SLP: Leading the Stroke Team in Collaborative Care of Dysphagia

ASHA Convention 2010
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Jeanes Hospital
Philadelphia, PA
Speech Pathology Department at Jeanes Hospital

- Staff of three SLPs and pool positions
- Populations served
- Committee Involvement
Jeanes Hospital’s Primary Stroke Center

- Achieved American Heart Association and American Stroke Association Silver Award 2007 and Gold Awards 2008-2009

- Achieved the Gold Plus Award in 2010

- Established Accreditation as a Primary Stroke Center in 2008 by the Joint Commission’s Disease Specific Certification Standards
SLP as Leader on the Stroke Team
SLP as Leader on the Stroke Team

• Team Members
  – Stroke Coordinator
  – Neurologist
  – Division Chief of Family Practice
  – Nurse Managers
  – Nurse Educators
  – Rehabilitation Specialists (PT/OT)
  – Pharmacist
  – Dietician
SLP as Leader on the Stroke Team

• Establishing yourself as a leader
  – Communicating
  – Participating
  – Keeping current
  – Sharing PI
  – Advocating for Services
  – Developing dysphagia screening tool
“Get With The Guidelines”

• All Stroke Patients:
  – Screened for rtPA therapy
  – Early Antithrombotic Therapy
  – Antithrombotic Therapy prescribed at discharge
  – DVT Prophylaxis
  – Anticoagulation for Atrial Fibrillation
  – Lipid Measurement and Treatment
  – Smoking Cessation

• Three Additional Measures by Joint Commission:
  – Dysphagia Screening
  – Patient/Caregiver Education re: Stroke Signs/Symptoms
  – Rehabilitation Assessment
Incidence of Dysphagia in Stroke Patients

• Incidence of dysphagia has been reported as 42%-67% of patients within the first 3 days of stroke onset, with 1/3\textsuperscript{rd} of those patients developing pneumonia (Hinchey et al., 2005).
An ounce of prevention...

• Several studies have demonstrated that aspiration pneumonia results in prolonged hospitalization, decreased quality of life, and increased complications and mortality rates (Doggett et al., 2001; Martino, Pron, & Diamant, 2000; Perry & Love, 2001; Odderson, Keaton, & McKenna, 1995; Reynolds et al., 1998; Smithard et al., 1996).
Decreasing Mortality

“If instituting a formal dysphagia screening protocol prevented just one half of the post-stroke pneumonias, it could save nearly 8300 lives and prevent nearly 40,000 pneumonias per year (based on 700,000 strokes per year).” Hinchey et al., (2005).
ASHA SID 13 Steering Committee Guidelines for Dysphagia Screenings (2009)

• Minimally Invasive Procedure to Determine:
  – Likelihood that dysphagia exists
  – Referral for further swallowing assessment
  – Safe to feed patient orally
  – Whether patient requires referral for nutritional or hydration support
Two Dysphagia Screening Tools at Jeanes Hospital

• Emergency Department (ED) Dysphagia Screening

• Nursing Floor Dysphagia Screening

Based on Dysphagia Screening Literature (DePippo, Holas, & Reding, 1992; Garon, Engle & Orminston, 1995; Hinds & Wiles, 1998; Mari et al., 1997; Nathadwarawala, Nicklin, & Wiles, 1992; Perry & Love, 2001; Suiter & Leder, 2008).
Thanksgiving in the Emergency Department

Joint Commission guidelines require that patients be screened for dysphagia prior to any oral intake including food, fluid, or medications.
Evolution of Emergency Department Dysphagia Screening

• Began as a Separate Screening Form for CVA Patients Triaged in ED 2005

• Incorporated into ED Assessment Form 2008

• Computerized Documentation in ED (MedHost) Performed on ALL ED Patients September 2009

• Full Liquid Diet Option in ED
ED Dysphagia Screening

Dysphagia Screen
Patient able to swallow 4 ounces of water without coughing or throat clearing. Potential TIA/CVA. Full liquid diet in ED.

