SPEECH AND LANGUAGE THERAPY DEPT. ST JAMES HOSPITAL

PREVENTION OF ASPIRATION PNEUMONIA IN STROKE

18/11/2021

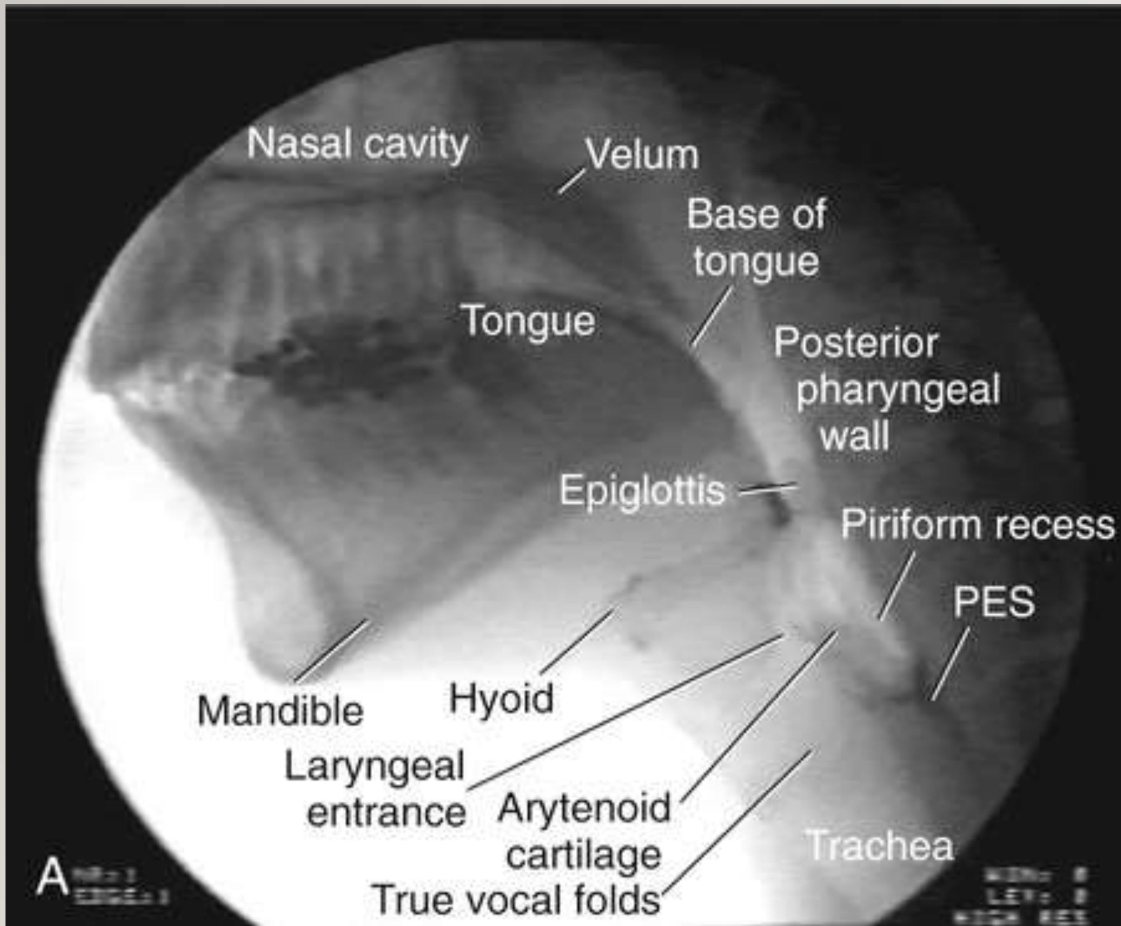
CIARA MORAN SPEECH AND LANGUAGE THERAPIST

