Adult Dysphagia Screening and Assessment - Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care and management of dysphagia screening and assessment throughout the WA Country Health Service (WACHS).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS. Health professionals who are involved with the dysphagia screening are accountable for their own practice and must only undertake activities which are within their scope of practice and for which they are legally entitled to perform, educationally prepared for and competent to undertake.

The code of conduct and practice standards are outlined in the following documents:

- AHPRA Medical Board Good Medical Practice: a code of conduct for doctors in Australia
- AHPRA Nursing and Midwifery Board Midwife Standards for Practice
- AHPRA Nursing and Midwifery Board Registered Nurse Standards for Practice
- AHPRA Nursing and Midwifery Board Enrolled Nurse Standards for Practice
- AHPRA Nursing and Midwifery Board Nurse Practitioner Standards for Practice

The WACHS Dysphagia Screening and Assessment CPS relates specifically to the identification of adult clients at risk for dysphagia, and the 1) dysphagia screening of patients; and/or 2) the referral to speech pathologists for assessment, diagnosis and management in WACHS inpatient settings.

For WACHS managed residential aged care settings the Residential Admission Assessment Form (RC5) and Nutrition and Hydration Flowchart for Use in Residential Aged Care identify the process of swallow assessment and referral to speech pathology services.

This CPS does not include information specific to stroke, nutrition or dysphagia management, or the screening and assessment of paediatric patients.

3. General Information

Dysphagia can result from a wide range of medical conditions including acute or progressive neurological conditions, trauma, disease or surgery. Dysphagia can cause dehydration and malnutrition as well as aspiration pneumonia which can lead to increased morbidity and mortality. Dysphagia screening and assessment of swallowing function is essential for the accurate identification and diagnosis of deficits in swallowing and the effective management of dysphagia.

Dysphagia screening is the process to identify at-risk patients, undertaken by clinicians competent in the procedure. Within WACHS, screening is typically performed by registered nurses, enrolled nurses and speech pathologists.

Dysphagia assessment is a more comprehensive process completed by a speech pathologist, involving a clinical examination of a patient's presenting behaviour, function and cognition as it relates to swallowing. A range of food and fluids of varying texture and consistency may be used to evaluate swallowing skills.
Additionally, examination of a patient's cranial nerve function, saliva management, and spontaneous airway protection may occur.[3]

Assessment may prompt referral for other types of instrumental assessments to determine disorders of the swallowing phase including modified barium swallow (MBS) and Video-fluoroscopy Swallow Study (VFSS).

4. Indications for Dysphagia Screening and Assessment

Patient conditions that have a higher dysphagia risk that **must** be screened and/or referred to speech pathology for assessment include[2,3,5]:

- acute and progressive neurological conditions, regardless of cause
- post-surgery or radiotherapy for upper aero-digestive tract, e.g. head/ neck cancer
- stroke / transient ischaemic attack
- traumatic / acquired brain injury.

Patient condition indicators with a potential dysphagia risk include but not limited to:

- age greater than 65 years, including aged care residents
- chronic obstructive pulmonary disease (COPD)
- decreasing levels of consciousness
- disability / debilitating illness e.g. multiple sclerosis, cerebral palsy
- taking medications that may have side effects for swallowing e.g. ACE inhibitors, antihistamines, anticholinergics, antipsychotics
- post-operative, including spinal surgery / injury
- those who are transitioning from enteral to oral intake e.g. ceasing nasogastric feeding
- any patient at risk of dysphagia or displaying signs of dysphagia.

Dysphagia signs and symptoms include[5,8]:

- coughs, chokes or gags whilst eating or drinking
- dehydration and / or dry mouth (xerostomia)
- difficulty holding or controlling food in the mouth
- frequent oropharyngeal suction
- gurgling voice e.g. voice sounding wet or hoarse
- pain on swallowing
- recent unintentional weight loss
- recurrent episodes of pneumonia
- refusal to eat, drink or take solid medications
- regurgitation, including nasal, of undigested food or fluids
- self-reporting of difficulty swallowing
- signs of aspiration pneumonia (recurrent chest infections, shortness of breath, increased heart rate, respirations, and increased temperature)
- sputum discoloured with food or fluid
- taking longer than 30 minutes to complete a meal.