MRSA Screen
Patient able to swallow
Pt unable to test pt
Suspected aspiration pt not applicable

Potential TIA/CVA
No neuro deficits
Other

Full liquid diet in ED.
ED Dysphagia Screening

<table>
<thead>
<tr>
<th>MRSA Screen</th>
<th>Dysphagia Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient able to swallow</td>
<td>Pt unable to swallow</td>
</tr>
<tr>
<td>keep NPO/no PO meds</td>
<td>Unable to test pt</td>
</tr>
<tr>
<td></td>
<td>Suspected aspiration pt not applicable</td>
</tr>
</tbody>
</table>

Dysphagia Screen Patient unable to swallow and will keep NPO with no PO medications.

10/06 11:56
Emergency Department Dysphagia Screening

• 4 oz. Water Test Performed by Triage Nurse

• Patient Failed Screening $\rightarrow$ n.p.o. for Meds and Food/Liquid

• Patient Passed Screening $\rightarrow$ Full Liquid Diet Allowed While Patient in ED
Collaboration with Pharmacy
# Evolution of Nursing Floor Dysphagia Screening Tool

- **2005:** Initiated Formal Dysphagia Screening

## Nursing Dysphagia Screening

*(To be completed with all CVA or TIA admissions)*

Please check these variables noted during your nursing assessment:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted with suspected pneumonia or history of aspiration pneumonia?</td>
<td></td>
</tr>
<tr>
<td>Coughing or throat clearing with food, liquids, or meds?</td>
<td></td>
</tr>
<tr>
<td>Oral motor weakness or speech difficulty?</td>
<td></td>
</tr>
<tr>
<td>History of dysphagia or tube feeding?</td>
<td></td>
</tr>
<tr>
<td>Dependent for oral care or for feeding?</td>
<td></td>
</tr>
<tr>
<td>Reflux or history of reflux?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name</td>
<td>Time</td>
</tr>
</tbody>
</table>

If any of the above variables are checked “YES”— ORDER SPEECH CONSULT
Developing Questions for Nursing Floor Dysphagia Screening

• Based on Predictors of Aspiration Pneumonia identified by Langmore et al., (1998):
  – Feeding status
  – Functional status
  – Medical status
  – Oral/Dental status
Evolution of Nursing Floor Dysphagia Screening Tool

• **2007:** Incorporated Screening into Nursing Assessment Form
Nursing Floor Dysphagia Screening

- **2008**: Added 4 oz. Water Test Observation to 6 Question Screening

“Following a successful 3-ounce water swallow test and taking into consideration any patient-specific factors that may impact resumption of safe oral intake, recommendations for specific diet consistencies can be made.” Suiter & Leder (2008)
Nursing Floor Dysphagia Screening

Does patient have history of dysphagia?...........................................☐ Yes ☐ No ☐ Unknown

Does patient have history of aspiration pneumonia?.........................☐ Yes ☐ No ☐ Unknown

Is patient admitted with suspected aspiration pneumonia?...........☐ Yes ☐ No ☐ Unknown

Is patient dependent for oral care and feeding?..............................☐ Yes ☐ No ☐ Unknown

Does patient have oral weakness or slurred speech (dysarthria)?.................................................................☐ Yes ☐ No

Does patient exhibit coughing or throat clearing with food, liquid, or meds?.................................................................☐ Yes ☐ No ☐ Untested
Reason: __________________________________________________________________________________________

Observe patient with 4 oz. H2O prior to any other PO (if admitting Dx is CVA/TIA). Observe with meds or snack (if admitting Dx other than CVA/TIA).