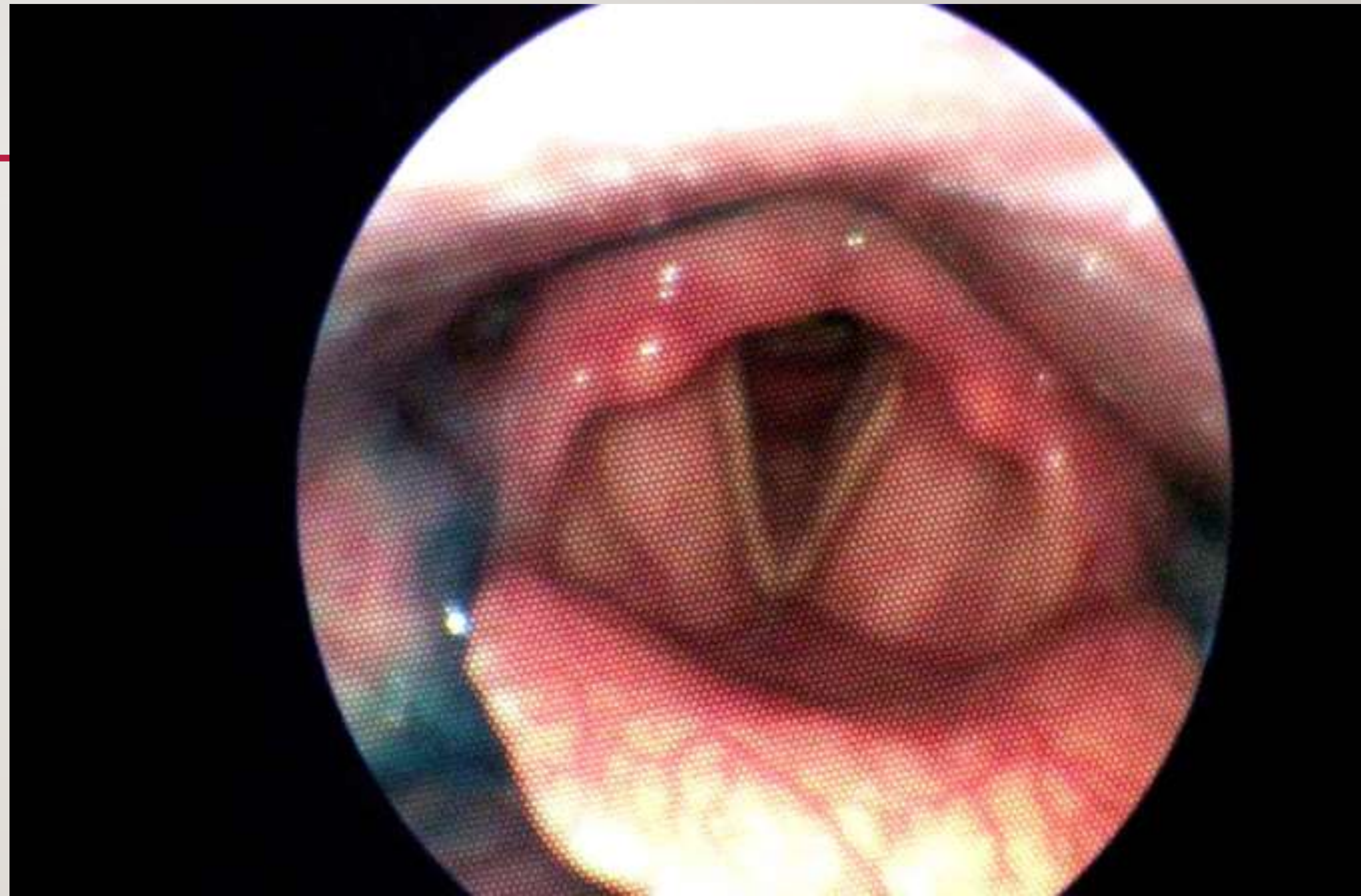
SWALLOW RECOMMENDATION SHEET

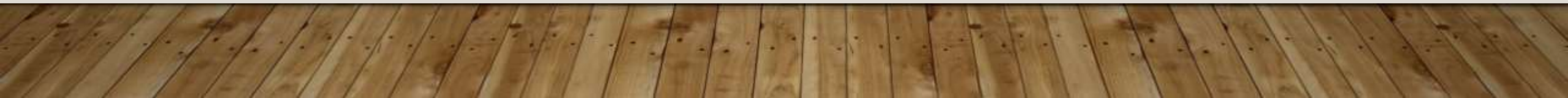
- At patient’s bedside (on their whiteboard or behind the bed)
- Conditions and strategies required
- Column to the right of the sheet with specific recommendations for that patient
- Instructions on how to thicken fluids and foods to avoid

