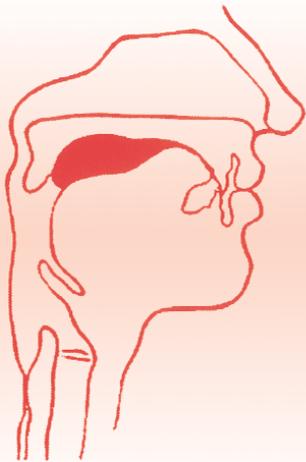


Improving Recognition and Management of Dysphagia in Acute Stroke

A Vision for Ontario



Best practice guidelines for managing dysphagia

These best practice guidelines, developed through a consensus process, provide a benchmark against which organizations involved in stroke care can measure their progress in improving the management of dysphagia after an acute stroke.

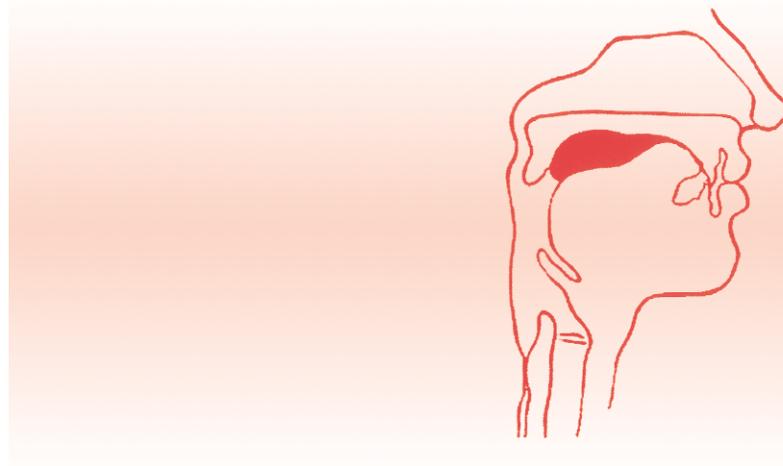
- 1** Maintain all acute stroke survivors NPO until swallowing ability has been determined. NPO prohibits the administration of oral medications, water and ice chips. Intravenous fluids may be required. Regularly perform mouth-clearing or oral care procedures, using a minimal amount of water, to prevent colonization of the mouth and upper aerodigestive tract with pathogenic bacteria.
- 2** Screen all stroke survivors for swallowing difficulties as soon as they are awake and alert. A registered nurse, registered practical nurse, or other swallowing team member, trained to administer swallowing screening tests and interpret results, should perform the screening.
- 3** Screen all stroke survivors for risk factors for poor nutritional status within 48 hours of admission. A registered nurse, registered practical nurse, or other swallowing team member, trained to administer nutritional screening tests and interpret results, should perform the screening.
- 4** Assess the swallowing ability of all stroke survivors who fail the swallowing screening. The assessment includes a clinical bedside examination and, if warranted by the clinical signs, an instrumental examination. A speech-language pathologist should:
 - assess the stroke survivor's ability to swallow food, liquid, and medications
 - determine the level of risk of dysphagic complications, including airway obstruction, aspiration of food and liquid, and inadequate nutrition, and hydration
 - identify associated factors that might interfere with adequate oral nutrition and hydration or lead to aspiration-related complications, such as impaired motor skills, cognition, or perception
 - recommend appropriate individualized management, which may include changes in food or fluid consistency, feeding strategies, swallowing therapy, oral care regimens, and possibly referral to other healthcare professionals.
- 5** Provide feeding assistance or mealtime supervision to all stroke survivors who pass the screening. An individual trained in low-risk feeding strategies should provide this assistance or supervision.

In addition, the stroke survivor's physician may monitor hydration status, initiate appropriate laboratory investigations and order supplementary intravenous fluid administration.



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- 6** Assess the nutrition and hydration status of all stroke survivors who fail the screening. A dietitian should:
 - assess energy, protein, and fluid needs
 - recommend alterations in diet to meet energy, protein, and fluid needs
 - support alterations in food texture and fluid consistency, based on the assessment by a speech-language pathologist or swallowing team.
- 7** Reassess all stroke survivors receiving modified texture diets or enteral feeding for alterations in swallowing status regularly. After the acute stroke management phase, usually the first week after the stroke, reassess patients at 2–3 month intervals during the first year after the stroke, and then every 6 months thereafter. The severity of swallowing impairment and the rate of improvement may alter the reassessment schedule.
- 8** Explain the nature of the dysphagia and recommendations for management, follow-up, and reassessment upon discharge to all stroke survivors, family members, and care providers.
- 9** Provide the stroke survivor or substitute decision maker with sufficient information to allow informed decision making about nutritional options. Consider the wishes and values of the stroke survivor and family concerning oral and non-oral nutrition when developing a dysphagia management plan.



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