

Clinical Swallowing Evaluation without CRT and FEES

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As you all know we have got very used to our new ways of doing things and removing two of our key tools, cough reflex testing and FEES, when working with people with dysphagia is not going to be an easy transition for many of us.

The reality is that during these times we have to look at it in terms of risk benefit and take advice from the experts in our field who tell us that these tests should be suspended for now. We know that clinically this is not ideal but that SLTs still have enormous value to add and have a whole load of additional tools in our toolkit that we can continue to use.

Hypothesis-driven clinical reasoning

The greatest of these tools is our **clinical reasoning**. That thing that you each do on a daily basis when we see a patient. Before you walk into the clinic room, patient's bed space or home you will have already gathered a lot of information about your patient and will have made a hypothesis that you may expect to see unfold in your assessment. You will ask more information from the patient and their whānau which either supports or dispels that hypothesis.

Cranial nerve exam

Your **cranial nerve exam and observations** provide you with enormous information towards that developing and evolving hypothesis, and while we don't know what the cough reflex might look like you can get some information on voluntary cough strength.

We need to think carefully about **social distancing** where possible avoiding droplet transference. All cranial nerve examinations should occur at as far a distance from the patient as possible. When testing the volitional cough, step back and give the patient 2 meters and ask them to cough hard into their elbow.

DHB infection control practices should be applied. These likely include:

- appropriate hand hygiene
- gloves for all procedures
- limit equipment / personal items taken into a patient bed space to only those essential for the procedure
- wipe down any reusable equipment with Mediwipes before *and* after all procedures. e.g. food boxes
- use plastic covers on equipment (including i-pads, i-phones) that can be removed and cleaned and keep i-phones in pockets.

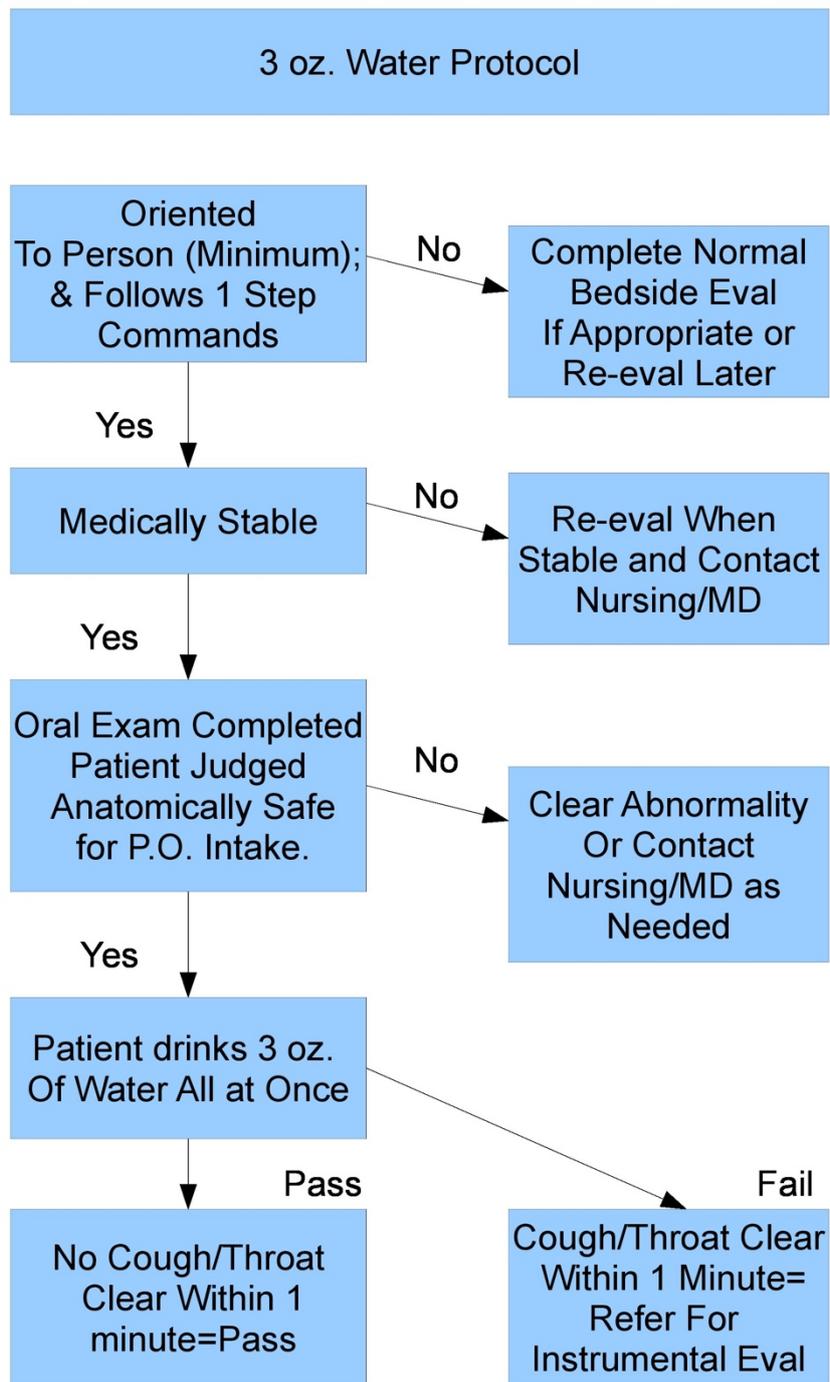
Additional infection control practices may or may not include: gowns, eye protection and face masks depending on the DHB and patient's infection status.