OBJECTIVE SWALLOW ASSESSMENT

- Videofluroscopy (VFU): x-ray of the swallow, lateral profile using barium to visualise the swallow.
- Fiberoptic Endoscopic Evaluation of Swallow (FEES): camera passed down the nose and the swallow is visualized from above.
- Both give a profile of the swallow at a particular moment in time. Limitations to both, but provide more information than a bedside assessment.
- Different food and drinks consistencies can be given
- Rehab exercises and food and drink recommendations made based on what's observed during the assessment


Nasal cavity
Velum
Base of tongue
Tongue
Posterior pharyngeal wall
Epiglottis
Piriform recess
PES
Mandible
Hyoid
Laryngeal entrance
Arytenoid cartilage
Trachea
True vocal folds
A





NURSING ROLE IN PREVENTION OF ASPIRATION PNEUMONIA

- Nursing provide invaluable information that SLT don’t have access to

  - present at all 3 mealtimes

  - present when giving medications

  - longer periods of time with patients

  - monitor acute changes in patient presentation, chest, temp, EWS

NURSING ROLE IN PREVENTION OF ASPIRATION PNEUMONIA:

- Monitoring for signs and symptoms of penetration and / or aspiration
- Identify when a patient is not managing their recommendations or required more assistance than specified
- Identify when a patient needs to be seen by SLT – either new referral or review assessment
- Identify when a patient needs to be made NPO and discuss this decision with the medical team
- Contacting SLT if any change in presentation (positive or negative)
- A change to swallow function can sometimes indicate a new event or a change in clinical presentation
- Deterioration in swallow function can increase risk of aspiration in absence of management

SIGNS AND SYMPTOMS OF PENETRATION AND ASPIRATION

- Can happen before during or after the swallow
- Penetration: food, drink or secretions enter the airway above the level of the vocal cords. Can remain in the airway and there is risk of aspiration with this material. Patient may or may not cough
- Aspiration: food, drink or secretions enter the airway and pass into the trachea and the lungs. The patient may or may not cough

SIGNS AND SYMPTOMS OF PENETRATION AND ASPIRATION

- Coughing
- Throat clearing
- Eye tearing
- Increased SOB when eating and drinking
- Desaturation during or following eating and drinking
- Change in vocal quality (wet, gurgly, strangled quality)

SILENT ASPIRATION AND STROKE

- Food, drink or secretions enter the airway and pass below the vocal cords without the patient coughing
- Chest status may deteriorate or clinical status may decline with no evident difficulty with food or drink
- High prevalence in brainstem strokes
- May pass the TOR BSST
- Objective assessment is the only way to confirm the presence of silent aspiration
- Difficult to manage in the absence of objective ax
- Contact SLT of concerned about silent aspiration

NURSING ROLE IN ORAL CARE AND MAINTAINING ORAL HYGIENE

Oral care can involve:

- Brushing teeth or sterilising dentures
- Using oral care packs and sponges with sterile water
- Removing food residue from oral cavity and dentures after meal
- Applying Bonjela / Bioextra and other topical gels to maintain healthy oral cavity
- Applying myostatin to oral thrush

WHY IS ORAL CARE SO IMPORTANT

- Aspiration of secretions occurs regularly and is difficult to manage
- Ensuring secretions are loose, clean and not noxious reduces the risks associated with aspiration of secretions
- Aspiration pneumonia can be caused by aspiration of noxious secretions
- Improves patient quality of life
- Improves patient experience of eating and drinking

SUMMARY

- Everyone has a role to play in the prevention of aspiration post stroke – nursing role is particularly important
- TOR BSST is a screening tool and SLT input should always be considered in patients who present as FAST +ive or with acute stroke
- SLT assess and manage swallowing difficultyies and oro-pharyngeal dysphagia post stroke
- Oral hygiene plays a vital role in reducing aspiration pneumonia
- Always consider silent aspiration
- Be aware of the signs and symptoms of penetration aspiration
- Contact your SLT if you've any concerns about swallow and /or communication