Nursing Bedside Swallowing Screen

*Adapted from the Massey Bedside Swallowing Screen and the Scottish Intercollegiate Guidelines Network Screen.

Date of screen: ________________  Time of screen: ________________

Follow algorithm and circle YES or NO

Can the patient be seated upright and remain awake and alert for at least 15 minutes?  \(\rightarrow\) NO \(\rightarrow\) Keep NPO, maintain oral hygiene, Consult Speech Therapy

YES

Is the patient’s mouth clean?  \(\rightarrow\) NO \(\rightarrow\) Implement oral hygiene immediately, and continue

YES

Is patient able to:
1. Cough voluntarily (have pt cough 2 times)?
2. Swallow own secretions?  \(\rightarrow\) NO \(\rightarrow\) STOP, Make NPO, and Consult Speech Therapy

YES

Sit patient up and give ONE teaspoon (administered by spoon) of water 3x. Place fingers on midline above and below the larynx and feel the swallow. Observe each teaspoon. Are any of these signs present?
- Absent swallow
- Cough
- Delayed cough
- Altered voice quality (e.g. “gurgly” or “wet” … ask the patient to say “Aah”)  \(\rightarrow\) YES \(\rightarrow\) STOP, Make NPO, and Consult Speech Therapy

NO

Are there any of these signs present?
- Absent swallow
- Cough
- Delayed cough
- Altered voice quality (e.g. “gurgly” or “wet” … ask the patient to say “Aah”)  \(\rightarrow\) YES \(\rightarrow\) STOP, Make NPO, and Consult Speech Therapy

NO

Initiate thin liquids and general diet as tolerated. (Please consider patient’s diet prior to admit and dentition when initiating diet consistency). Continue to closely observe for immediate or delayed coughing, change in vocal quality, change in lung sounds, and/or temperature spikes. If any occur, consult Speech Therapy.

Diet initiated: ____________________________  Completed by: ____________________________