Swallowing Screening for Stroke Patients			
Signing Authority:	Chief Nursing Executive		
Approval Date:	12-28-2018	Revision Date:	12-28-2018

SCOPE:

This policy applies to all interprofessional staff at Royal Victoria Regional Health Centre (RVH) who are involved in the care of adult patients with symptoms of stroke or trans ischemic attack (TIA)/non-disabling stroke. It is designed as a resource and reference for all staff at RVH.

POLICY STATEMENT:

It is the policy of RVH that any patient with symptoms of ischemic stroke or TIA/non-disabling stroke shall have their swallowing ability screened in order to minimize the risk of complications arising from dysphagia (i.e., a swallowing disorder) in accordance with Canadian Stroke Best Practice Recommendations.

1. Patients with suspected ischemic stroke or TIA/non-disabling stroke shall remain NPO (i.e., *nil per os*, Latin for *nothing by mouth*, including no water, ice chips or oral medication) until Toronto Bedside Swallowing Screening Test (TOR-BSST©) is completed. Alternate routes for oral medications may be considered until swallowing ability is verified.
2. All patients presenting to or admitted to RVH with suspected ischemic stroke or TIA/non-disabling stroke shall have a TOR-BSST© swallowing screen completed as early as possible, within 24 hours of arrival.
3. Screening shall only be completed by members of the interprofessional team who have successfully completed the TOR-BSST© training.

It is expected that staff shall adhere to the principles outlined in this policy.

DEFINITIONS:

Dysphagia: An impairment or disorder of the process of deglutition (i.e., swallowing) affecting the oral, pharyngeal and/or esophageal phases of swallowing.

Toronto Bedside Swallowing Screening Test© (TOR-BSST©): A validated, evidenced based dysphagia screening test used at RVH to determine risk of dysphagia post-stroke.

TOR-BSST© Screener: An interprofessional team member who has successfully undergone training by a Speech-Language Pathology TOR-BSST© Trainer. Training sessions are four hours in length, offered quarterly by the Speech-Language Pathology (SLP) department. TOR-BSST© screeners can be any member of the interprofessional

team, including Registered Nurse (RN), Registered Practical Nurse (RPN), Occupational Therapist (OT), or Registered Dietitian (RD).

PROCEDURE:

1. Until the TOR-BSST© screening has been completed and notification received that the patient has passed, the primary nurse shall ensure:
   a. the NPO sign is placed at the patient's bedside;
   b. order entry for NPO is completed;
   c. NPO is written on the Kardex; and
   d. Provide the patient and/or family with education and counselling regarding swallowing safety and ensure they are aware of NPO status.
2. Place order for TOR-BSST© screening in MEDITECH. This will notify Staffing Office who will liaise with the primary nurse to identify an available TOR-BSST© screener, should one not be available on the patient's unit. During MEDITECH downtime, call Staffing Office and document on the patient's paper chart.
3. Determine if a TOR-BSST© screener is available at the patient's current location by referring to the list of trained screeners available at S:/RVH/Stroke Care/Stroke TOR-BSST© Swallowing Screening.
4. If a trained screener has not been identified two hours after the initial order is entered, the Staffing Office shall page the SLP team. During SLP off-hours (i.e., evenings, weekends, and holidays), the Staffing Office shall identify the next trained screener scheduled to work and notify the requesting unit.
5. The TOR-BSST© screen shall be completed and scored by the trained screener. The results shall be entered in the Patient Care System (PCS). In the Emergency Department, results shall be entered on the patient's tracker by adding the TOR-BSST© as an intervention. During MEDITECH downtime, results shall be documented on the patient's paper chart and SLP services shall be notified of results of the screening.
6. When screening is complete, the screener shall notify the Resource/Charge Nurse of the results. The primary nurse shall document the results of the TOR-BSST© on the SBARD upon transfer to another unit.
7. In the event the patient has **PASSED** the TOR-BSST©, the primary nurse shall:
   a. Ensure the nutrition order for diet texture is entered as chopped/soft and bite-sized, thin fluids and include any therapeutic diet restrictions ordered by the Most Responsible Provider (MRP);
   b. Write diet texture on Kardex;
   c. Add the need for monitoring during oral intake and use of feeding/swallowing strategies on care plan and Kardex;
   d. Post "Monitoring Oral Intake" sign at bedside or write "Monitoring Oral Intake" on patient whiteboard;

e. Monitor, observe and assist patient for three meals. Document assessment and observations in the patient's health record. If any difficulties arise:
   i. Notify MRP and obtain a referral for SLP to complete an additional swallowing assessment;
   ii. Change diet to NPO in MEDITECH according to MRP order;
   iii. Place the NPO sign at bedside;
   iv. Change diet on care plan and enter NPO in the Kardex; and
   v. Consider an alternate route for medication administration (consult with Pharmacy).

f. If no difficulties are noted after monitoring for three meals, the nurse shall remove the monitoring oral intake information from the patient whiteboard.

8. In the event the patient has **FAILED** the TOR-BSST©, develop an individualized care plan to address dysphagia, dietary needs, and specialized nutrition. The primary nurse shall:
   a. Notify MRP regarding results;
   b. Keep patient NPO (including water, ice chips and medications);
   c. Consider an alternate route for medication administration (consult with Pharmacy); oral medications shall be provided only on direction of MRP;
   d. Ensure bedside NPO sign in place;
   e. Ensure NPO is entered in PCS and on Kardex;
   f. Maintain routine oral care as per RVH Policy and Procedure: Oral Care;
   g. Obtain MRP referral to SLP for full swallowing assessment;
   h. Obtain a referral to RD for nutritional assessment; and
   i. A trained screener shall repeat the TOR-BSST© every 24 hours or if condition significantly changes while awaiting SLP assessment.
9. If the patient is to be repatriated to his/her home hospital, the nurse shall provide swallowing screening results to the receiving hospital using RVH communication documents such as the RVH Physician Report for Stroke/TIA Bypass Patients (RVH-0985);
   i. If screening is completed and passed, communicate that the patient shall be placed on a chopped/soft and bite-sized, thin fluid diet and monitored for any difficulty in swallowing for the next three meals;
   ii. If screening is completed and failed, communicate that the patient is to remain NPO until a swallowing assessment by SLP is complete; and
   iii. If screening is not completed, communicate that the patient shall remain NPO until swallowing screening is completed at receiving hospital.
10. If the patient is to be discharged home and has passed the TOR-BSST© screen, the interprofessional team member shall provide the patient and family with swallowing precaution education.
11. A patient who has failed the TOR-BSST© shall not be discharged home until a full swallowing assessment by SLP has been completed and swallowing issues addressed.

CROSS REFERENCES:

Royal Victoria Regional Health Centre. (2017). Policy and Procedure: *Oral care*

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Central East Stroke Network Clinician Toolkit. http://cesnstroke.ca/professional/knowledge-translation/common-assessment-toolkit/

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Appendix A: Flow Chart of Swallowing Screening for Stroke Patients process