Developing a screening tool and training package to identify dysphagia in all settings

Patients with a wide variety of conditions can develop feeding and swallowing problems. An observation screening tool aimed to increase detection of dysphagia

INTRODUCTION

Although it is widely recognised that dysphagia is a common consequence of stroke, it is also associated with a variety of other conditions. The perception among healthcare professionals that feeding and swallowing problems are primarily related to stroke could result in them being missed in patients who have other conditions. In order to minimise the chance of this happening, I developed a screening tool to assess these difficulties in all patients in all settings. This article describes the tool’s introduction into a hospital setting and plans to use it in the community, as well as the development of an accompanying training package.

WHAT IS DYSPHAGIA?

Dysphagia is an impairment of eating and drinking throughout any or all of the different phases of swallowing. The phrase “feeding and swallowing problems” tends to describe a slightly wider remit – including other considerations such as patients’ ability to feed themselves – not just a matter of swallowing. Speech and language therapists (SLTs) often use both terms interchangeably. Problems can arise in any or all of the different phases of the swallow. The initial or oral preparatory phase occurs when food is put into the mouth, moved by the tongue in between the teeth to chew and coated with saliva to produce a manageable sized bolus. The next, or oral phase, occurs when chewing has ceased and the tongue propels the bolus from the anterior to the posterior part of the oral cavity.

The pharyngeal phase occurs when the swallow is triggered, the nasal cavity is separated from the oral cavity by the action of the soft palate, the tongue base moves backwards to contact the posterior pharyngeal wall and the epiglottis moves horizontally to protect the airway. The larynx elevates and moves forwards and the vocal folds close together, again protecting the airway. It is this elevation and forward movement of the larynx that opens the cricopharyngeus, allowing passage into the oesophagus, which is the final phase of the swallow. Peristaltic waves move the bolus of food towards the stomach.

CAUSES AND RISK FACTORS

Causes

Although the most common cause of dysphagia is probably stroke, many progressive neurological illnesses can also result in difficulties with eating and drinking. Dementia is another major cause of eating and swallowing difficulties and studies show there are high numbers of people in nursing homes who have this problem.

Perhaps a slightly less recognised cause is respiratory illness. This produces breathlessness, which can interfere with swallowing which, in turn, interferes with the respiratory cycle.

Another common cause of dysphagia, particularly in older people, is urinary tract infection. Although this is temporary until cured by antibiotics, it can lead to feeding and swallowing problems. If these problems are either unrecognised or inappropriately managed, they can lead to aspiration pneumonia.

PRACTICE POINTS

● As there are many causes of dysphagia, nurses need to think in wide terms about which individuals in their patient group may have feeding and swallowing difficulties, rather than simply focusing on the illnesses most commonly associated with the condition, such as stroke.

● The Dewsbury Feeding and Swallowing Screen assesses patients’ capabilities and safety with both food and drink, and is quick and easy to use even for those with little or no experience of dysphagia. It also has clear instructions on when it is necessary to refer to speech and language therapy for a more detailed assessment.

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Identifying dysphagia is vital to prevent further complications and problems. Although the condition is common in patients with stroke, nurses must be aware that feeding and swallowing problems can occur in a wide range of illnesses.

The Dewsbury Feeding and Swallowing Screen was developed as an observational screening tool for nurses to ensure early and accurate identification of such problems in all patients in all settings. In addition, a training package, consisting of two manuals and a DVD, was designed to help train staff to use the tool and as a means of checking competence.

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The underlying cause. The consequences of late or missed accurately, then surely this should apply to have their problems identified early and for one group of patients with dysphagia health, 2001). However, if it is important that a patient has a feeding and swallowing capabilities with both food and drink are assessed. Too often feeding and swallowing assessments are undertaken using only fluids – the consistency that is most likely to cause problems. Patients who have problems with fluids may be needlessly designated “nil by mouth” because food, which may be perfectly safe, has not been assessed. In 2003 when nursing staff at Dewsbury and District Hospital were initially approached about introducing the screening tool, I was concerned that they may be resistant to having yet another form to fill in. However, my concerns were unfounded – all those who were approached were extremely enthusiastic.

SCREENING TOOL
The screening tool was designed as an observational instrument to enable nurses to observe patients eating and drinking in a functional setting while following a simple, yet comprehensive, checklist. Many factors can indicate that a patient has a feeding and swallowing problem and nurses need to be vigilant for signs other than coughing. It is also important to ensure that capabilities with both food and drink are assessed. Too often feeding and swallowing assessments are undertaken using only fluids – the consistency that is most likely to cause problems. Patients who have problems with fluids may be needlessly designated “nil by mouth” because food, which may be perfectly safe, has not been assessed.

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TRAINING
All nursing staff who would carry out screening attended a training session. This included night staff as patients can be admitted in the middle of the night. The session began by highlighting the high risk nature of dysphagia and the importance of early detection. Each item in the screening tool was discussed, so those nurses who had had no basic dysphagia training could still identify when there was a problem. There was also discussion about the remit for their ward: who was to be assessed, when to carry out assessment, and how to score it. All this took approximately 45 minutes.

Nursing staff completed a questionnaire before beginning the training, which was used to assess their baseline knowledge, skills and confidence in the area of dysphagia.

CHANGES IN PRACTICE
The second questionnaire recorded a number of changes in practice, and nursing staff and SLTs also made verbal observations about these.

The changes noted were:
- Quicker identification of feeding and swallowing problems. This resulted in patients being started on the dysphagia care pathway more quickly, thereby reducing risk of related problems occurring.
- A systematic assessment of both food and drink, reducing the probability of the need to put patients nil by mouth unnecessarily.
- More prompt referrals to speech and language therapy for a detailed swallowing assessment.
- More accurate and detailed content of these referrals.
- Increased awareness and involvement of nurses when dealing with feeding and swallowing problems.
- Increased confidence in identifying problems; nurses preferred being able to use the checklist, rather than having to rely on their own knowledge and skills.

