

Detecting dysphagia

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Early assessment and intervention can prevent complications.

It's 8:00 AM and time for your 83-year-old patient, Virginia Johnson*, to take her oral medication. She was admitted with a left femoral fracture following a fall. After the initial surgery, she developed a urinary tract infection, and this morning she's disoriented and confused. As Mrs. Johnson takes the first pill, you notice she's slow to swallow and then coughs immediately after. You recognize that Mrs. Johnson may have dysphagia and that she's at risk for developing aspiration pneumonia.

As the population ages, hospital clinicians see more patients with dysphagia resulting from stroke, dementia, and Parkinson's disease. (See *Causes of dysphagia*.) Patients with dysphagia are at high risk for developing aspiration pneumonia as a result of food, liquid, or oral bacteria going into the lungs. Other complications include dehydration, malnutrition, and airway obstruction. Through consistent patient interaction and using a simple assessment technique, nurses can recognize dysphagia early and make referrals to help prevent com-

plications, decrease hospital stay, and contribute to the health and safety of patients.

Bedside assessment

Use the PASS acronym to determine your patient's risk for dysphagia (See *Don't PASS up the opportunity*.) Start by asking if it's *probable* that the patient will have difficulty swallowing. For example, intubated patients and those with feeding tubes are at risk for dysphagia. Next, ask for an *account* or history of previous swallowing problems, which may indicate future problems and the need for additional or immediate intervention.

The third step is to *screen* your patient for observable symptoms such as drooling, coughing, or change of voice or speech. Your observation doesn't need to be formal; simply watch the patient while he or she is eating or taking medications. However, to ensure accuracy, make the following preparations:

- Ensure that the patient is seated as upright as he or she can tolerate without significant discomfort or pain.
- Make sure the patient is fully awake and alert.
- Note patient behaviors when eating or taking medication. For example, does the patient appear impulsive or anxious?

Any of the following signs or symptoms may indicate the need for an immediate referral to a *speech-language pathologist* (SLP) for dysphagia assessment:



Causes of dysphagia

Dysphagia can be divided into two categories—esophageal and oropharyngeal.

Causes of esophageal dysphagia

Esophageal stricture
Esophageal tumors
Foreign bodies
Gastroesophageal reflux disease
Radiation therapy
Scleroderma

Causes of oropharyngeal dysphagia

Cancer
Neurological disorders (for example, multiple sclerosis and Parkinson's disease)
Neurological damage (for example, stroke or spinal cord injury)
Pharyngeal diverticula

Source: www.mayoclinic.org/diseases-conditions/dysphagia/basics/causes/con-20033444

- coughing or throat clearing before, during, or after swallowing
- wet, gurgling voice before, during, or after swallowing
- shortness of breath after swallowing
- drooling or loss of liquid from the mouth
- holding food or liquid in mouth for extended time without swallowing
- complaining of food or liquid feeling stuck.

Patients with risk indicators should also be referred for assessment by an SLP. Making a referral may not require input from a provider, but check your organization's policy.

Interdisciplinary referral

Collaboration between speech pathology and nursing can help reduce complications related to poor swallow-

Don't PASS up the opportunity

Use this acronym to assess your patient's potential risk for dysphagia.

Probability—Is it probable that this patient will experience swallowing difficulties (for example, a patient with a nasogastric tube or tracheostomy)

Account for any previous swallowing problems

Screen for objective signs or symptoms (for example, coughing, throat clearing, wet vocal quality, drooling)

Speech-language pathologist referral, if patient exhibits any indicators of swallowing difficulty

ing. The SLP, after careful assessment, can adjust the patient's diet related to the degree of swallowing difficulty. In addition, the SLP may prescribe the following exercises:

- neck muscle exercises
- tongue and oral exercises
- coughing exercises
- pursed lip breathing
- effortful swallowing.

Nursing considerations

Poor oral function can lead to an increase in gram-negative anaerobic bacteria and masticated food residue in the mouth, both of which increase the patient's risk of developing upper respiratory infections and aspiration pneumonia. And in patients with decreased mobility, compromised respiratory status, or reduced cognition, poor oral hygiene may increase the risk of bacterial infections secondary to aspiration of secretions, food, or liquid into the lungs.

To prevent these complications secondary to dysphagia, ensure good oral hygiene. Provide consistent oral care, at least three times a day, including cleaning the tongue, palate, and teeth with a brush or swab. You or the SLP also can train patients, nursing assistants, and family members to provide oral care. It's best to choose a consistent time, such as lunch, for reminding and encouraging the patient to perform swallowing exercises prescribed by the SLP.

To ensure consistency of care, document all nursing interventions, including aspiration precautions, education, and patient understanding.

Stop complications before they start

Your early and accurate detection of dysphagia helps reduce patient complications. Using the PASS bedside swallowing assessment is an easy way to identify at-risk patients, make appropriate referrals, and stop the complications of dysphagia before they start.

After recognizing Mrs. Johnson's difficulty swallowing, you notify her physician and make a referral to the SLP, reporting your PASS observations. After completing the swallowing evaluation, the SLP informs you that Mrs. Johnson appears safe for nectar thickened liquids and requests that her pills be administered crushed in puree. By working as a team, you and the SLP adjusted Mrs. Johnson's plan of care, thus avoiding potential complications and ensuring Mrs. Johnson an uneventful recovery. ★

Visit www.americannursetoday.com/?p=26333 for a list of selected references.

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*Name is fictitious.