family Hospital        | St. Vincent's Hospitals               |
| <input type="checkbox"/> Mount Saint Joseph Hospital | <input type="checkbox"/> Brock Fahrni |
| <input type="checkbox"/> St. Paul's Hospital         | <input type="checkbox"/> Langara      |
| <input type="checkbox"/> Youville Residence          |                                       |

#### DYSPHAGIA TRANSFER INFORMATION

Date: \_\_\_\_\_

Diagnosis and Relevant Medical History \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assessment Summary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Diet Recommendations

NPO/Alternate Methods of Feeding: \_\_\_\_\_  
Solids: \_\_\_\_\_  
Fluids: \_\_\_\_\_  
Medication Administration: \_\_\_\_\_  
Therapeutic Diet Order: \_\_\_\_\_  
Other: \_\_\_\_\_

Level of Assistance \_\_\_\_\_

Positioning \_\_\_\_\_

#### Mealtime Strategies and Precaution:

- |  |  |
|--|--|
| <input type="checkbox"/> Ensure patient is alert                   | <input type="checkbox"/> Monitor chest and temperature           |
| <input type="checkbox"/> Keep patient upright 20+ min. after meals | <input type="checkbox"/> Fluids by teaspoon only                 |
| <input type="checkbox"/> No straws                                 | <input type="checkbox"/> Encourage patient to eat slowly         |
| <input type="checkbox"/> Mouth care before and after meals         | <input type="checkbox"/> Remind patient to take small sips/bites |
| <input type="checkbox"/> Encourage self-feeding                    |  |
| <input type="checkbox"/> Other: _____                              |  |

#### Recommendations

- |  |  |
|--|--|
| <input type="checkbox"/> Notify RD / OT / S-LP at your site          |  |
| <input type="checkbox"/> If any swallowing difficulties noted, _____ |  |
| <input type="checkbox"/> Follow-up arranged _____                    |  |
- Level of Safety Risk:  Urgent (follow up within 48 hours)  High (within 1 week)  Tolerable (within \_\_\_\_\_ weeks)  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by: (OT/S-LP/Dietitian/Other)

Designation \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Contact Information \_\_\_\_\_

Designation \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_ Contact Information \_\_\_\_\_

Form No. PHC-PM159 (R. Sep-08)



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix Q: Holy Family Rehabilitation; Education in Preparation for Discharge: Interdisciplinary Dysphagia Management Plan

#### PART 1

##### EDUCATION

- RDN and S-LP to arrange to educate the patient/family re: most appropriate diet, food preparation, feeding techniques, and non-oral feeding as necessary.
- PT and OT to arrange to educate the patient/family re: seating, positions and adaptive equipment as necessary.
- RN to arrange to educate patient/family re: administering medications, first aid, and non-oral feedings as necessary.

##### TEAM ROUNDS & DOCUMENTATION

- S-LP or RDN to address “Dysphagia” in Neuro team rounds and team member to record in the Neuro Weekly flow sheet. Even if dysphagia has been resolved prior to team conference, it will still be written. The outcome of dysphagia will be discussed in subsequent team meetings.
- S-LP or RDN to insert copy of the interdisciplinary Dysphagia Management Plan in the chart (next to flow sheet) and to encourage completion at team rounds.
- S-LP or RDN to present to patient/family upon discharge and to put copy on chart.
- Team members to document education in progress notes.



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### PART 2



Holy Family Hospital  
7801 Argyle Street, Vancouver, B.C. V5P 3L6  
604- 321-2661

#### REHABILITATION INTERDISCIPLINARY DYSPHAGIA MANAGEMENT PLAN (OR Eating/Feeding Recommendations)

##### Recommended Diet

###### **Texture:**

- Regular
- Soft (bite size, moist)
- Minced
- Pureed

###### **Fluid Consistency:**

- Thin
- Natural thick (milk, tomato juice)
- Nectar
- Honey-like

###### **When preparing to eat or drink:**

- be in a quiet room away from the TV
- sit upright (don't eat or drink while lying on the couch or in bed)
- other suggestions \_\_\_\_\_

###### **When drinking:**

- avoid using straws when drinking
- take small sips
- don't talk while drinking

###### **When eating:**

- take small bites and chew well
- don't "shovel" food (swallow each mouthful before putting more in your mouth)
- don't talk while eating

