FeSS Swallow Protocol

The FeSS Swallow Protocol consists of nurses undergoing education and assessment of their competency by a speech pathologist to screen patients for swallowing difficulties (the QASC trial used the ASSIST screening tool). The protocol includes:

- an in-service education package including a PowerPoint® presentation
- an assessment of knowledge tool
- a clinical competency assessment tool

Nurses attend an education session. To be considered competent at swallowing screening, nurses must attend the education, pass a written test and, witnessed by a speech pathologist, successfully screen three patients using a screening tool (the QASC trial used the ASSIST screening tool).

- Patients should be screened before being given food or drink
- Patients should be screened with 24 hours of admission to hospital
- Patients who fail the swallowing screening should be referred to a speech pathologist for a full swallowing assessment

This protocol was used in conjunction with the other FeSS protocols and the FeSS implementation strategies and not as a stand-alone protocol.
Assessment of Knowledge (Post practical)

1. Why is knowledge of CT results required prior to screening?

2. Explain the significance of a brainstem stroke.

3. List the three pre-feeding skills required before screening can commence.

4. How do you ensure the patient is in an upright position?

5. If the patient fails the pre-feeding skills, how should medications be administered?

6. Describe what is meant by NBM and explain its significance.

7. Identify the limitations of the gag test.

8. Why is it important to check the patient’s ability to cough?
9. How do you screen for facial weakness and what are its features?

10. What is the implication of coughing on saliva and drooling?

11. What behaviours are indicative of failure following the sip test?

12. What is the implication of coughing/throat clearing after swallowing water?

13. When should referral to Speech Pathology occur?

14. Name two indicators of silent aspiration.

15. Name three indicators of swallowing difficulty for a patient who has commenced an oral diet.
Answers: Assessment of Knowledge (Post Practical)

1. Why is knowledge of CT results required prior to screening?

   *CT is used to determine type of stroke. Haemorrhagic strokes require neurosurgical assessment prior to screening swallow in the event that the patient is required to fast for surgery*

2. Explain the significance of a brainstem stroke.

   *The incidence of dysphagia following brainstem stroke is significantly higher than for cortical stroke, and has been reported to be as high as 70% - 80%. All suspected brainstem strokes should therefore be referred to Speech Pathology for swallowing assessment*

3. List the three pre-feeding skills required before screening can commence.

   *Ability to maintain alertness
   Patient sitting upright
   Head control*

4. How do you ensure the patient is in an upright position?

   *The patient should be placed in high sitting, with hips flexed at 90° to trunk, shoulders positioned over hips*

5. If the patient fails the pre-feeding skills, how should medications be administered?

   *NG should be considered if meds are unable to be given via IV*

6. Describe what is meant by NBM and explain its significance.

   *Nil by Mouth means the patient is not allowed to eat, drink or take medications. Nil by mouth means strict NBM – no sips of water*

7. Identify limitations of the gag test.

   *Not predictive of swallow status
   Absent in 43% normals*

8. Importance of checking ability to cough?

   *It indicates voluntary control of airway protection mechanism*
9. How do you screen for facial weakness and what are its features?

   Ask patient to smile, pout. Observe during conversation
   Flattening of nasolabial fold, droop of mouth, asymmetry of smile

10. What is the implication of coughing on saliva and drooling?

   It indicates an inability to swallow saliva, and possibly reduced sensation,
   penetration/aspiration or facial weakness if loss anteriorly

11. What behaviours are indicative of failure following the sip test?

   Cough, throat clearing after swallow, change in vocal quality to ‘wet’ sounding, drooling,
   change in respiration

12. What is the implication of coughing/throat clearing after swallowing water?

   Indicates penetration/aspiration of liquid into airway.

13. When should referral to Speech Pathology occur?

   Immediately following failure of any section after Section 1

14. Name 2 indicators of silent aspiration.

   Spike in temperature, unexplained deterioration in chest condition

15. Name 3 indicators of swallowing difficulty for a patient who has commenced an oral diet.

   Any three of these:
   Food pooling in cheek or mouth,
   Difficulty chewing,
   Coughing/choking during meal
   Change in vocal quality
   Loss of food from mouth when eating
   Overfilling mouth
   Spike in temperature
   Deterioration in chest condition
   Patient reports difficulty
### CLINICAL COMPETENCY
#### Swallow Screening using ASSIST

