# 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
- $\cdot$  3 oz (90 mL) of drinking water
- · Straw (optional)
- $\cdot$  Towel

#### **CONTENT:**

#### **PROCEDURE STEPS**

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:

## **KEY POINTS**

- 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"

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#### Yes No

- □ □ Intubated or Tracheostomy tube present
- □ □ Unable to manage oral secretions
- □ □ Obvious signs of respiratory distress
- $\Box$   $\Box$  Not alert/ unable to follow commands
- $\Box$  Unable to sit up  $\geq$  30 degrees
- $\Box$   $\Box$  Existing PEG or feeding tube

#### **PROCEDURE STEPS**

- 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.
- 5. During and after swallowing, assess for coughing or choking.
- 6. Determine if patient passed or failed the screening.

Staff may assist the patient by holding the cup and/or the straw.

Coughing or choking are overt signs of dysphagia.

#### 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

### **KEY POINTS**

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#### Post Swallow Assessment

- 7. Notify the provider and keep patient NPO, <u>if the</u> <u>patient fails</u>.
- 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
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#### 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

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Motor Function	Duratheir		
IH Stroke Scale	Dysarthria		
edside Swallow Screen/Stroke Patient	Extinction and Inattention INIH Stroke Score		
Stroke Education			
	⊿ Bedside Swallow Screen/Stroke Patient		
	Contraindications to Swallow Screen	Contraindications to Swallow Screen	
	⊿ Stroke Education	Not alert/can't follow commands	
	Written Education Info Given	Intubated/tracheostomy tube	
	Activation of EMS	Unable to sit up 30 degrees or higher	
	Follow-up After Discharge		
	Medication Prescribed	Obvious signs of respiratory distress	
	Risk Factors	No contraindications	
	Warning Signs and Symptoms		
	Discharge Instructions for Stroke Given		

# **Bedside Swallow Screen**

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

NIH Stroke Scale	Dysarcinia	
Bedside Swallow Screen/Stroke Patient	Extinction and Inattention	
Stroke Education	NIH Stroke Score	
Stoke Education	⊿ Bedside Swallow Screen/Stroke Patient	
	Contraindications to Swallow Screen	Not alert/
	Swallow Screen Result	Swallow Screen Result 🛛 🗙
	⊿ Stroke Education	Keep NPO, inform provider
	Written Education Info Given	
	Activation of EMS	
	l	

#### 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.

NIH Stroke Scale	INIT STOKE SCOLE		
Bedside Swallow Screen/Stroke Patient	Bedside Swallow Screen/Stroke Patient		
Stroke Education	Contraindications to Swallow Screen	No contr	
Stoke Education	Three Ounce Water Swallow Screen	Three Ounce Water Swallow Screen 🗙	
	⊿ Stroke Education	Passed swallow screen	
	Written Education Info Given	Wet/Gurgly sounding voice	
	Activation of EMS	Cough-wet, weak Coughing/choking immediately after completion Unable to drink entire 3 oz	
	Follow-up After Discharge		
	Medication Prescribed		
	Risk Factors		

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

NIT Stroke Scale Bedside Swallow Screen/Stroke Patient	Extinction and Inattention	
Stroke Education	IIII NIH Stroke Score	
	⊿ Bedside Swallow Screen/Stroke Patient	
	Contraindications to Swallow Screen	No contr
	Three Ounce Water Swallow Screen	Wet/Gur
	Swallow Screen Result	Swallow Screen Result 🛛 🗙
	⊿ Stroke Education	Keep NPO, inform provider
	Written Education Info Given	