###### **The suggestions ticked off below should also be followed when eating or drinking:**

- use a teaspoon when taking thin fluids
- use a chin tuck or head turn during the swallow
- use a second dry swallow after each sip or mouthful
- other suggestions \_\_\_\_\_

###### **After eating or drinking:**

- clear pocketed food from your mouth
- sit up in a chair for at least 15 minutes

###### **Other recommendations:**

- specialized eating utensils \_\_\_\_\_
- sitting in a wheelchair for meals
- sitting in a dining chair for meals
- administering medications \_\_\_\_\_

The above recommendations have been compiled by the team to help you safely manage your swallowing. contact your doctor immediately if you observe any of the following:

- frequent coughing/choking during meals
- chest pain
- sudden fever
- shortness of breath

Distributed to Patients or Family by:

Form No. F.M.11 (R. Dec-02) Stock # 220454

## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix R Patient Education Handout – Swallowing Problems

#### What Can Be Done to Help?

The main goals are to make eating and drinking as safe and enjoyable as possible and help each person get proper nutrition. The Swallowing Team can help reach those goals by suggesting:

- Positioning changes
- Special feeding equipment
- Environmental changes
- Swallowing techniques
- Exercises to increase mouth and throat muscle strength
- Food texture/fluid thickness changes
- Nutritional supplements

#### How to Refer

Referrals are accepted from a variety of sources including clients, their families, physicians and health care professionals.

Clients must be at least 19 years old and have a BC Personal Health Number. A physician's referral is required for any Diagnostic Imaging studies.

#### What Services do We Offer?

The Dysphagia Team at UBCPHC includes:

- Dietitian
- Occupational Therapist
- Radiologist
- Speech-Language Pathologist

We provide services to people living in our community.

**The Outpatient Swallowing Clinic Team provides:**

- Swallowing and feeding assessments
  - Treatment and education for swallowing problems
  - Recommendations for diet changes
  - Videofluoroscopy in conjunction with Diagnostic Imaging
  - Consultation to community therapists
- Information Contact Speech-Language Pathology at:**
- UBCH: 604-822-7185  
• PHC: 604-322-2629

Developed by: Clinical-Nutrition, Occupational Therapy, Speech-Language Pathology (UBCH)

For more copies, go online at <http://vch.eduhealth.ca> or email [phem@vch.ca](mailto:phem@vch.ca) and quote Catalogue No. FL710.Sw18  
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The information in this document is intended solely for the person to whom it was given by the health care team.  
[www.vch.ca](http://www.vch.ca)



### Swallowing Problems



How you want to be treated.

#### Outpatient Swallowing Clinic

UBC Hospital  
2211 Wesbrook Mall  
Vancouver BC V6T 2B5  
Tel: 604 822-7185

Providence Health Care  
Tel: 604-322-2629

Promoting wellness. Ensuring care.

#### What is Dysphagia?

Dysphagia (dis-fay-ja) means difficulty swallowing. Swallowing problems occur with certain medical diseases such as stroke, neurological diseases and acid reflux.

#### What are the Signs of a Swallowing Problem?

Some things that may point to a swallowing problem are:

- Coughing or choking while eating or drinking.
- A lot of throat clearing or a gurgly voice after eating or drinking
- Complaints of discomfort or difficulty swallowing food or liquids
- Taking a long time to get the swallow started
- Taking many swallows to get each bite down
- Having food left in the mouth after swallowing
- Drooling or food spilling out of the mouth
- Food or liquid coming out of the nose
- Getting frequent pneumonias and chest problems

#### How do Swallowing Problems Happen?

Problems can happen during any of the following stages of the swallow:

##### Oral Stage

A person may have problems chewing or moving food to the back of the mouth. This may be because of weakness, lack of sensation, or poor muscle control in the lips, cheeks, and tongue. Food or liquid may fall into the throat before the person is ready to swallow.

##### Pharyngeal Stage

If the swallow is too slow or absent, food or drink can accidentally go down the wrong way. At the larynx does not move up the opening at the top of the airway may not close and food or drink can go into the lungs. A weak swallow can lead to food being left in certain areas of the throat even after the swallow is finished.

