LOS ANGELES COUNTY+USC MEDICAL CENTER

DEPARTMENT OF NURSING SERVICES AND EDUCATION

3-OUNCE WATER SWALLOW SCREENING PROCEDURE

PURPOSE:

To summarize nursing responsibilities when performing a 3-ounce (oz) water swallow screen.

SUPPORTIVE DATA:

Normal swallowing involves multiple complex and coordinated interactions within the central and peripheral nervous systems necessitating that each system is intact.

Dysphagia, or impaired swallowing, is a common complication of acute stroke with an incidence that ranges from 37% to 78%. Aspiration can be a frequent and common complication among this population. If aspiration occurs about one-third will develop pneumonia, hence increasing morbidity and mortality. Utilization of an evidence-based swallow screen can help identify patients who can safely receive medications by mouth,and identify those patients who should remain NPO until an in-depth evaluation can be performed by a speech-language pathologist.

Any patient presenting for stroke or stroke symptoms must be screened before receiving anything by mouth. A swallow screen may be ordered by the provider via the use of a stroke order set, however the bedside nurse can independently perform the screen and document the results in iView. A swallow screen may also be ordered for other diagnoses in addition to stroke.

EQUIPMENT LIST:

- 8oz cup
- 3 oz (90 mL) of drinking water
- Straw (optional)
- Towel

CONTENT:

PROCEDURE STEPS	KEY POINTS
Pre-Swallow Screen Safety Assessment	
1. Assess patient by using the following safety screening questions; the nurse will document if the answer is yes to any of these screening questions:	• If the answer to any of the safety screening questions is **YES, STOP! DO NOT** proceed with the swallow screen. Keep patient NPO, including medications and inform the provider. • If the answer to all of the safety screening questions is **NO, CONTINUE** with the swallow screen. • Pre-swallow Screen Safety Assessment is documented in Stroke Navigator Band in "contraindications to swallow screen"

Yes	No	
□	□	Intubated or Tracheostomy tube present
□	□	Unable to manage oral secretions
□	□	Obvious signs of respiratory distress
□	□	Not alert/ unable to follow commands
□	□	Unable to sit up ≥ 30 degrees
□	□	Existing PEG or feeding tube

PROCEDURE STEPS	KEY POINTS
2. Explain procedure to patient.	
3. Sit patient upright with HOB 80 - 90 degrees or as high as tolerated.	
Performing the Swallow Screen	
4. Instruct patient to drink entire 3oz cup of water, with or without a straw, in sequential swallows without interruption.	Staff may assist the patient by holding the cup and/or the straw.
5. During and after swallowing, assess for coughing or choking.	Coughing or choking are overt signs of dysphagia.
6. Determine if patient passed or failed the screening.	**Criteria for failure are:** • Inability to drink the 3oz in its entirety • Interrupted drinking • Coughing during drinking • Coughing immediately after completion of drinking 3oz of water

Post Swallow Assessment

7. Notify the provider and keep patient NPO, if the patient fails.

- Document results of the screen and notification of provider in the Stroke Navigator Band.
- Patients who fail the swallow screen may need a formal swallow evaluation by speech-language pathologist.

8. Notify the provider if the patient passes the screen.

Note: attached screen shots from Orchid

Initial date approved: 11/16	Reviewed and approved by: Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	Revision Date: 8/20, 04/22