BACKGROUND TO DEVELOPING THE SCREENING TOOL
The National Service Framework for Older People states that all patients who have had a stroke should have a swallowing assessment within the first 24 hours (Department of Health, 2001). However, if it is important for one group of patients with dysphagia to have their problems identified early and accurately, then surely this should apply to all patients whatever their diagnosis – the consequences of late or missed identification are equally serious, whatever the underlying cause.

Design
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TRIALS
The initial trial was carried out on one of two wards for older people aged over 75 years. Many had feeding and swallowing difficulties caused by stroke and a variety of progressive disorders such as Parkinson’s disease and dementia. Often they also had other conditions that can cause feeding and swallowing problems, like urinary tract infections and respiratory diseases such as chronic obstructive pulmonary disease, both of which are common in older hospital patients.

At the time of this initial trial, nursing staff and SLTs discussed which patients should be screened. As a large proportion of older people admitted to hospital were likely to be at risk of developing feeding and swallowing problems, it was decided, in conjunction with the ward sister, that the remit would be that all new patients admitted to the ward should be screened when they had their first food or drink.

When the tool was introduced to other wards later, ward sisters were also consulted about the appropriate remit for that particular ward. The remit, therefore, is always flexible according to the needs of each patient group. However, as the aim is to ensure that no patient is missed, it should always be as comprehensive as possible.

The trials on each ward generally continued for 100 screens. The ward clerk photocopied completed screening forms, which I evaluated continuously to ensure that documentation was complete, accurate and timely. Any problems, such as missing dates and signatures, incomplete scoring and missed sections, were fed back to the ward sister who discussed the issues with nursing staff. If it was clear that particular nurses were having difficulty, they were offered further training or given more clarification.

However, the problems were minor and generally related to nurses’ unfamiliarity with the tool.

At the end of the trial period it was deemed that nursing staff were carrying out the screen appropriately. There was then an agreement that supervision was no longer necessary and that nursing staff would train any nurses who were new to the ward. Nurses were asked to fill in a second questionnaire to establish what changes in knowledge, skills, confidence and practice their use of the screening tool over the trial period had brought about.

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CORRELATION BETWEEN NURSE AND SLT ASSESSMENTS

It was important to find out whether nurses were able to accurately identify both normal and abnormal swallows when checked against SLTs’ findings. The SLTs therefore reassessed 80 patients whom nurses had identified as having abnormal swallows and 20 patients identified as having normal swallows, as soon as possible after nurses’ assessments. The time lapse between both assessments varied from patient to patient, and was needed to accompany it. As a result, the tool had the potential to be used more widely, when it became obvious that the screening assessment varied from patient to patient, and was needed to accompany it. As a result, the tool had the potential to be used more widely, when it became obvious that the screening tool and a description of each item on the DVD and contains the 12 completed assessments of the swallows seen on the DVD. These can be used to train staff on how to use the tool and to check competence.

USE OF THE TOOL AND FUTURE PLANS

Hospitals

The tool has been in use at Dewsbury and District Hospital since 2003 and has proved to be extremely successful in identifying feeding and swallowing problems in thousands of patients. These patients have been on a variety of wards, including the medical assessment unit, stroke unit, older people’s ward and two medical wards.

At the request of a senior sister, the tool is to be introduced on the respiratory ward. It has already been introduced to two other local hospitals, not covered by my service, which are initially using it with patients who have had a stroke.

Community

Heads of nursing and residential homes have commented in previous dysphagia training questionnaires that they would like to use the screening tool in their homes and have been extremely enthusiastic about the prospect of doing so. Since its recent availability, some local homes have introduced it, as have others outside the district. The Kirklees multidisciplinary intermediate care team has also expressed an interest in using it.

Although the tool was originally designed for nurses, its flexibility and simplicity means a variety of other professionals can use it to identify dysphagic problems. In the community, commissioners have said they want the tool to be a quality indicator in service specifications for stroke indicators and will take this forward in Kirklees through the stroke health improvement team. Further plans to include use of the screen to identify non-stroke patients with dysphagia are under discussion.

By using the screening tool in the same way as hospital nursing staff, it is expected that community nurses will find similar changes in their practice:

- An increased awareness of feeding and swallowing difficulties and the risks associated with them;
- Quicker referrals to speech and language therapy for a detailed assessment and treatment plan;
- A reduction in GP callouts and courses of antibiotics—unless the cause of the problem is treated, antibiotics will only improve symptoms temporarily;
- Improved health and quality of life for patients;
- A reduction in the number and frequency of hospital admissions.

CONCLUSION

The importance of early and accurate identification of feeding and swallowing difficulties in stroke has been recognised both locally and nationally, in documents such as the National Institute for Health and Clinical Excellence’s (2008) guidance. However, patients with Parkinson’s disease, dementia and indeed any other kind of illness that causes feeding and swallowing problems need prompt assessment and treatment of their life-threatening dysphagia as much as those with stroke. This can only happen once the problem has been identified, which nursing staff are in an ideal position to do.

By implementing The Dewsbury Feeding and Swallowing Screen locally, we aim to ensure that all nursing staff focus on screening all those who may be at risk of dysphagia in all settings to ensure early and accurate identification.

For more information on the screening tool contact Mariani Tanton on 01924 4816058 or at mariani.tanton@kirkleeschs.nhs.uk

To obtain the screening tool and training package, go to tinyurl.com/dewsbury-screen, or call Medipex on 0113 3970 839

REFERENCES


FURTHER READING