SWALLOWING DEFICITS

PURPOSE: To outline the nursing management of the patient with impaired swallowing (dysphagia).

SUPPORTIVE DATA: Patients with swallowing deficits are at risk for aspiration and must be monitored carefully. Patients who are diagnosed with stroke must pass a swallow screen before being allowed to take anything by mouth.

ASSESSMENT:

1. Assess the following a minimum of:
   - Every 4 hours ICU, every 8 hours ward
     - Level of consciousness (LOC)
     - Presence/absence cough and gag reflexes
     - Quality and rate of respiration, breath sounds
     - Color, quality of secretions
     - Drooling
   - Every 8 hours intake and output (I&O)
   - Each oral intake
     - Ability to chew and swallow
     - Regurgitation of food or fluid
     - Residual food in mouth
   - For difficulty breathing, choking
   - Weigh patient on admission, then every 24 hours (ICU), every week or more often as ordered (acute care units)

INTERVENTIONS:

2. Maintain NPO status if ordered.
3. Provide oral hygiene before and after oral feedings and q hs.
4. Provide environment conducive to eating (e.g. empty urinal, commode, maintain quiet environment as desired, assist patient to chair with bedside table in front).
5. Prohibit use of drinking straw.
6. Provide special diet and snacks as ordered. Encourage patient to do the following if able to chew and swallow:
   - Place food in the unaffected side of the mouth
   - Alternate fluid with solid foods
   - Not to take solid and liquids in the same bite
   - Eat slowly and chew completely
7. Add thickener as ordered.
8. Ensure patient is using dentures and eyeglasses for meals.

SAFETY:

9. Ensure emergency airway and suction equipment availability.
10. Maintain in high Fowler's position with head and shoulders slightly forward during meals and 30 minutes after completion of meals or if respiratory distress occurs.
11. Position patient on side when recumbent.

REPORTABLE CONDITIONS:

12. Report to provider any deterioration in assessment findings.

COLLABORATION:

13. Collaborate with the following as needed:
    - Speech Therapy
    - Food & Nutrition Services
    - Occupational Therapy

PATIENT/CAREGIVER EDUCATION:

14. Instruct on the following:
    - Dietary requirements
    - Avoidance of mucus producing foods such as milk, milk products and chocolate
    - Positioning during meals
    - Avoid talking while eating
15. Reinforce feeding techniques taught by OT or speech therapy, to include:
    - Facial/tongue exercises
    - Tipping head and shoulders forward
    - Checking oral cavity frequently for food particles (remove if present)
    - Chewing thoroughly and eating slowly
16. Encourage family members to obtain CPR education.

ADDITIONAL STANDARDS:

17. Refer to the following as indicated:
    - Artificial Airway

DOCUMENTATION:

18. Document in accordance with documentation standards.
19. Document aspiration assessment in iView -> Systems Assessment in Neurological section.

Initial date approved: 08/96	Reviewed and approved by: Professional practice Committee Nurse Executive Committee Attending Staff Association Committee	Revision Date: 11/00, 03/05, 3/15, 9/20

References

Richman, S., Richards, S., Pravikoff, D. (2014). Stroke complications related to nutrition. Retrieved from Nursing Reference Center.

Cabrera, G., & Pravikoff, D. (2014). Stroke complications: dysphagia. Retrieved from Nursing Reference Center.