If any of above are checked YES ➔ obtain Physician Order for Speech Consult and keep patient NPO
Outcome of Screening

• Passed screening → **Cardiac diet** ordered
• Passed water test, but aspiration risks identified (one or more positive responses) → Start **Full Liquid diet**, and consult speech
• Failed water test → **n.p.o.**, and consult speech
# Stroke Order Set

<table>
<thead>
<tr>
<th>SPECIFY STROKE TYPE</th>
<th>ORDERS NOT VALID UNLESS SPECIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Stroke (IS)</td>
<td>Ischemic Stroke, Intracerebral Hemorrhage (ICH)</td>
</tr>
<tr>
<td>Transient Ischemic Attack (TIA)</td>
<td>Intracerebral Hemorrhage (ICH)</td>
</tr>
<tr>
<td>Vertebrobasilar insufficiency (VI)</td>
<td></td>
</tr>
</tbody>
</table>

## CARE PROVIDERS
- **Attending Physician**: Admit to Dr.
- **Neurology**: Consult Dr.
- **Intensivist (required for CCU admission)**: Consult Dr.
- **Physical Medicine and Rehabilitation**: Consult Dr.
- **Physical and Occupational Therapy**: Speech Therapy
- **Nursing Stroke Coordinator extension**: 2033

## SITE OF CARE
- **STROKE TYPE**: ACC312/2033
- **Situs**: Stroke Unit (4A) Remote Telemetry Monitoring for 24 hours, then discontinue telemetry
- **HCA**: Critical Care Unit
- **CCH**: Critical Care Unit
- **4A Stroke Unit**: Remote Telemetry

## ACTIVITY
- **STROKE TYPE**: Activity
- **FOLEY CATHETER**: Head of Bed
- **SIT**: Bed Rest for 24 hours then as tolerated if SBP is > 120
- **TNC**: No Foley, Straight Cath G 8 hours PRN no void
- **EPA**: Bed Rest for 24 hours then as tolerated if TNP > 150
- **CCH**: Bed Rest until symptoms resolved, then CCH as tolerated

## NURSING
- **DIAGNOSTICS**
  - Order Cardiac Diet
  - Order Full Liquids and Consult Speech
  - Order Full Liquid and Consult Speech

- **DIAGNOSTICS**
  - Cardiac Output Panel in AM
  - Cardiac Output Panel in AM
  - Cardiac Output Panel in AM

- **MEDICATIONS**
  - Intravenous
    - IV: D5W 1000 mL NS
    - D5W 1000 mL NS

- **OXYGEN**
  - O2: 2 L/min nasal cannula to maintain Oxygen Saturation at least 92%
  - After 24 hours: 2 L/min nasal cannula to maintain Oxygen Saturation at least 90%

- **STATIN**
  - 40 mg PO daily

- **ANTITHROMBOTIC**
  - NOT ALLERGIC TO ASPIRIN
  - Aspirin 90 mg PO daily, NPO ASA 30 min prior

- **VENOUS THROMBOEMBOLISM PROPHYLAXIS**
  - Heparin 5000 units subcutaneously Q 8 hours
  - Warfarin: Start day of admission
  - Heparin
  - Heparin

- **MISCELLANEOUS**
  - No sedatives or hypnotics without consent of attending physician
  - No smoking (or smoking cessation if patient has smoked in past one year, Consult Respiratory Therapy)
  - Infection and Pneumonia precautions. See infection control sheet

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Jefferson Health Systems
Temple University Health System

**STROKE ADMISSION ORDERS**

JE-KNN 5700029T (07/10)
# Stroke Order Set

<table>
<thead>
<tr>
<th>DYSPHAGIA SCREEN RESULT</th>
<th>NUTRITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed Full Screen (6/6 negative) →</td>
<td>Order Cardiac Diet</td>
</tr>
<tr>
<td>Passed Water Test but Aspiration Risks Identified (1 or more positive responses) →</td>
<td>Order Full Liquid Diet and Consult Speech</td>
</tr>
<tr>
<td>Failed Water Test →</td>
<td>NPO and Consult Speech</td>
</tr>
</tbody>
</table>
Nursing Compliance in Completing Dysphagia Screenings

- 2003/2004: 49%
- 2005/2006: 88.5%
- 2007/2008: 93.5%
- 2009-Present: 93%
Rates of Pneumonia in Patients Admitted with CVA

Acute care hospitals that have established formal dysphagia screening protocols have pneumonia rates significantly lower than those of sites without a formal written protocol: 2.4% versus 5.4% (Hinchey et al., 2005).