5. Procedural Information

5.1 Dysphagia Screening

Clinicians must work within their scope of practice in performing a dysphagia screen. Nurses undertaking screening must:

- hold a basic life support competency
- have completed the Dysphagia Screening (DYSWA EL1) via MyLearning LMS.

Dysphagia screening by Nurses at Regional Resource Centres

All WACHS Regional Resource Centre Hospitals (Broome, Port Hedland, Geraldton, Kalgoorlie, Albany and Bunbury) are required to ensure capacity exists for nurses to perform dysphagia screening.

Dysphagia screening by Nurses at District and Small sites

All WACHS district and small sites are required to use the risk assessment matrix (Appendix 1), to determine the suitability of nurses to perform dysphagia screening of patients presenting to the site.

If it is ascertained that nurses at a district or small site **are not to perform dysphagia screening**, all clients identified as at risk (see Section 4 Indications for Dysphagia Screening and Assessment) are to be referred to speech pathology for dysphagia assessment, in accordance with local referral processes.

The MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital [RBWH]) is a quick and accurate nurse-administered tool for triaging dysphagia. The tool is suitable for a general acute and surgical inpatient population, in addition to stroke patients[10]. The sensitivity and specificity of the tool means that there are neither large

numbers of inappropriate referrals to speech pathology or large numbers of patients with dysphagia who are not identified. For these reasons the RBWH Dysphagia Screening Tool has been chosen for use in WACHS inpatient facilities.

Dysphagia education is critical to the success of the screening tool. The e-learning tool (DYSWA EL1) via MyLearning LMS must be completed by all nurses prior to being able to use the tool. In addition, further support is available from WACHS speech pathologists employed within local hospital sites.

Use of the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH) is restricted for use:

- only in WACHS sites applying the dysphagia screening process
- by staff who have completed the required training.
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Refer to Appendix 2 for the procedure for screening administration.

5.2 Dysphagia Assessment

Dysphagia assessment should be completed by a speech pathologist with input from other members of the patient's health care team as required. Assessment should take place in a timely manner for:

- Clients who are unable to undertake or fail the dysphagia screen as per the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH)).
- Clients identified as at risk (see Section 4 Indications for Dysphagia Screening and Assessment) in the district / smaller sites that are not applying the **dysphagia screening process**, in accordance with local referral processes.
- Clients referred for a swallowing assessment by nursing or other health staff following concerns about swallowing function.

Referral to speech pathology should follow site referral processes.

The speech pathologist may use a range of food and fluids of varying texture and consistency to evaluate swallowing skills. The speech pathologist may also examine a patient's cranial nerve function, saliva management, and spontaneous airway protection.[3] The MR64A WACHS Dysphagia Speech Pathology Swallow Assessment form may be utilised.

5.3 Dysphagia Management

Following assessment, a speech pathologist may recommend a range of dysphagia management strategies to reduce the risk of aspiration, choking and compromised nutritional intake. This may include modification of food and fluids, behaviour management and compensatory techniques, environmental management and rehabilitation. All clinical staff involved in supporting the patient with dysphagia are to be aware of, and adhere to, recommended dysphagia management strategies.

The International Dysphagia Diet Standardisation Initiative (IDDSI) for modified diet and fluids will be used within all WACHS sites from 1 November 2019. Relevant staff

are to have an understanding of the terminology used, the consistency and testing methods for each type of food and fluid modification:

Modified Food

Standardised terminology	Description
7 Regular	Everyday foods. No exclusions
6 Soft and Bite Sized	Pieces less than 15mm x 15mm (adult) or 8mm x 8mm (child) No separate thin liquid Push with a fork, with enough pressure that the thumbnail turns white, the food can be squashed and not return to its original shape (Fork pressure test) Food can be cut using pressure from a fork
5 Minced and Moist	Soft and moist, but no liquid dripping from a fork Lumps 4mm in size or fit in between prongs of the fork Biting is not required Minimal chewing required Holds its shape on a spoon and falls off fairly easily if spoon is tilted (Spoon tilt test) Lumps can be mashed with the tongue Should not be firm or sticky
4 Pureed	Usually eaten with a spoon Does not require chewing Has a smooth texture with no lumps Holds shape on a spoon Falls off a spoon in a single spoonful when tilted (spoon tilt test) Is not sticky Liquid (like sauces) must not separate from solids Must be tested with fork drip test and Spoon tilt test – pureed food must pass both tests
3 Liquidised	Fluid food Drips slowly or in strands through prongs of a fork (fork drip test) 8 – 10 ml liquid remaining in *specified syringe (syringe test)