##### Esophageal Stage

Food may "stick" in the esophagus or not travel down to the stomach as quickly as it should.

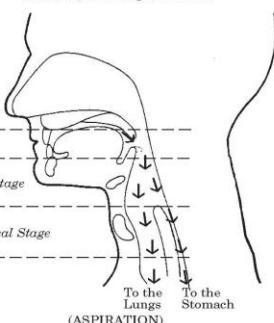
Problems in this stage are dealt with by a physician who specializes in this area.

#### Why is Dysphagia a Serious Condition?

Dysphagia can make eating and drinking very difficult or even dangerous.

Difficulties eating, drinking or swallowing may cause a person to stop enjoying meals. This can lead to dehydration (lack of water) or malnutrition (lack of proper nutrition).

A swallowing problem can also cause food or liquid to go into the lungs. This is called aspiration. Aspiration can cause choking or lead to a lung infection, such as pneumonia.





## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix S: Free Water Rehabilitation

#### Procedure:

1. S-LP completes a “Free Water Assessment” (Form [PHC-PM185](#)) and meal observation/dysphagia assessment within the first 48 hours from admission. Tube fed/NPO—Dysphagia Patients, are also assessed for free water with a physician’s referral. Results and recommendations for free water are placed into the “Assessment” section of the patient’s chart.
2. S-LP flags “free water” candidates on the daily patient schedule (with an “I”=Independent or “S”=Supervision for strategies or “X”= Not a free water candidate) and on guidelines posted above patient’s bed. As well, S-LP will schedule “Oral Care” into the 9:30 and 1:00 time slots (after meals).
3. A sign for “Guidelines for Giving Drinking Water” will be placed above the patient’s bed for family members, visitors and nursing staff to follow.
4. S-LP informs RN of the results from the Dysphagia and “Free Water” assessments (i.e. patient’s candidacy for free water, level of supervision required, and strategies required). RN flags these results in the Kardex/Care Guide.
5. S-LP enters “free water” recommendations in the physician’s orders of the chart.
6. S-LP provides education to the patient and family members on the free water assessment results and informs them to refer to the guidelines posted over the bed. A handout entitled, “Swallowing Problem? Drink Water Safely”—will be provided.
7. All rehabilitation staff will be oriented to the water protocol to ensure consistency across disciplines.
8. RN ensures oral care is provided for all dysphagia patients, including free water candidates.
9. Members of the interdisciplinary team and family may offer water to these patients. Water is only to be given between meals and at least 30 minutes after meals. Oral care, post meals is mandatory.
10. RN ensures medications are never given with water for dysphagia patients on thick fluids or NPO.
11. S-LP re-assesses for “free water” upgrades when appropriate.



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix T PHC-PM185 Speech Language Pathology Free Water Assessment



#### SPEECH-LANGUAGE PATHOLOGY FREE WATER ASSESSMENT

Date: \_\_\_\_\_

Free Water Assessment is completed after oral care and in conjunction with the dysphagia assessment.

It can be used for patients admitted to the Rehabilitation Unit at Holy Family Hospital who have:

- failed the dysphagia screen (Form no. PHC-NF208)
- been admitted with a modified dysphagia diet
- been admitted NPO for dysphagia