<table>
<thead>
<tr>
<th>Year</th>
<th>Sum of Cases</th>
<th>Sum of Pneumonias</th>
<th>Sum of Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>62</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>2006</td>
<td>130</td>
<td>2</td>
<td>0.02</td>
</tr>
<tr>
<td>2007</td>
<td>104</td>
<td>7</td>
<td>0.07</td>
</tr>
<tr>
<td>2008</td>
<td>135</td>
<td>8</td>
<td>0.06</td>
</tr>
<tr>
<td>2009</td>
<td>134</td>
<td>6</td>
<td>0.04</td>
</tr>
<tr>
<td>2010</td>
<td>63</td>
<td>2</td>
<td>0.03</td>
</tr>
<tr>
<td>Grand Total</td>
<td>628</td>
<td>26</td>
<td>0.04</td>
</tr>
</tbody>
</table>
Improving Compliance: Rapid Response Team
Improving Compliance: Rapid Response Team

<table>
<thead>
<tr>
<th>RRT OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did event progress to Acute Respiratory Compromise (ARC) during the RRT event?  □ Yes □ No</td>
</tr>
<tr>
<td>Did event progress to Cardiopulmonary Arrest (CPA) during RRT event?  □ Yes □ No</td>
</tr>
<tr>
<td>Patient transferred to:  □ Not Transferred □ ICU □ Cath Lab □ OR □ Telemetry / Step-Down □ Emergency Department □ Other ____________________</td>
</tr>
<tr>
<td>Stroke protocol?  □ Yes □ No □ N/A □ Dysphagia Screen □ Pass □ Fail □ Unable to Test □ Patient made DNR?  □ Yes □ No</td>
</tr>
</tbody>
</table>
SLP as Leader in Hospital Wide Education and Performance Improvement
SLP as Leader in Hospital Wide Education and Performance Improvement

• Educating all staff and caregivers in risk factors affecting patients post-stroke
• Encouraging caregivers to take an active role in promoting safe oral feeding and oral care
• One-to-one dialog with staff to reinforce stroke protocol objectives
Education

• Monthly New Nursing Orientation
• Annual Nursing Education for NIHSS Certification and Stroke Competency Testing
• Rounding
• Written Materials including preprinted visual aides
Visual Aides: Swallowing Precautions

<table>
<thead>
<tr>
<th>Solids</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Pureed</td>
</tr>
<tr>
<td>Mechanical Soft</td>
</tr>
<tr>
<td>Soft</td>
</tr>
<tr>
<td>Regular (House)</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liquids</th>
</tr>
</thead>
<tbody>
<tr>
<td>None by mouth</td>
</tr>
<tr>
<td>Honey thick</td>
</tr>
<tr>
<td>Nectar Thick</td>
</tr>
<tr>
<td>Thin</td>
</tr>
<tr>
<td>Small, single sips</td>
</tr>
<tr>
<td>No Straws</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>None by mouth</td>
</tr>
<tr>
<td>Crushed/placed in pureed food (if possible)</td>
</tr>
<tr>
<td>Liquid form only</td>
</tr>
<tr>
<td>With food</td>
</tr>
<tr>
<td>With water</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Posture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit up straight or 90° in bed</td>
</tr>
<tr>
<td>Out of bed (if possible)</td>
</tr>
<tr>
<td>Remain upright after a meal</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn head left/right</td>
</tr>
<tr>
<td>Tuck chin for each bite/sip</td>
</tr>
<tr>
<td>Swallow twice for each bite/sip</td>
</tr>
<tr>
<td>Alternate liquids &amp; solids</td>
</tr>
<tr>
<td>Slow rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision/Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs to be fed slowly</td>
</tr>
<tr>
<td>1:1 assistance</td>
</tr>
<tr>
<td>Spot supervision</td>
</tr>
<tr>
<td>Distant supervision</td>
</tr>
<tr>
<td>Keep mouth clean throughout day</td>
</tr>
</tbody>
</table>