Oral trials

Oral trials are next, this is where we feel we can make the most changes. We know that cough response to aspiration differs across both bolus volumes and viscosity so our best tool is to try increased volumes of oral trials with patients in order to identify aspiration risk, as we can assume that with increased volume the cough threshold is more likely to be reached in order to trigger a cough response.

Stethoscopes are difficult to clean, evidence is poor and cervical auscultation should probably be avoided.

You may want to consider the Yale 3oz (100m) water test



<https://www.ncbi.nlm.nih.gov/pubmed/18058175>

Or, the GUSS

GUSS

(Gugging Swallowing Screen)

GUSS-EVALUATION

RESULTS	SEVERITY CODE	RECOMMENDATIONS
20 Semisolid / liquid and solid texture successful	Slight / No Dysphagia minimal risk of aspiration	<ul style="list-style-type: none"> • Normal Diet • Regular Liquids <u>(First time under supervision of the SLT or a trained stroke nurse!)</u>
15-19 Semisolid and liquid texture successful and Solid unsuccessful	Slight Dysphagia with a low risk of aspiration	<ul style="list-style-type: none"> • Dysphagia Diet (pureed and soft food) • Liquids very slowly – one sip at a time • Functional swallowing assessments such as Fiberoptic Endoscopic Evaluation of Swallowing (FEES) or Videofluoroscopic Evaluation of Swallowing (VFES) • Refer to Speech and Language Therapist (SLT)
10-14 Semisolid swallow success successful and Liquids unsuccessful	Moderate dysphagia with a risk of aspiration	<p>Dysphagia diet beginning with:</p> <ul style="list-style-type: none"> • Semisolid textures such as baby food and additional parenteral feeding. • All liquids must be thickened! • Pills must be crushed and mixed with thick liquid. • No liquid medication! • Further functional swallowing assessments (FEES, VFES) • Refer to Speech and Language Therapist (SLT) <p style="text-align: center;"><i>Supplementation with nasogastric tube or parenteral</i></p>
0-9 Preliminary investigation unsuccessful or Semisolid swallow unsuccessful	Severe dysphagia with a high risk of aspiration	<ul style="list-style-type: none"> • NPO (non per os = nothing by mouth) • Further functional swallowing assessment (FEES, VFES) • Refer to Speech and Language Therapist (SLT) <p style="text-align: center;"><i>Supplementation with nasogastric tube or parenteral</i></p>

Screenshot

These offer reasonable sensitivity and specificity in the absence of CRT and FEES.

Monitoring

We may also need to monitor our patients more closely than we have been used to doing, asking our nursing colleagues to look at the 24 hour pattern of swallowing, asking our physiotherapy colleagues to tell us if they have concerns about the respiratory system and looking for signs of infection such as: fever, doctors chest auscultation results and increasing CRP. We may need to be quite specific in our notes about what we need from our colleagues. In addition we can ask our therapy assistants to do more mealtime observations observing for signs of difficulty over a whole meal.

VFSS

Where our bedside assessment is unclear VFSS is still available for now however and we should use this for those cases who are most in need of the information this provides. Slots are limited and we will need to prioritise those who we feel will get the most benefit of the test.

Telehealth

For community based patients the use of telehealth/ telephone screening should be encouraged as a first line especially in residential care facilities, we can do a lot of our assessment this way and it protects our often elderly patient from physical external contact.

Clinical risk estimation

There is no doubt, we are going to need to make clinical risk estimations without all our usual instrumental tools. Do not see this as your responsibility. This is a team decision and articulate what you do and don't know to the medical team so you can as a team make these decisions.

We all have to be a team player in swallow management decisions in this challenging situation. Reducing infection spread may be a more important action than aspiration reduction for some patients on some days. Make this a team decision.

We urge you to be brave in advocating for the value of swallow assessment and the significant limitations of bedside assessment (especially without cough testing and FEES). We encourage you to be having conversations about balanced risk for patient and staff.

Where you and the team decide to **risk feed without adequate swallow assessment**, please document this feeding at risk decision so we continue to articulate the value of our profession. Please, don't let sub-standard assessment become acceptable. We've worked so hard in this country to practice such high standards of practice that we should be so proud of!