Modified Fluids

Standardised terminology	Description
1 Slightly Thick	1-4 ml liquid remaining in *specified syringe (syringe test)
2 Mildly Thick	4-8 ml liquid remaining in *specified syringe (syringe test)
3. Moderately Thick	Drips slowly or in strands through prongs of a fork (fork drip test) 8 – 10 ml liquid remaining in *specified syringe (syringe test)
4 Extremely Thick	Falls off a spoon in a single spoonful when tilted (spoon tilt test) Liquid sits in a mound above fork prongs and does not drip through (fork drip test)

* Syringe used must be - 10 mL slip tip hypodermic syringe

Nursing staff are responsible for ensuring that patients on modified food and/or fluid receive the appropriately modified food/fluid at meal and snack time. Nurses may delegate responsibility for checking patient's food and fluid to another staff member (including AIN, PCA, etc). Decisions to delegate the task will take into account the complexity/risk of patient care and the competency/skill of the staff member to which the task is being delegated.

Diet and fluid modifications requirements should be documented (1) in the health record, (2) at the patient bedside, and (3) on the food service systems.

All staff responsible for the preparation of modified fluids and food are recommended to complete the Thickened Fluids and Modified Diet (THFWA EL1) eLearning program via MyLearning LMS.

6. Clinical Communication

Clinical Handover

Information exchange is to adhere to the WA Health Clinical Handover Policy using the iSoBAR framework. Dysphagia related instructions and alerts should be included in bedside handover (see WACHS Shift to Shift Bedside Clinical Handover Nursing Process).

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Where relevant, any dysphagia related safety or dietary alerts (including

modified diet and fluid requirements) should be documented at the patient's bedside.

Documentation

An individualised management plan is to be documented in the patient's health records as soon as practicable, in regard to this CPS.

Refer to the WACHS Documentation CPS.

All results and recommendations of a Dysphagia Screen must be documented on the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH) and included within the patient's heath record. Health record documentation must include date and time the screen was conducted, observations, outcome of screen, communications and referrals made.

7. Staffing Requirements

A collaborative multidisciplinary team approach including; medical practitioners, radiologists, speech-language pathologists, dietitians, and nurses is ideal in the screening, assessment and management of the patient with dysphagia.[9]

Role	Responsibility
Speech pathologist	Assess, diagnose and manage dysphagia. Provide dysphagia education for patient, family / carers, and other health professionals.
Pharmacist	Provide advice to determine safe oral alternatives for drug formulations and management plans for medication-related dysphagia.
Physiotherapists	Assess and recommend management of the patient's respiratory conditions.
Occupational therapists	Assess and make recommendations of the patient's posture, position and seating requirements, as well as use of any adaptive or assistive equipment. Assess and make recommendations of the patient's cognitive status and its impact on dysphagia in collaboration with the multidisciplinary team.
Nursing staff	Provide dysphagia screening in collaboration with the multidisciplinary team and / or refer to speech pathologist for assessment. Monitor diet and fluid intake as directed. Assist with diet and fluids, and implement swallowing strategies where required.

Role	Responsibility
Medical officer	Refer patient for further investigation(s). Provide nutrition requirements in conjunction with the multidisciplinary team to ensure nutritional requirements are met. Consider medication requirements.
Dietitian	Nutrition assessment and recommendations for the management of patients with dysphagia. Provide education on nutritional management plans for the patient, family, carers and health professionals.