1. Does the patient demonstrate ACTIVE PNEUMONIA?	<input type="checkbox"/> YES—Go no further This patient is <u>NOT</u> a free water candidate. <b>Assessment is complete.</b>	<input type="checkbox"/> NO—Go to step 2
2. Check off all the following risk predictors for aspiration pneumonia that apply to this patient: <input type="checkbox"/> Acute/unstable medical conditions <input type="checkbox"/> Severe/uncontrolled GERD <input type="checkbox"/> Immuno-suppressed conditions <input type="checkbox"/> 3 or more medications <input type="checkbox"/> Oral/Dental Bacteria (oral thrush/sores, bleeding gums etc.) <input type="checkbox"/> Poor oral hygiene/condition (halitosis, decayed teeth, coating, etc.) <input type="checkbox"/> Dependent for oral feeding <input type="checkbox"/> Current smoker <input type="checkbox"/> Decreased activity level <input type="checkbox"/> Tube-feeding/NPO	<input type="checkbox"/> Score of "5 or more" = <u>HIGH RISK</u>  This patient is <u>NOT</u> a free water candidate <b>Assessment is complete.</b>	<input type="checkbox"/> Score of "4 or less" = <u>LOW to MODERATE RISK</u>  Go to step 3
3. Provide 90 mL of water for patient to drink <u>prior</u> to meal.  Is there <u>severe</u> coughing / choking?	<input type="checkbox"/> YES—Go no further This patient is <u>NOT</u> a free water candidate <b>Assessment is complete</b>	<input type="checkbox"/> NO—Go to step 4
4. Is there some mild coughing or throat clearing?	<input type="checkbox"/> YES. Go to step 5	<input type="checkbox"/> NO. Patient <u>IS</u> a free water candidate <b>Assessment is complete</b>
5. Does safety for drinking water improve with the use of strategies (e.g. head turn, chin, tuck, smaller sips, etc.)?	<input type="checkbox"/> YES. This patient <u>IS</u> a free water candidate with supervision/strategies <b>Assessment is complete</b>	<input type="checkbox"/> NO. Go no further This patient is <u>NOT</u> a free water candidate <b>Assessment is complete</b>

#### Summary/Recommendations:

- Patient is NOT a free water candidate due to moderate to high risk of developing aspiration pneumonia with free water consumption. Continue to follow recommendations from dysphagia assessment.
- Patient IS a free water candidate and may have water ONLY between meals.
- Patient MUST have supervision and use the following strategies during water consumption:
  - S-LP will monitor free water status and upgrade as appropriate.
  - Nursing to continue to provide oral care for all patients with dysphagia. For free water candidates, oral care must be provided before water consumption.

S-LP Signature: \_\_\_\_\_ Printed name and Local: \_\_\_\_\_

Form No. PHC-PM185 (Jan-10)



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix U – PHC-PM186 Fiberoptic Endoscopic Evaluation of Swallowing



#### SPEECH-LANGUAGE PATHOLOGY FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING (FEES) ASSESSMENT REPORT

Date of FEES: \_\_\_\_\_

Patient consent obtained

#### BACKGROUND INFORMATION

Refer to previous assessment(s) (Type of assessment & date) \_\_\_\_\_

Diagnosis: \_\_\_\_\_

History of dysphagia: \_\_\_\_\_

Current diet: \_\_\_\_\_

Current respiratory status: \_\_\_\_\_

Other: \_\_\_\_\_

#### FEES ASSESSMENT

Purpose of FEES: \_\_\_\_\_

Nare entered:  Right  Left

NG tube in situ:  No  Yes Nare:  Right  Left

Factors influencing results: (behaviour, attention, fatigue, etc.) \_\_\_\_\_

#### A. ANATOMIC/PHYSIOLOGIC FINDINGS

REFER TO ENT ASSESSMENT: (Date) \_\_\_\_\_

##### Nasopharynx:

Anatomy:  WNL  Abnormal \_\_\_\_\_

Symmetry of closure:  WNL  Abnormal \_\_\_\_\_

Speed of closure:  WNL  Abnormal \_\_\_\_\_



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix V: PHC-PH698 FEES Prescriber Orders

