Patient Label here

Grey Bruce Health Services – All sites

Dysphagia Screening Tool

Based on the Barnes Jewish Hospital Acute Stroke Dysphagia Screen

To be completed within 24 hours on all patients with a diagnosis of stroke or signs and symptoms of swallowing difficulties. Patients who are not alert should be closely monitored and screened when clinically appropriate. *Screen can be repeated at 24 hours for an assessment of change. If change in the patient's medical status is questioned, repeat the screen.

	YES	NO
1. Is score on Glasgow Coma Scale less than 13? Record score: _______	❒	❒
2. Is there Facial Asymmetry/Weakness?	❒	❒
3. Is there Tongue Asymmetry/Weakness?	❒	❒
4. Is there Palatal Asymmetry/Weakness?	❒	❒

❒ *Were **any of** the above questions answered with a **YES?***

1) Maintain patient NPO
2) Repeat screen in 24 hours
3) If patient remains NPO, complete referral to:

   ☒ Speech/Language Pathologist for a clinical swallowing assessment

   ☒ Dietitian Consult

If no SLP or dietitian for detailed assessment consider **enteral feeding support** (nasogastric feeding). The decision to proceed with tube feeding should be made as early as possible, usually within 3 days of admission, in collaboration with patient's and family's wishes.

❒ MD/NP for alternative feeding (trial thickened water and pudding. If no concerns ask MRP to order dysphagia pureed and thickened fluids)

❒ *Were **all** of the above questions answered with a **NO?***

1) Are there signs of aspiration during the 90 ml water test?

❒ Yes → If **YES** to throat clearing, coughing, or change in vocal quality, maintain the patient NPO.
Refer to:

- ❒ Speech/Language Pathologist for a clinical swallowing assessment
- ❒ Dietitian Consult

❒ No → If **NO**, start the patient on a regular textured diet. *Supervise first meal.

______________________________ Assessor's signature

______________________________ Date and time of screening

Adapted with permission (February 2014) from Barnes Jewish Hospital, St Louis, Missouri.

Refer to Assessment Guidelines on page 2.

Barnes-Jewish Hospital Acute Stroke Dysphagia Screen
Assessment Guidelines

1) Glasgow Coma Scale (GCS): ****Record score on page 1***

- Eye Opening Response: Spontaneous (4 points), in response to verbal stimuli (3 points), in reaction to pain that is not applied to the patient's face (2 points) or no response (1 point).
- Verbal Response: Oriented (5 points), able to answer questions despite apparent confusion (4 points), inappropriate words (3 points), unable to understand speech (2 points), or no response (1 point).
- Motor Response: Able to obey motor commands (6 points), deliberate movements in response to a pain stimulus (5 points), withdrawal in response to painful stimulus (4 points), flexion in response to painful stimulus (3 points), extension in response to painful stimulus (2 points), or no response (1 point).

Score __________

2) Facial Asymmetry/Weakness:

- Instruct the patient: "Show me a smile." Provide a visual model if the patient cannot follow verbal directions.
- What to look for: Facial weakness or droop on one side of the face. **If there is a droop, check "yes".**

3) Tongue Asymmetry/Weakness:

- Instruct the patient: "Stick out your tongue. Now, move your tongue from side to side." Provide a visual model if the patient cannot follow verbal directions.
- What to look for: Tongue deviation to one side during the tongue protrusion task. Difficult, laborious movements to one side during movement from side to side. **If there is deviation or weakness, check "yes".**

4) Palatal Asymmetry/ Weakness: ***Use a tongue depressor***

- Instruct the patient: "Open your mouth. I am going to place this stick on your tongue to look at the back of your throat. Say 'ah'."
- What to look for: Look to see if the soft palate is elevating symmetrical on both sides. Look for one side hanging lower than the other. **If there is asymmetry, check "yes".**

5) Signs of aspiration during 3 ounce water test: ***Use a cup filled with 3 ounces of water***

- Instruct the patient: "I want you to drink this water without stopping". Allow swallow completion. "Say 'ah' for as long as you can." Provide auditory and visual model if the patient cannot follow directions.
- What to look for: Note any of the following signs, **immediately or within 1 minute** following the swallow.
  1. Changes in vocal quality – any changes such as wetness, gurgly sounds, breathy or hoarse quality.
  2. Throat Clearing
  3. Coughing

If there are any of the above signs, check "yes".

Validation of a Dysphagia Screening Tool in Acute Stroke Patients American Journal of Critical Care 2010; 19:357-364