---

Speech-Language Pathologist
215-728-3946

Date
Visual Aides: Swallowing Guidelines

GENERAL GUIDELINES FOR SAFE SWALLOWING
FROM YOUR SPEECH PATHOLOGIST

THESE MAY BE SIGNS OF DIFFICULTY SWALLOWING:
- Coughing or choking during meals
- Gurgly or wet vocal quality
- Pocketing food in the mouth
- Excessive Drooling
- Reflux (indigestion)
- Complaint of “food stuck” in mouth or throat
- Poor intake or loss of appetite

TO KEEP YOU SAFE WHEN EATING, PLEASE FOLLOW THESE SUGGESTIONS

1. Whenever eating and drinking, you should be seated upright (in a chair if possible).
2. Stay in an upright position for at least ½ hour after meals/snacks.
3. Allow plenty of time for each meal. Do not rush!
4. Alternate sips of liquid with small bites of food. Clear your mouth before the next bite.
5. Avoid distractions. Avoid talking when eating because this could lead to a choking event.
6. Swallow two times before the next bite or sip.
7. If you become tired, take a break and stop eating for awhile.
8. If your voice sounds “wet” or “gurgly,” clear your throat until your voice is clear.
9. If you cough when you eat or drink this could mean something is about to go into your lungs.
10. Remember to always take small bites and go slowly. Do not gulp your drinks.

FOR CAREGIVERS

1. Help the individual sit in an upright position.
2. Feed the individual with respect and do not rush.
3. Do not leave the individual alone while eating unless you are sure they will be safe and alert.
4. The impulsive individual may perform best with one food placed in front of them at a time.
5. Help the individual clear their mouth frequently throughout the day; especially after meals.
6. Please follow your Speech Pathologist’s recommendations regarding food and liquid textures.
7. A Nutritionist can help you regarding meal planning and specific dietary needs based on individual medical needs.
Visual Aides:
n.p.o. Signage

NPO
Nothing by Mouth
Bed #1

NPO
Nothing by Mouth
Bed #2
Visual Aides: “Friendly Reminders” Card

Friendly Nursing Reminders:
Caring for Patients with Speech or Swallowing Disorders

We appreciate our nurses at Jeanes Hospital and the hard work you do each day. Thank you for helping us maintain high standards in caring for patients with speech and swallowing disorders by remembering the following tips:

- The Nursing Dysphagia Screening is part of the Nursing Admission Assessment and MUST be completed on ALL patient admissions, not just CVA patients.
- All questions on the Nursing Dysphagia Screening MUST be completed in full (not partially completed).
- All patients must be given the 4oz. water test as part of the Nursing Dysphagia Screening unless they are obtunded or intubated or unable to sustain arousal. DOCUMENT YES or NO if they exhibit coughing or throat clearing! If unable to test, DOCUMENT reason why.

- **Patients on Stroke Protocol:** Any question answered YES on the Nursing Dysphagia Screening is considered a failed screening and Speech Therapy is consulted. No physician’s order is necessary IF the patient is on Stroke Protocol.

- **Patients NOT on Stroke Protocol:** A physician’s order must be obtained if they fail the Dysphagia Screening.

- While we appreciate nursing expertise in alerting us to patients with potential speech or swallowing disorders, Speech Therapy CANNOT accept orders from nurses. A physician’s order must be on the chart before Speech Therapy can evaluate the patient.