IF YOU RECEIVED THIS FAX IN ERROR, PLEASE CALL 604-806-8886 IMMEDIATELY																					
<b>Providence HEALTH CARE</b> <b>PRESCRIBER'S ORDERS</b>																					
NO DRUG WILL BE DISPENSED OR ADMINISTERED WITHOUT A COMPLETED <b>CAUTION SHEET</b> ALLERGY/INTOLERANCE STATUS FORM (PHC-PH047)																					
DATE AND TIME	<b>FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING EXAM ORDERS</b> (Items with check boxes must be selected to be ordered) <small>Page 1 of 1</small>																				
<b>ASSESSMENT:</b> <b>SECTION A:</b> <table border="1"><tr><td>Is this patient:</td><td>Yes</td><td>No</td></tr><tr><td>Able to sit upright for approximately 30 minutes</td><td></td><td></td></tr><tr><td>Able to follow 1 step commands</td><td></td><td></td></tr></table> <b>SECTION B:</b> <table border="1"><tr><td>Is this patient:</td><td>Yes</td><td>No</td></tr><tr><td>Allergic to lidocaine</td><td></td><td></td></tr><tr><td>Allergic to xylometazoline (Otrivin)</td><td></td><td></td></tr><tr><td>At high risk of epistaxis</td><td></td><td></td></tr></table> If any of the assessment questions are answered NO in Section A *OR* YES in Section B: DO NOT proceed with the fiberoptic endoscopic evaluation of swallowing exam without additional discussion with the referring physician	Is this patient:	Yes	No	Able to sit upright for approximately 30 minutes			Able to follow 1 step commands			Is this patient:	Yes	No	Allergic to lidocaine			Allergic to xylometazoline (Otrivin)			At high risk of epistaxis		
	Is this patient:	Yes	No																		
	Able to sit upright for approximately 30 minutes																				
	Able to follow 1 step commands																				
	Is this patient:	Yes	No																		
	Allergic to lidocaine																				
	Allergic to xylometazoline (Otrivin)																				
At high risk of epistaxis																					
<b>MEDICATIONS:</b> <input type="checkbox"/> lidocaine 4% topical solution 0.2 mL into affected nostril to be administered by certified Speech-Language Pathologist prior to insertion of scope																					
<input type="checkbox"/> xylometazoline 0.1% nasal spray 1 to 3 sprays into affected nostril to be administered by certified Speech-Language Pathologist prior to insertion of scope																					
<b>ADDITIONAL INFORMATION:</b>																					
Fax completed orders to <b>Speech-Language Pathology:</b> SPH: 604-806-9823 MSJ: 604-877-8168 HFH: 604-322-2657																					
Printed Name	Signature	College ID	Contact Number																		

Form No. PHC-PH698 (Feb 1-17)

**ALL NEW ORDERS MUST BE FLAGGED**

FAX COMPLETED ORDERS TO PHARMACY PLACE ORIGINAL IN PATIENT'S CHART



## INTERDISCIPLINARY GUIDELINES

B-00-07-10010- Dysphagia

### Appendix W: PHC-PM FEES Short Form



#### SPEECH-LANGUAGE PATHOLOGY FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING (FEES) ASSESSMENT REPORT – Short Form

Date of FEES: \_\_\_\_\_

Patient consent obtained

Diagnosis: \_\_\_\_\_

History of dysphagia: \_\_\_\_\_

Current diet: \_\_\_\_\_

Purpose of FEES: \_\_\_\_\_

Nare entered:  Right  Left NG tube in situ:  No  Yes Nare:  Right  Left

Factors influencing results: (behaviour, attention, fatigue, etc.) \_\_\_\_\_

#### A. ANATOMY

Anatomy:  Unremarkable  Remarkable for \_\_\_\_\_

#### B. MOVEMENTS

Velar Elevation	<input type="checkbox"/> Complete <input type="checkbox"/> Incomplete – R / L <input type="checkbox"/> Absent	
Base of Tongue Elevation	<input type="checkbox"/> Present <input type="checkbox"/> Reduced - R / L <input type="checkbox"/> Absent	
Vocal Fold / Arytenoid Mobility	<input type="checkbox"/> Present <input type="checkbox"/> Reduced - P / L <input type="checkbox"/> Absent	
Laryngeal Closure	<input type="checkbox"/> Present <input type="checkbox"/> Reduced - R / L <input type="checkbox"/> Absent <input type="checkbox"/> CNA	
Pharyngeal Wall Medialization	<input type="checkbox"/> Present <input type="checkbox"/> Reduced - R / L <input type="checkbox"/> Absent <input type="checkbox"/> CNA	
Epiglottic Retroflexion (during swallow)	<input type="checkbox"/> Present <input type="checkbox"/> Reduced - R / L <input type="checkbox"/> Absent	

#### C. SECRECTIONS

LANGMORE SECRETION RATING SCALE	
0	Normal
1	Standing secretions in the valleculae, lateral channels, and pyriform sinus
2	Standing secretions in the laryngeal vestibule transiently
3	Consistent standing secretions in the laryngeal vestibule or aspirating secretions without clearance

#### D. SENSATION

WNL  Reduced \_\_\_\_\_