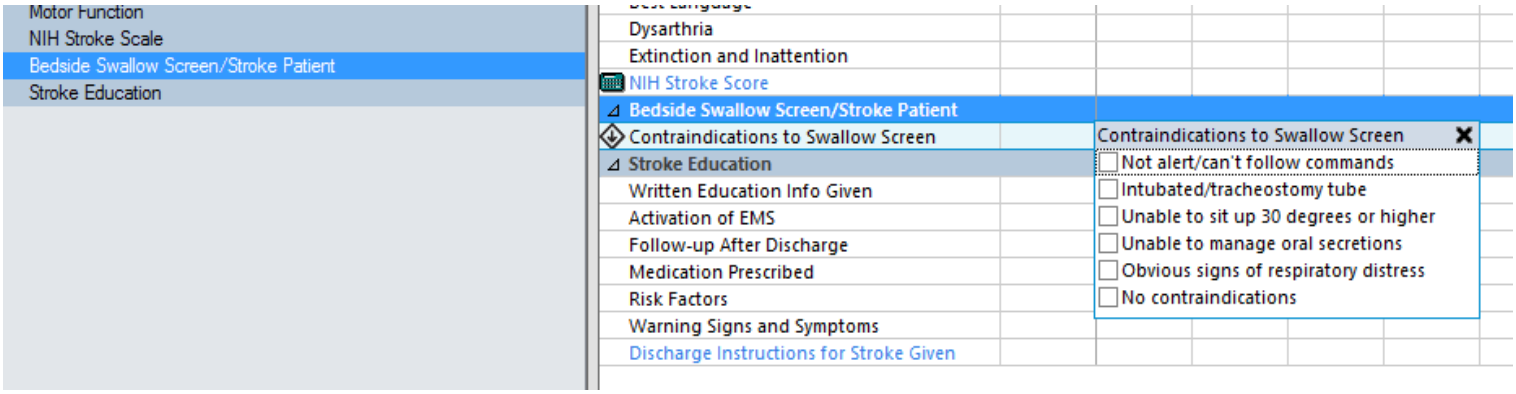
References

Armstrong, J.R. & Mosher, B. D. (2011). Aspiration pneumonia after stroke: intervention and prevention. *The Neurohospitalist, 1* (2), 85-93. Doi: 10.1177/1941875210395775

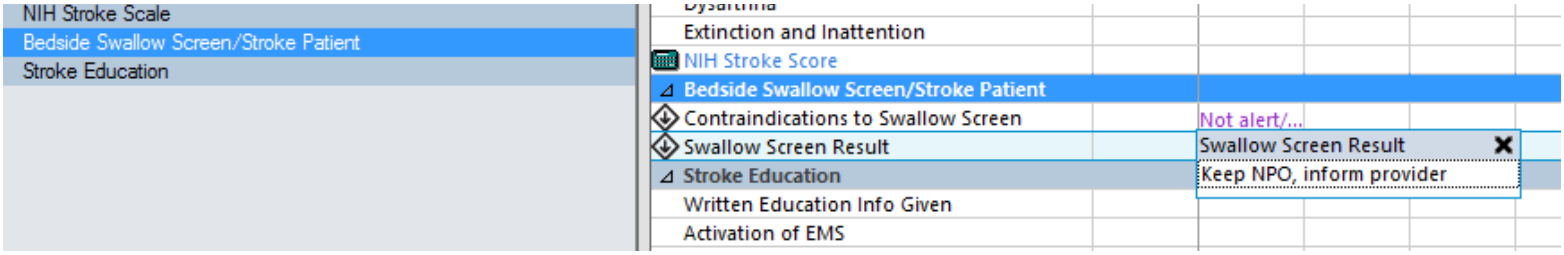
Fedder, W.N. (2017). Review of evidenced-based nursing protocols for dysphagia assessment. *Stroke, 48*, 99-101. Doi: 10.1161/STROKEAHA.116.011738

Schrock, J.W., Berstein, J., Glasenapp, M., Drogell, K. & Hanna, J. A. (2011). A novel emergency department dysphagia screen for patients presenting with acute stroke. *Academic Emergency Medicine, 18*, 584-589. doi: 10.1111/j.1553-2712.2011.01087.x

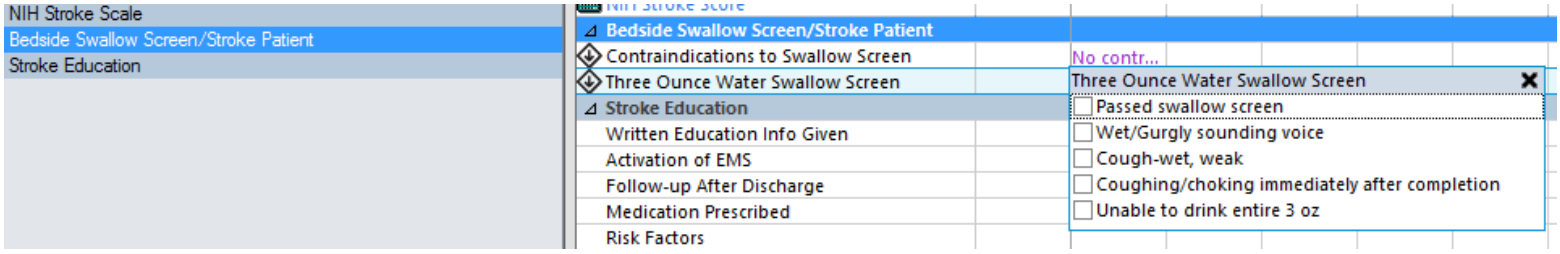
Bedside Swallow Screen



If any of the contraindications apply, it triggers the "Keep NPO, inform provider"



If NO CONTRAINDICATIONS, it still continues to guide nurses to the procedure and safety precautions.
Patients have to be able to tolerate the entire 3 ounces, no coughing, or wet/gurgled voice.



If the patient fails the swallow test, it will alert the nurse to keep patient NPO and notify provider.