- Speech Therapy does NOT screen the patient. Nursing does this as part of the admission assessment. Nursing cannot order a “Speech Screen”. You are the screener and are the first line of defense in preventing an aspiration event.

- At any time during the patient’s stay, if they experience signs and symptoms of dysphagia during meals or with meds, keep patient NPO, document change in swallowing function in the progress notes, and obtain physician order for Speech Consult.

*It’s not just about the swallow! ... On the NIHSS: Have you scored the patient 1, 2, or 3 on the Language or Dysarthria sections? Are they having NEW problems with communicating with others?*

- Be mindful of patients exhibiting recent changes in their communication status:
  - Are they exhibiting problems getting words out? Are they hard to understand? Are they unable to follow directions or conversation?
  - If so, obtain a physician order for Speech Consult to further evaluate cognitive-communication skills.

Thank you again for helping to insure high standards of care in these patients.
Oral Health and Safety Signage

ORAL HEALTH AND SAFETY

- PLEASE PROVIDE FREQUENT MOUTH CARE AFTER ALL MEALS AND THROUGHOUT THE DAY

- KEEP HEAD OF BED ELEVATED

  30° AT REST

  90° AT MEALS

- FEED SLOWLY IF PATIENT REQUIRES ASSISTANCE
Oral Hygiene Rating

4= **Grossly WNL**
   - Lips, gingiva, and tongue are smooth, pink, moist, intact
   - Dentition clean, no debris
   - Saliva thin, watery

3= **Mildly decreased**
   - Lips slightly wrinkled, dry
   - Gingiva and oral mucosa pale and slightly dry
   - May have 1 or 2 isolated lesions, blistered areas
   - Tongue slightly dry
   - Dentition with minimal debris

2= **Moderately decreased**
   - Lips, gingiva and oral mucosa moderately dry, swollen
   - Generalized redness
   - More than 2 isolated lesions, blisters, reddened areas
   - Tongue tip and papillae reddened
   - Dentition: moderate debris clinging to half of visible enamel
   - Saliva scanty or thicker than normal

1= **Severely decreased**
   - Significant dry oral mucosa
   - Gingiva significantly reddened and inflamed
   - Dried secretions on hard palate
   - Thick saliva coating tongue
   - Dentition covered with debris
## Charting: Interdisciplinary Plan Of Care

<table>
<thead>
<tr>
<th>26. Research Drug</th>
<th>Patient, family, and staff will know patient is on research drug.</th>
<th>27. Stroke</th>
<th>Achieve optimum level of independence.</th>
<th>28. Swallowing Difficulty</th>
<th>Ensure safety of swallowing functions, prevent aspiration.</th>
<th>29. Hemodynamic</th>
<th>Unstable Patient</th>
<th>Vital signs / cardiac output / urine output will be stabilized or normalized.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
<td>□ Goal met _____ date____</td>
</tr>
</tbody>
</table>

**Plan of Care**
- Place sticker on chart indicating “Patient is on research drug.”
- Educate family and patient of side effects and adverse effects to report to nurse.
- Copy of signed informed consent for participation in research study placed in chart.

**Additional Interventions:**
- Diet texture modification
- Swallowing precautions posted
- Keep head of bed elevated
- Keep head of bed elevated 30° or more
- Reflux precautions

**Additional Interventions:**
- Monitor vital signs frequently
- Monitor IV fluids / cardiac output as ordered
- Monitor urine output / NO frequently
- Monitor ABG / SPO2 as ordered
- Monitor response to IV fluids / vasopressors closely
- Monitor T & T medications as needed to support blood pressure, heart rate, urine output
- Explain all interventions to patient and family
- Provide emotional support for the critically ill / unstable patient and their family and loved ones

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**Temple University Health System**

**Interdisciplinary Plan Of Care**

**Interdisciplinary Plan Of Care**

**Goal**: Care will be evidenced by patient outcomes.

**Interventions**:
- Incorporate patient’s voice into care planning.
- Collaborate with all team members to ensure patient’s goals are met.