<table>
<thead>
<tr>
<th>Element of ASSIST</th>
<th>Element of Competency</th>
<th>Performance Criteria</th>
<th>Yes/No/NA</th>
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<tbody>
<tr>
<td><strong>Preparation</strong></td>
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<tr>
<td></td>
<td>▪ Prepares the environment and gathers necessary information/equipment prior to performing screening</td>
<td>▪ Ensures patient has undergone CT scan prior to commencing screening</td>
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<td>▪ Displays awareness of stroke pathway</td>
<td>▪ Reads medical file</td>
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<td></td>
<td>▪ Provides information to patient</td>
<td>▪ Screens within 24hrs of admission</td>
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<td>▪ Responds appropriately to Non English Speaking Background (NESB) patients</td>
<td>▪ Explains procedure to patient/carer</td>
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<td>▪ Aware of infection control issues</td>
<td>▪ Uses interpreter or family member to explain all procedures to patient</td>
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<tr>
<td></td>
<td>▪ Ensures patient has undergone CT scan prior to commencing screening</td>
<td>▪ Washes hands before and after screening patient</td>
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<p>| <strong>Section 1</strong>     | Is the patient able to:- |                      |           |
|                   | ▪ Maintain alertness for at least 20 minutes? | ▪ Engages patient in conversational speech. |           |
|                   | ▪ Maintain posture/positioning in upright sitting? | ▪ Patient placed in 90° upright sitting position, (hips flexed, shoulders over hips) prior to commencing screening. Support provided if hemiplegic. Maintains adequate upright position throughout. |           |
|                   | ▪ Hold head erect? | Screening terminated if alertness or posture inadequate. Patient reviewed when condition improves. |           |
|                   | ▪ Demonstrates accurate assessment of alertness | |           |
|                   | ▪ Demonstrates knowledge of positioning &amp; head control | | |</p>
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<tr>
<td><strong>Section 2</strong></td>
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</table>
| Does the patient have any of these? | ▪ Demonstrates accurate identification of risk factors and responds appropriately | ▪ Suspected brainstem stroke  
Checks medical file  
Facial weakness/droop  
Observes at rest, asks to smile  
Slurred/absent speech  
Noted from conversation  
Coughing on saliva  
Observes patient  
Drooling  
Observes patient  
Hoarse/absent voice  
Note from conversational speech, request patient say "Ah"  
Weak/absent cough  
Request patient to cough  
Shortness of breath  
Observes patient at rest & during conversation  
Pre-existing swallowing difficulty  
Asks patient/carer  
**Screening terminated if any of the above observed.** |           |
| ▪ Suspected brainstem stroke | ▪ Facial weakness/droop | ▪ Slurred/absent speech | ▪ Noted from conversation |
| ▪ Facial weakness/droop | ▪ Coughing on saliva | ▪ Drooling | ▪ Observes patient |
| ▪ Slurred/absent speech | ▪ Hoarse/absent voice | ▪ Weak/absent cough | ▪ Request patient to cough |
| ▪ Coughing on saliva | ▪ Shortness of breath | ▪ Pre-existing swallowing difficulty | ▪ Observes patient at rest & during conversation |
| ▪ Drooling | ▪ Pre-existing swallowing difficulty | | |
| ▪ Hoarse/absent voice | ▪ | ▪ |
| ▪ Weak/absent cough | ▪ | ▪ |
| ▪ Shortness of breath | ▪ | ▪ |
| ▪ Pre-existing swallowing difficulty | ▪ | ▪ |
| **Section 3**     |                       |                      |           |
| Test patient with a sip of water and observe: | ▪ Correctly performs sip test | ▪ Gives patient single sip of water.  
Holds cup if required.  
Any coughing/throat clearing  
Observes patient  
Change in vocal quality  
Asks patient to say ‘Ah’  
Drooling  
Observes patient  
Change in respiration/shortness of breath  
Observes patient  
**Screening terminated if any of the above observed.** |           |
<p>| ▪ Any coughing/throat clearing | ▪ | ▪ |
| ▪ Change in vocal quality | ▪ | ▪ |
| ▪ Drooling | ▪ | ▪ |
| ▪ Change in respiration/shortness of breath | ▪ | ▪ |</p>
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<td><strong>Section 4</strong></td>
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<tr>
<td>Observe the patient drink a cup of water and observe:</td>
<td>▪ Correctly performs extended swallow test</td>
<td>▪ Gives patient cup of water. Hold cup if required. No straw used. Observations as above</td>
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<tr>
<td>● Any coughing/throat clearing</td>
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<td>● Change in vocal quality</td>
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<td>● Change in respiration/shortness of breath</td>
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<td><strong>Section 5</strong></td>
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<tr>
<td>Commence premorbid oral diet</td>
<td>▪ Demonstrates knowledge of mealtime safety</td>
<td>▪ Determines patient’s premorbid diet. Asks patient or carer</td>
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<td>Observes patient with first meal</td>
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<td>▪ Notifies food services Contacts kitchen, enters diet on computer or informs ward clerk</td>
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<td>▪ Ensures dentures are worn</td>
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<td>▪ Monitors patient during first meal Provides standby supervision</td>
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<td>Notes difficulty chewing, pooling or signs from Section 4</td>
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<tr>
<td><strong>Documentation</strong></td>
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<td></td>
<td>▪ Correctly determines when to terminate screening</td>
<td>▪ Refers to Speech Pathology as required</td>
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<td>▪ Correctly documents and reports the Screening outcome in the appropriate manner</td>
<td>▪ Advises MO of outcome.</td>
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<td>▪ Demonstrates awareness of indicators of aspiration</td>
<td>▪ Documents results of screening in medical record.</td>
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<td>▪ Notes if patient NBM and places sign above bed if required.</td>
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<td>▪ Confirms diet order with food services</td>
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<td>▪ Explains results to patient/carer</td>
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<td>▪ Monitors patient for spike in temperature or deterioration in chest condition</td>
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DEEMED COMPETENT: YES / NO  
Assessed by Name: ________________________________  
Date:  
Signature:  

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Swallow Screening References


