INSTRUMENTAL ASSESSMENT OF DYSPHAGIA AFTER STROKE

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Quality issue / initial problem

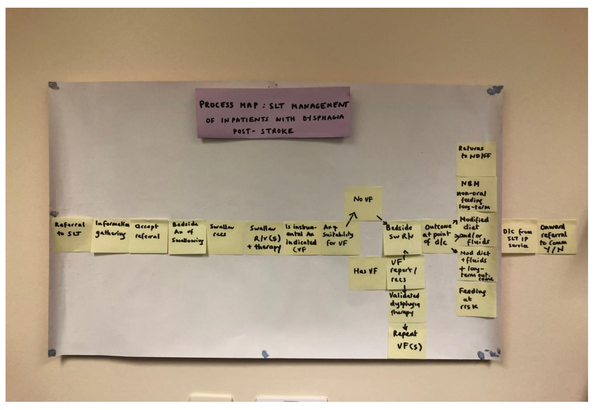
Instrumental assessment is used to confirm the presence or absence of silent aspiration in patients with dysphagia after stroke. When food or fluid enters the airway below the level of the vocal cords this can be a contributing factor to patients developing aspiration pneumonia. When Speech and Language Therapists are unable to carry out instrumental assessment to exclude silent aspiration, then this can lead to an increase in cautious recommendations around patients' oral intake, or conversely non-detection of silent aspiration. It was identified that from Oct – Dec 2017 only 1 out of 21 patients who could have benefitted, received an instrumental assessment.

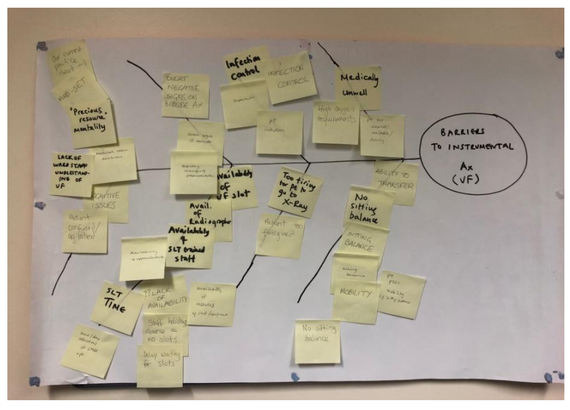
Specific aim

To improve access of patients in the Stroke Unit in RIE to instrumental assessment of dysphagia.

Tools

Process mapping
Fishbone diagram
Driver Diagram





Tests of change

Revise swallow pathway to identify patients who could benefit from instrumental assessment earlier.
Make Fibreoptic Endoscopic Evaluation of Swallowing (FEES) available in stroke unit.
Maximise use of C-Arm Videofluoroscopy slots (modified barium swallow requiring only partial sitting balance).

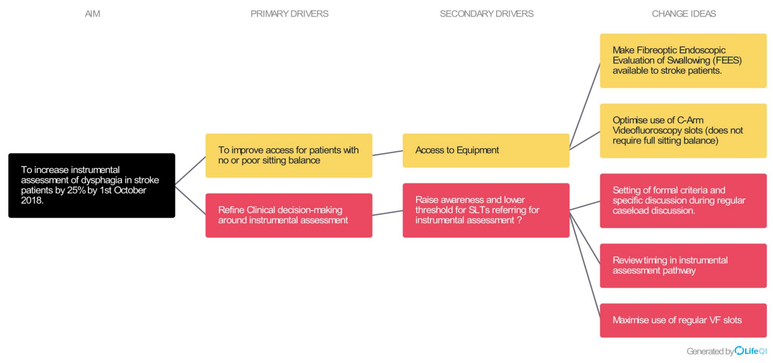


Figure 1

Measurement of improvement

Proportion of appropriate patients receiving instrumental assessments (outcome) Figure 1
Changes in Patients Management (outcome) Figure 2
Number of days with NG tube (process)
Time from decision to instrumental assessment (process)

