Aspiration Prevention
Teaching Points for Inpatient RN

Complete a Nursing Swallow Screen on any of the following patients at high-risk for aspiration:

- Stroke patients with GCS 13, 14, 15 (Glasgow Coma Scale)
- Patients who test positive for delirium
  - DOSS > 3 (Delirium Observation Scale for non-ICU patients)
  - CAM ICU positive (Confusion Assessment Method)
- Patients with altered mental status
- Post-extubation patients (wait 2 hours after extubation)

Before performing the Nursing Swallow Screen:
First evaluate the patient for:

- **Facial asymmetry or weakness** by having the patient smile and assessing for asymmetry; by having the patient blow up their cheeks with air and assessing for air escaping on one side of the mouth or the other
- **Tongue asymmetry or weakness** by having the patient open their mouth wide, stick out their tongue and assessing for deviation to one side or the other
- **Soft palate asymmetry or weakness** by having the patient open their mouth wide, using a tongue blade while shining a light in their mouth, asking the patient to say “ahh”, and assessing for uvula sway towards one side or the other

If a patient tests positive for asymmetry in any of the above, **do not proceed** with the Nursing Swallow Screen. Obtain a provider order for NPO status and for an Inpatient Speech Pathology Consult.

If a patient is negative for asymmetry, proceed with the Nursing Swallow Screen.

Performing the Nursing Swallow Screen:

- Have patient sit in an upright position
- Place fingers over thyroid cartilage
- Give 90 mls of cool water in a cup (have the patient hold the cup if they can and avoid using straws)
- Instruct patient to take small sip of water
- If problem is detected: Stop swallow screen, get provider order for NPO status and for Inpatient Speech Pathology Consult
- If no problem: continue screening
- Have the patient drink the remaining water as quickly and comfortably as possible
- Allow 5 seconds for patient to drink water
- Have patient count out loud from 1 to 10

A Failed Nursing Swallow Screen:
Does the patient have a delay in the initiation of swallowing? Does the patient cough or choke during or within one minute after swallowing? Does the patient have a “wet” sound to the voice after swallowing? Does the patient take more than 5 seconds to consume the water? Does the patient have drooling or do they lose water from a corner of the mouth?

If the answer is “yes” to any one of these questions, a patient has failed the swallow screen and a provider order for NPO status and Inpatient Speech Pathology Consult is indicated.

Documentation in Epic:
Document the swallow screen in the Flowsheet activity within the Daily Care tab.
Source: Patty Graham, Ellen Nyheim