

Appendix 3: Nurse Led Swallow Screen Protocol (Water Swallow Test)

NHS Ayrshire and Arran

Swallow Screen Protocol (Water Swallow Test)

Write or attach label

HCR No:
 CHI No:
 Surname:
 Forename: Sex:
 Address:

 Date of Birth:

To be carried out with all patients admitted with acute Stroke or Transient Ischemic Attack symptoms within 4 hours of admission to ED / CAU by a nurse trained in the procedure

Part 1: Pre – assessment criteria

A 1) Is the patient consistently alert for 10 minutes? YES NO

2) Is the patient able to be supported in an upright position? YES NO

If **NO** to either: **STOP**. Record the patient **NIL BY MOUTH**. Repeat daily until the patient's clinical condition improves and you can proceed to the next section.

Before proceeding further; check the patient's mouth and perform and maintain oral hygiene as required.

B Does the patient show any sign of:

1) A hoarse, wet, weak or absent voice? YES NO

2) Being unable to deal with own oral secretions? YES NO

If **YES** to either: **STOP**. Record the patient **NIL BY MOUTH** and refer to Speech and Language Therapy.

Part 2: Water Swallow Test

Give the patient a teaspoon of water, watch for swallow and observe. (Do this 3 times.)

Does the patient show any signs of the following?

No or delayed swallow?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Immediate or delayed coughing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Choking?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Change in voice quality? (Check by eliciting a verbal response or by asking patient to say "aaah")	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Change in breathing pattern, or Increased breathlessness whilst sipping?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If **YES** to any of the above: **STOP**. Record the patient **NIL BY MOUTH** and refer to Speech and Language Therapy (SLT).

If **NO** to all the above, continue with the Water Swallow Test.

Observe the patient taking several controlled sips (a minimum of 3) from a glass of water.

Does the patient show signs of any of the following?

No or delayed swallow?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Immediate or delayed coughing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Choking?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Change in voice quality? (Check by asking patient to say "aaah")	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Change in breathing pattern, or increased breathlessness whilst sipping?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If **YES** to any of the above: **STOP**. Record the patient **NIL BY MOUTH** and refer to Speech and Language Therapy.

If there are no difficulties:

- Allow the patient to commence with diet and thin fluids (Level 0).
- Ensure the patient initially selects Level 6 diet from the normal menu.
- Supervise the patient with a Level 6 main course. If the patient is managing to chew and swallow fully then resume Regular /Level 7 diet. If any difficulties are observed refer to Speech and Language Therapy for a full clinical swallowing assessment.

Initials _____ Time _____ Date ___ / ___ / _____

N.B.

The water swallow test is used to identify new Stroke patients who are at risk of aspiration and require a full clinical assessment by an SLT before commencing oral intake.

Therefore it must NOT be:

- Repeated after assessment by an SLT.
- Carried out on patients who show symptoms of dysphagia but are not being investigated for Stroke i.e. are not under Stroke protocol.