Acute Stroke Swallow Screen

Only to be completed by qualified & competent staff

Use with NEW STROKE PATIENTS ONLY - Complete within 4 HOURS of admission

Addressograph

Exclusion criteria

Answer the following before proceeding:

1.	Is the patient unable to remain alert/conscious for screening?	Yes ❒ No ❒
2.	Is the patient taking modified diet/fluids due to pre-existing dysphagia?	Yes ❒ No ❒
3.	Patient unable to be positioned higher than 30 degrees?	Yes ❒ No ❒
4.	Is the patient NBM for other medical reasons?	Yes ❒ No ❒
5.	Does patient have a tracheostomy	Yes ❒ No ❒

IF 'YES' TO ANY OF THE ABOVE THE PATIENT IS NOT SUITABLE FOR THIS SCREENING ASSESSMENT. SEE OVERLEAF FOR DETAILED GUIDANCE ON FURTHER MANAGEMENT

COGNITIVE EXAM

Screening Questions:

Where are you now?
Correct ❒ Incorrect/unable to respond ❒

What date is your birthday?
Correct ❒ Incorrect/unable to respond ❒

What year is it?
Correct ❒ Incorrect/unable to respond ❒

How old are you?
Correct ❒ Incorrect/unable to respond ❒

ORAL EXAM

Oral exam: (if not following instructions- tick unable)

"Say ooo eee" (look for symmetry)
Unable ❒ Able/full smile ❒
Weakness one side ❒

"Puff out your cheeks" (check is able to keep lips shut/no air escape)
Unable ❒ Able ❒

"Stick out your tongue. Wiggle your tongue all the way to the left and right"
Unable ❒ Full range ❒
Weakness/deviation to one side ❒

PROCEED WITH THE WATER CHALLENGE

85ml WATER SWALLOW TEST

Ensure patient is sat in as upright a position as possible (no less than 30 degrees)
Measure 85mls of water into an open cup or patient's preferred drinking vessel
Ask the patient to DRINK THE ENTIRE 85mls from a cup or with as straw if preferred WITHOUT STOPPING
The cup or straw can be held by yourself or the patient

PASS (Circle as appropriate)

Patient was **able** to drink 85ml continuously without stopping, coughing or throat clearing during or shortly after

ACTIONS:

- Find out patient's pre-admission diet and order this for next meal (check texture/allergies/halal etc).
- Supervise first meal and drink. Take extra caution and supervise closely if:
  - you are unsure of the baseline diet
  - if difficulties identified on oral exam
  - if patient has no teeth
- If you have ongoing concerns refer to Speech and Language Therapy

From the Yale Swallow Protocol (Leder & Suiter, 2014)

FAIL (Circle as appropriate)

Patient **unable** to drink 85mls continuously without stopping, coughing or throat clearing during or shortly after

ACTIONS:

- Keep NBM including medications
- Repeat screen at least every 24hrs if reason for failure was poor alertness
- Refer to Speech and Language Therapy on number below for a full assessment
- Seek advice from medical team/dietetics as to whether to commence NG feeding
- Ensure oral hygiene is administered in accordance with oral/mouth care guidance *see overleaf for detailed guidance.

Name of assessor (PRINT name): _____ Designation: _____

Date: _____ Time: _____ Location: _____

Telephone: Speech and Language Therapy - 33855 (Morriston Hospital)