**Charting**:
- Use standardized symbols and abbreviations.
- Ensure clear communication among interdisciplinary team.

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**Temple Hospital**

**Interdisciplinary Plan Of Care**

**Goal**: Patient outcomes will be achieved.

**Interventions**:
- Implement evidence-based practices.
- Foster a culture of continuous improvement.

**Charting**:
- Use color coding for different disciplines.
- Maintain a clear and organized chart layout.
## Charting: Interdisciplinary Plan Of Care

<table>
<thead>
<tr>
<th>28. Swallowing Difficulty</th>
<th>Ensure safety of swallowing function; prevent aspiration.</th>
<th>Diet texture modification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Goal met ________ (date)</td>
<td>Swallowing precautions posted</td>
</tr>
<tr>
<td></td>
<td>□ Goal not met ________ (date)</td>
<td>Keep head of bed elevated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keep head of bed elevated 90° at meals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reflux precautions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional Interventions:</td>
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</table>
# Charting: Education

**SPECIAL LEARNING NEEDS:**
- □ Preferred Language
- □ Limited English Proficiency
- □ Religious Beliefs
- □ Cultural Lifestyle
- □ Disability
- □ Education Level
- □ Physical Limitation
- □ Emotional/Behavioral
- □ Impaired Thought Process
- □ Impaired Motor Skills
- □ Impaired Hearing
- □ Impaired Vision
- □ Other:

**CATEGORIES:**
1. Illness/Disease
2. Treatment Plan
3. Medications
4. Nutritional/Diet
5. Tests/Procedures
6. Medical Equipment
7. Rehabilitation Techniques
8. Potential Food/Drug Interaction
9. Safety/Fall Prevention
10. Psychosocial Issues
11. Available Community Resources
12. Continuing Care/Follow Up
13. Preventative Measures
14. Immunizations
15. Activities of Daily Living

**Person Instructed:**
- □ PT = Patient
- □ M = Mother
- □ S = Spouse
- □ D = Daughter
- □ O = Other
- □ Son

**Teaching Method/Preference:**
- □ A = Auditory
- □ S = Spoken
- □ V = Visual
- □ R = Reading
- □ T = Teaching
- □ I = Interpreter

**Response to Teaching:**
- □ NR = Needs Reinforcement
- □ NA = Needs Assistance
- □ NOT = Not receptive

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**Isolation:**
- □ Contact precautions
- □ Non-applicable
- □ MRSA
- □ CIWRE
- □ Resistant Gram Negative Bacteria
- □ Clostridium difficile

**Initials**

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(Teams Hospital)

**INTERDISCIPLINARY PATIENT AND FAMILY EDUCATION FLOWSHEET**

[Logo: Temple University Health System]

JE-WIN 500214F-R (06/10)
Additional Referrals

- Registered Dietician
- GI
- ENT
Obstacles

• New Staff
• Changing Established Nursing/Physician Culture
• Overwhelming Paperwork
• Family/Patient Expectations
• Minimizing Dysphagia
• Overestimating Compliance
Overcoming Obstacles Through Education

- New Nursing Orientation
- On-the-Floor Education
- Establishing Seasoned Nurses as Mentors
Overcoming Obstacles Through Collaboration

- Ongoing Communication and Establishment of PI Objectives with Stroke Coordinator
- Providing Objective Data to Staff and Stroke Committee
- Meeting with Patients and Families to Develop a Plan of Care
Overcoming Obstacles Through Facilitation

• Streamlining and Incorporation of Dysphagia Screening into Nursing Assessment

• Dietary Modifications to Meet Patient Needs
Conclusions

• SLP as Leader:
  – On the Stroke Team
  – In Hospital Wide Education
  – In Performance Improvement Program
SOPHISTICATED CARE.
PERSONAL TOUCH.
References