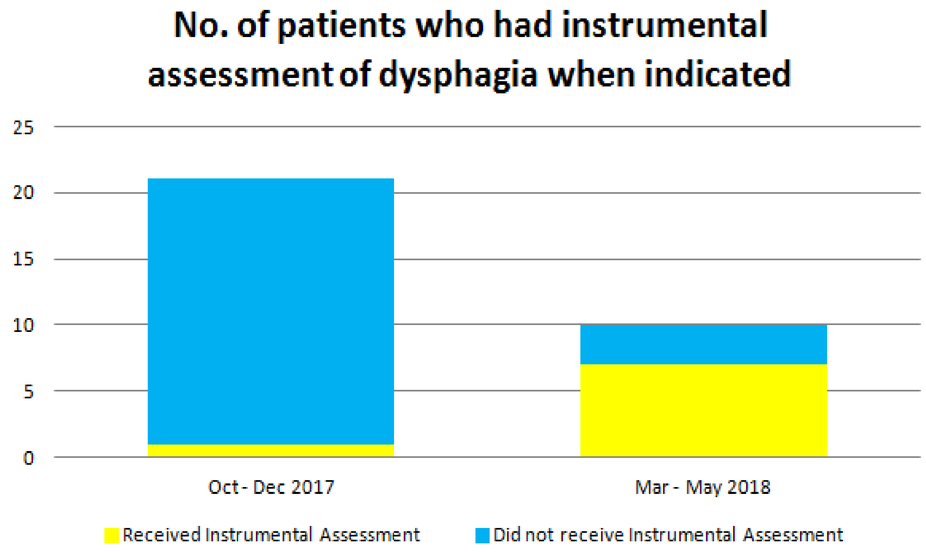
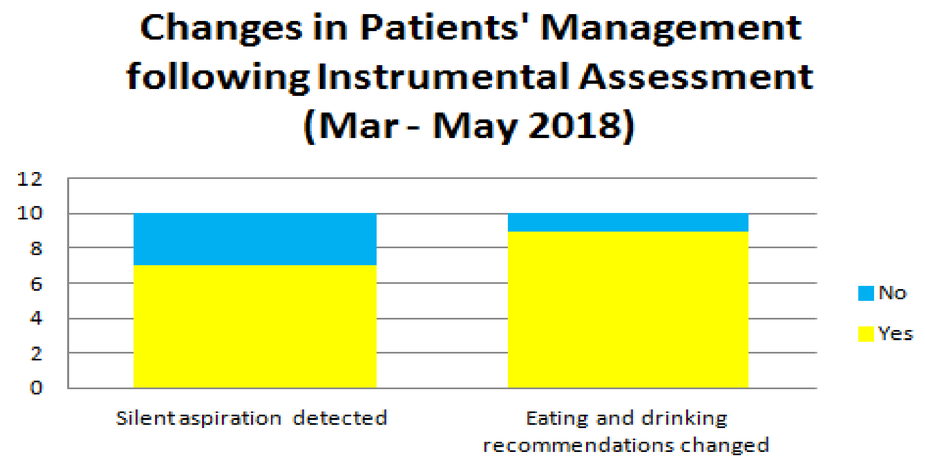


Figure 2



Effects of change

Faster return for some patients to oral diet and fluids.
Identification of silent aspiration contributing to reduced risk of aspiration pneumonia for some patients.
Increased access to instrumental assessment of swallowing and more efficient patient pathway.
Increased SLT confidence in management of dysphagia.

Lessons learned and message for others

Retrospective data-collection was time-consuming but has now been built into SLT systems.
Has made us really consider the best ways to measure whether a change is an improvement.
Have learned useful tools to facilitate involvement of whole team in change process. These revealed unexpectedly that one barrier to patients receiving instrumental assessment was related to SLT clinical decision making.

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