Exclusion criterion and FAQs	Recommendation
Patient is unable to remain alert/conscious for screening	You will need to agree with the stroke physician responsible for this patient's care how long to wait before considering appropriateness for NG feeding. It will be useful to seek dietetic opinion to contribute to this decision. **You should re-administer the screen when patient becomes sufficiently alert or at least every 24hrs**
Patient is taking modified diet/fluids due to pre-existing dysphagia	Pre-existing dysphagia complicates the assessment of the patient with a new admitting condition and may cause or exacerbate an existing dysphagia. Keep the patient NBM and **refer directly to SLT for assessment**. A medical and dietetic opinion is useful in considering whether to consider alternative nutrition and hydration pending SLT assessment.
Patient is NBM for other medical reasons	Discuss the reason for NBM with the medical team who made this decision. Seek further guidance from them as to whether a swallow screen is appropriate.
Patient is unable to be positioned higher than 30 degrees	Patients with a new neurological event coupled with an inability to sit at 30 degrees or more pose greater dysphagia/aspiration risk. **Refer directly to SLT for an assessment.**
Patient has a tracheostomy	Patients with a tracheostomy breathe through a tube in their neck. The presence of a tracheostomy can cause dysphagia and greater aspiration risk. **Refer directly to SLT for an assessment.**
What oral care can I do with a patient that is NBM?	Oral care is essential for all patients including NBM patients. Oral care should include the teeth, gums and all soft tissues including tongue. A non-foaming toothpaste should be used on a dry toothbrush, with the paste pushed well into the bristles. Suction toothbrushes can be used if required. Dry mouth gels can be used as required, ensuring the mouth is cleaned to avoid a build-up of gel. Corsodyl gel should be used under guidance from the dental team only, it can be applied on a toothbrush, using a circular motion with the bristles angled at 45 degrees to the gum margin. Dentures should be cleaned twice daily and ideally removed at night, stored in a labelled denture pot, with a daisy behind the bed to prevent loss. Contact the SBU's Oral Health Coordinator on Ext 23654 for further advice.
Patient is starting to clinically improve - can I re-screen?	If the patient initially failed the swallow screen and you have been waiting for an SLT assessment for longer than 24hrs since you last carried out the screen, then you can re-attempt the screen. Update SLT if there is any change in outcome when the screen is repeated.
Patient passed the screen initially but they have since clinically deteriorated - what do I do?	You should place the patient NBM and re-attempt the screen. You can also seek advice from the medical team or SLT if available.
Patient is insisting on drinking from their sports bottle/straw/spouted beaker etc. Can I complete the screen with their preferred drinking vessel or should I use an open cup?	It is fine to carry out the screen using the patient's preferred drinking vessel. If they fail using this, it is advisable to try the screen again cautiously with an open cup to check if they are able to pass via this method. An open cup helps to keep the patient's head posture in a neutral position and allows the water to flow in a more controlled way, which can improve swallow safety.
Patient initially failed a screen and is NBM but has since been confirmed as NOT a stroke, what should I do?	Discuss with the medical team if they agree for you to cautiously introduce oral intake and refer to SLT if there are any concerns. This will be decided on a case by case basis.
What about patient's with aspiration pneumonia?	Aspiration pneumonia is sometimes caused during vomiting rather than swallowing per se or if the patient presents late to hospital, swallow problems may have improved since the time of the CVA. Please proceed with the screen and refer to SLT if patient fails. If uncertain, consult the stroke physician for advice.
My patient drank the 85mls but they could not drink it in once go, can I pass them?	No. The sensitivity of the screen is volume dependent. The patient needs to drink continuously in order for the screen to accurately detect or exclude aspiration risk. If they cannot drink continuously, mark this reason the on form, keep NBM and refer to SLT.
If the above do not answer your concerns please discuss with the SLT in your area or telephone the department on **33855 (Morriston Hospital)**	

COIN clinical online information network

Swansea Bay University Health Board

Authorisation Form for Publication onto COIN

PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED – IF NOT APPLICABLE PLEASE PUT N/A

COIN ID.	CID108
Document Title.	YALE Acute Swallow Screen
Name of Author.	Jade Farrell, Clinical Lead, Speech and Language Therapy.
Name of Lead Pharmacist.	N/A
Is the document New, Revised or a Review of a previous version.	Revised
Where on COIN do you want the document to be published.	Neurology and Stroke Nutrition and Dietetics - Acute Tools
Is the document relevant to the GP Portal.	No
Sign to confirm that the document has been authorised by an approved governance process in a specialty or delivery unit.	Jade Farrell, Clinical Lead, Speech and Language Therapy.
If NICE guidance been considered/referenced when producing this document, please provide the title or reference number.	No
Please provide a brief description/abstract of the document.	Acute Swallow Screen Pathway
Equality Statement. *(All policies and procedures need to comply with CID76 Policy for the Management of Heath Board Wide Policies, Procedures and other Written Control Documents (WCD).*	N/A
Published Date.	July 2011
Last Reviewed Date.	May 2025
Next Review Due/Expiry Date.	May 2028