8. Compliance Monitoring

Evaluation, audit and feedback processes are to be in place to monitor compliance. This is the responsibility of Speech Pathology Area Coordinator. At a minimum this will occur every three years, facilitated by the policy review contact, using the following means or tools:

- Standardised clinical documentation
- Audit completion rate of relevant training
- Audit of utilisation of dysphagia screen at sites across WACHS
- Annual audit of IDDSI compliance at kitchens across WACHS

The Datix Clinical Incident Management System (Datix CIMS) is to be used to monitor and review trends, and investigate incidents as determined by individual regions.

Failure to comply with this policy document may constitute a breach of the WA Health system Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory

9. Records Management

Health Record Management Policy

10. Relevant Legislation

Health Services Act 2016 (WA)

11. Relevant Standards

National Safety and Quality Health Service Standards - 1.1, 1.7, 1.27, 5.27, 5.28
Australian Aged Care Quality Agency Accreditation Standards– Standard 2 & Standard 3)

12. Related WA Health Policies

MP 0095/18 Clinical Handover Policy
MP 0122/19 Clinical Incident Management Policy
MP 0171/22 Recognising and Responding to Acute Deterioration Policy
Code of Practice for Clinical and Related Waste Management

13. Relevant WACHS documents

Airway Suctioning - Clinical Practice Standard
Infection Prevention and Control Policy
MR64A WACHS Dysphagia Speech Pathology Adult Swallowing Assessment
MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH)
Nutrition Screening, Assessment and Management Procedure
Pressure Injury Prevention and Management Policy
Personal Protective Equipment (PPE) Procedure.
Residential Admission Assessment Form (RC5)
Nursing / Midwifery Shift to Shift Bedside Clinical Handover - Process Flowchart

14. WA Health Policy Framework

Clinical Governance, Safety and Quality

15. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Dysphagia Screening and Assessment Clinical Practice Standard.

16. References

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10. Cichero J, Heaton S, Bassett,L Triaging Dysphagia: nurse screening for dysphagia at an acute hospital *Journal of Clinical Nursing* (2009); 18 1649 - 1659.

17. Definitions

Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged.
Dysphagia	Difficulty in swallowing. Swallowing is defined as the movement of a bolus of food, fluid or saliva from the mouth to the stomach.
Patient	A person who is receiving care in a health service organisation.

18. Appendices

Appendix 1 - District and Smaller Site Dysphagia Screening Risk Assessment
Appendix 2 - Dysphagia Screening Process

This document can be made available in alternative formats on request for a person with a disability

Contact:	Area Coordinator Speech Therapy		
Directorate:	Allied Health	**EDRMS Record #**	ED-CO-15-92632
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Appendix 1: District and Smaller Site Dysphagia Screening Risk Assessment

District and small sites are required to risk assess, using the following risk matrix, the requirement of nurses to perform dysphagia screening of patients presenting to the hospital.

Risk Factor	**Status**		
Frequency of presentations requiring screening	Once per shift or more, daily, weekly	Less than weekly	Rare Occurrence
Capacity to ensure staff competent in performing a dysphagia screen present on all/most shifts	Always	Sometimes	Rarely
Ability to ensure maintenance clinician competency in dysphagia screening (frequency of presentations)	High	Medium	Low
Recommendations	Nurses at site recommended to perform dysphagia screening	Decision made in consultation with nursing and speech pathology	Nurses at site not recommended to perform dysphagia screening

Each risk factor is to be considered, with recommendations at the end of the columns applicable when the majority of cells are selected within the column. Where there is uncertainty, consultation between nursing management and speech pathology services is recommended.

Access to support by local speech pathology services is a factor determining the need for nursing performance of dysphagia screening. In some cases, infrequent speech pathology visits to sites may be indicative of needing dysphagia screening because this will mean that patient's swallow skills are addressed while waiting for a speech pathology visit.

It may also mean that nursing staff can discuss patient swallow skills in more detail, using the results from the screen, when having phone discussions with the off-site speech pathologist. In other situations, the infrequent visits from a speech pathologist may mean that dysphagia screening is inappropriate because of the reduced capacity for nursing support by a speech pathologist for using the dysphagia screen.

If it is ascertained that the district and smaller site **will not apply dysphagia screening**, all clients identified as at risk (see Section 4. Indications for Dysphagia Screening and Assessment) are to be referred to speech pathology for dysphagia assessments, in accordance with local referral processes.

