## Dysphagia – Clinical Protocol

### Assessment and Recognition

1. As part of the initial assessment, the staff and physician will help identify individuals with a history of swallowing difficulties or related diagnoses such as dysphagia.
2. In addition, the nurse shall assess and document/report the following:
   - Vital signs
   - Oral and pharyngeal assessment, including any coughing or choking while swallowing and excessive accumulations of saliva
   - Hydration status (dizziness, recent change in mental status, dry mucous membranes, recent decrease in endurance, decreased urine output)
   - Decreased intake with potential for dehydration or malnutrition
   - Resident’s age and sex
   - Onset, duration, severity, precipitating and relieving factors or events
   - History of stroke, other neurological event, mouth or throat surgery or diseases
   - All active diagnoses
   - All current medications

3. The staff will identify individuals who have difficulty swallowing or chewing food.
   - Any staff member observing an incident or situation will document details of the circumstances or have a nurse observe and document those details.

4. The staff will monitor for any swallowing difficulty; for example, if there is coughing, whether it happens with all meals, selectively, or at other times as well; whether the problem is new or there have been previous complications, etc.
   - It is important to clarify the symptoms and to help identify causes since not all symptoms related to chewing or swallowing constitute dysphagia.
   - In most cases, treatment should not be instituted or dietary restrictions imposed without clarifying such issues. Exceptions might include individuals with obvious inability to clear saliva or swallow food or liquids.

### Cause Identification

1. The staff and physician will seek and identify causes of dysphagia, coughing, or choking such as thyroid disorders, candidal esophagitis, psychiatric disorders (anxiety, depression, and various personality disorders), pharyngitis, thyroiditis, gastroesophageal reflux disease, achalasia, esophageal spasm, other esophageal disorders, malignancy, oral and dental disorders, and medication side effects (especially aspirin, nonsteroidal anti-inflammatory drugs, corticosteroids, chemotherapy agents, antipsychotics, antidepressants, ACE inhibitors, antibiotics, cholinesterase inhibitors, seizure medications, and proton pump inhibitors).
2. If dysphagia is suspected, speech therapist will perform a screening clinical evaluation of swallowing, which should document the resident’s:
   - Level of consciousness.
   - Ability to follow commands.
   - Gross strength and coordination of muscles of the face, mouth and tongue.
   - Ability to swallow 3 ounces of water without drooling, coughing or choking (unless contraindicated by clear clinical evidence).
   - Any speech therapy evaluation should identify and report abnormalities, but should not prematurely document conclusions about whether eating or drinking can or should be allowed, or whether diet or fluid consistency must be modified.

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1. The Attending Physician and staff will review carefully all pertinent findings, including the resident’s overall condition, prognosis, wishes, and nutritional status.

2. The physician will address underlying conditions causing or contributing directly or indirectly to cough or difficulty eating, chewing, or swallowing; for example, treat esophagitis, address conditions affecting mental status or ability to eat appropriately, or reduce, change, or stop medications associated with dyspepsia, coughing, or dysphagia.

3. The staff and physician will try to identify simple interventions to manage the situation; for example, cutting food into smaller pieces, allowing the individual to eat more slowly, or addressing factors that make the individual less attentive or drowsier during meal times.

4. The physician and staff will identify other optimal treatments after weighing all relevant considerations.
   a. Relevant considerations should include the individual’s nutritional status, their overall prognosis, the differential diagnosis of the problem, relevant medications and conditions that may affect eating and swallowing, and their quality of life.

5. The physician will order an altered consistency diet when it is clinically relevant to manage significant risks of aspiration in individuals for whom other alternatives are unavailable, not feasible, or have not worked.
   a. The risks and benefits of allowing individuals to eat and drink must be weighed appropriately. Swallowing abnormalities are common, but do not necessarily imply a problem needing an intervention.
   b. There is not a simple and obvious relationship between prandial liquid aspiration and pneumonia. Some individuals have unmistakable aspiration, while others have “subclinical” (asymptomatic) or occasional aspiration. Aspiration does not necessarily cause pneumonia, and many people who occasionally aspirate can eat and drink without clinically significant complications.

6. If it is determined that an individual has a clinically significant risk of aspiration complications and that the risk outweighs the benefits of being allowed to eat and drink an unaltered or minimally altered diet, the physician will explain the relative risks and benefits of the options to the resident and/or family.
   a. The risk of aspiration pneumonia should be presented in the same balanced context as any of the other risks that face frail elderly and chronically ill individuals.
   b. Resident wishes regarding diet, including its content and consistency, should weigh heavily when considering whether to recommend restrictions.

7. The physician will order speech therapy interventions where they are relevant to the underlying causes and nature of the swallowing disorder.
   a. Examples of situations in which speech therapy interventions may be helpful include individuals who have had a recent stroke with subsequent impaired chewing and swallowing; or individuals with neuromuscular disorders in which compensatory techniques may allow the individual to eat more freely and reduce the frequency of aspiration.

8. Downgrading diet consistency (for example, from thin to thickened liquids or mechanical soft to pureed) will only occur after a review and discussion with the physician and consideration of all relevant factors.

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a. If it is decided that alterations in food or fluid consistency are indicated, the physician and/or staff will document why such alterations are appropriate for the resident given the various risks and relevant factors involved for that individual, and show that pertinent medical conditions or medication side effects have been considered.

9. If a resident or family decline downgraded diet recommendations, the staff or physician will document this in the medical record.
   a. The facility management, medical director, and director of nursing will identify whether a signed waiver is also desirable.

10. The staff and physician will identify and address complications of swallowing disorders and their underlying causes.
11. Generally, tube feeding should not be recommended unless the above steps have been followed and other pertinent interventions are not feasible or have failed to prevent complications of clinically significant aspiration.
   a. Percutaneous gastrostomy tubes may be beneficial for short-term use in individuals with dysphagia due to a new stroke, but are less beneficial for individuals with advanced dementia or other end-stage or terminal conditions.
   b. The physician must carefully consider the clinical and ethical appropriateness of recommending that the resident should not be allowed to eat at all or should be tube fed because of potential aspiration risk.

1. The staff and physician will monitor the progress of individuals with swallowing difficulties; for example, ease of eating, improvement of symptoms, and resolution of underlying causes.
2. For individuals who have modified consistency diets, the staff will monitor for, and report to the physician, how the resident is tolerating any altered consistency diet and identify evidence of complications such as unexpected weight loss or fluid and electrolyte imbalance.
   a. The staff and physician will identify individuals whose food and fluid restrictions can be upgraded; for example, from thickened to thin liquids or pureed to mechanical soft.
3. The staff and physician will identify individuals whose swallowing capabilities decline, fluctuate, or result in clinically significant complications and will adjust diet and food consistency where relevant and make other appropriate interventions.

### References

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<th>MDS (RAPs)</th>
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<tr>
<td>Survey Tag Numbers</td>
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