

McLaren Flint
FLINT, MICHIGAN
NURSING BEDSIDE SWALLOW SCREEN
YALE SWALLOW PROTOCOL
(SUITER & LEDER, 2008)

Perform general oral care prior to swallow screen.

Step 1 Exclusion Criteria Is patient unable to stay awake and alert? Is patient unable to manage secretions? Is patient unable to manage secretions without suctioning? Does patient have wet, gurgly vocal quality? Is patient unable to tolerate sitting upright in bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p style="text-align: center;">If any of these questions were answered "YES", then:</p> <ul style="list-style-type: none"> • Make patient NPO, including oral medications • Notify Physician • Consult Speech Therapy for a swallow evaluation 	

If all questions were answered "NO", then proceed to step 2.

<p>Step 2 Administration</p> Brief Cognitive screen: What is your name? _____ What year is it? _____ Where are you right now? _____ Oral mechanism examination: Symmetrical lip closure? _____ Symmetrical smile/pucker? _____	
<p style="text-align: center;">If any of the following questions are answered "YES", then:</p> <ul style="list-style-type: none"> • Stop the screen • Make patient NPO, including oral medications • Notify Physician • Consult Speech Therapy for a swallow evaluation 	
<p>Seat patient in upright position:</p> <p style="text-align: center;">Assess with 2-3 ice chips by spoon:</p> Does patient cough or clear throat? Is patient unable to swallow? Does patient have wet, gurgly vocal quality after swallow?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p style="text-align: center;">Assess water intake by teaspoon:</p> Does patient cough or clear throat? Is patient unable to swallow? Does patient have wet, gurgly vocal quality after swallow?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p style="text-align: center;">Assess with 90ml/3oz of water by cup in sequential swallow; cup may be held by RN:</p> Does patient cough or clear throat? Is patient unable to swallow? Does patient have wet, gurgly vocal quality after swallow?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
RN feels uncomfortable. Please explain: _____	<input type="checkbox"/> Yes
Bedside Swallow Screen Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Passed <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have new onset slurred speech <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", consult Speech Therapy for a Speech Evaluation.	

If all answers are "NO", place patient on diet as per Physician Orders.

RN Signature _____ Date (Required) _____ Time (Required) _____

**NURSING BEDSIDE SWALLOW
SCREEN
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PT.

MR.#/P.M.

DR.