Appendix 2: Dysphagia Screening Process

Staffing Requirements

Screening for dysphagia must only be undertaken by clinical staff that meets the following criteria:

- Current in basic life support
- Completed the Dysphagia Screening (DYSWA EL1) eLearning program via MyLearning LMS

Indicators

Patients presenting as at risk for dysphagia or displaying signs and symptoms of dysphagia (Section 4), must be screened as soon as possible.

Please note that the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH) requires that all inpatients are screened for dysphagia. However, for the purposes of screening within WACHS, the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH) will be used for those patients identified in this CPS as at risk for dysphagia or displaying signs and symptoms of dysphagia (Section 4).

Contra indications

Absolute: All patients who are unable to follow commands must be referred for screening / assessment by a speech pathologist or a senior medical practitioner.

Relative: Clients who have already been diagnosed with dysphagia or are on a modified diet. Depending on the reason for admission, these clients may not require screening (maintain current diet / fluid modifications) or are to be directly referred to a speech pathologist.

Pre-Screening Key Points

Before commencing the dysphagia screen, it is important that the equipment, the environment and the patient are adequately prepared for the screen. This includes:

- ensuring all the required equipment is prepared
- ensuring that suctioning equipment is available / working
- ensuring patient is alert and cooperative
- the patient has received information relating to the intended procedure, and has given appropriate consent
- patient identification and procedure matching processes are undertaken
- ensuring to maintain patient privacy and dignity, and distractions are removed
- offering the presence of a chaperone where appropriate to patient and clinician requirements
- providing the opportunity for an accredited interpreter and / or Aboriginal Liaison Officer where appropriate to the patient's language, cultural or communication requirements
- ensuring the patient is seated in an upright position, as clinically indicated

- assessing the patient for mouth care and undertake as required.

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

Equipment

The following equipment is required for screening:

- Gloves
- 1/3 Glass of water (85 ml).

Additional equipment consideration and requirements:

- Dysphagia screening is to be performed where suction equipment is available and functioning. Refer to WACHS Airway Suctioning Clinical Practice Standard.
- Equipment must be appropriate for the age / size of the patient.
- Specific sites may have pre-prepared equipment packs where contents may vary.
- Equipment must be checked, serviced and calibrated in accordance with manufacturer's recommendations to ensure reliability and accuracy.
- Select and include the use of Personal Protective Equipment (PPE) where appropriate to the intended procedure and comply with the specific requirements in alignment with the WACHS Personal Protective Equipment (PPE) Procedure.

Procedure

Follow procedures as outlined in the MR64B Dysphagia Screening Tool (Royal Brisbane Women's Hospital (RBWH).

Post Procedure

Following the completion of the dysphagia screen, the following actions must be completed:

- Ensure the patient remains in an upright position for a minimum of 30 minutes.
- Inform catering staff and nursing co-ordinator of dietary changes
- Update ward / unit diet board.
- Document assessment findings in the medical record
- Leave completed screen in patient's file
- Make any referrals as required (e.g. speech pathology, dietetics)
- Advise the following of the screening outcome (as relevant):
  - speech pathologist
  - medical staff
  - nurse coordinator
  - dietetics
  - patient and family.

Parameters During or Post Procedure

- All patients who are unable to follow commands are to be screened by a speech pathologist or a senior medical practitioner.
- Refer to site procedures for escalation of care in relation to patient dysphagia screening, assessment and management in clinical settings other than hospital inpatient, and / or where resources are limited in the provision of specific allied health staff services.
- Patients who meet criteria from the dysphagia screening for Nil By Mouth are to be referred to a speech pathologist for a more comprehensive dysphagia assessment and management plan. In addition, the medical team must be notified regarding oral medications and discuss with senior clinical nurse.
- In sites where there are limited speech pathology services and patients meet criteria for Nil By Mouth, contact the relevant speech pathologist by phone as soon as possible to discuss when the patient can expect to receive a speech pathology assessment and any possible interim management plans and/or dysphagia monitoring. In addition, liaise with the medical team and senior clinical nurse regarding the management until the speech pathologist can assess the patient.

Documentation

Refer to the Section 6: Documentation within this CPS.