

Dysphagia Screening: Moving to a Simulation-based Competency Assessment

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Disclosures

- None



Objectives

Outline the process of developing and implementing a simulation-based dysphagia screening competency assessment

Describe strategies to improve the number of nurses and providers demonstrating competency in dysphagia screening

Examine the effectiveness of simulation-based dysphagia screening competency assessment utilizing standard patients

Triad Approach to Improvement



- NeuroScience Clinical Nurse Specialist
- Speech Language Pathologist
- Stroke Program Coordinator/NP



Outline of previous Training Process

- SLP offered in-service Class
- Overview of the anatomy and physiology of swallowing and swallowing difficulties with rationale for dysphagia screening
- Pre and post-test completion
- RN/provider observed SLP or supertrainer RN conducting the screen
- SLP or supertrainer RN observed RN/provider conducting

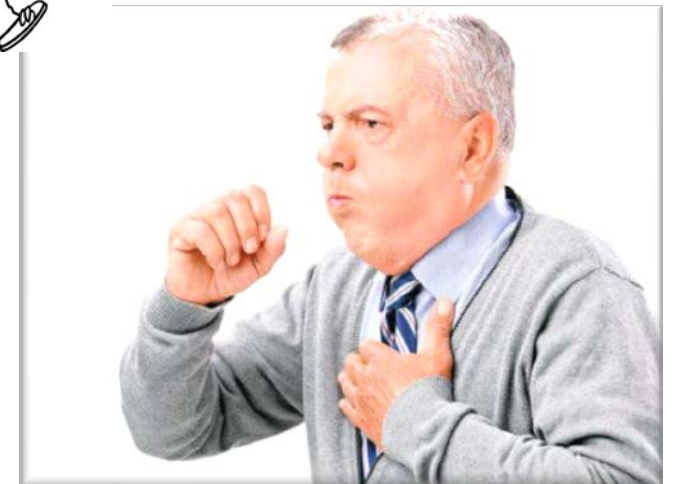
Identified Gaps in the Previous Training Process



- Inability to provide enough classes with SLP to keep up with new hires
- Mismatch of opportunities where there is both a new stroke patient and a SLP/supertrainer to sign off RN/provider
- No mechanism to periodically reassess RN/provider competency
- No standard definition of some of the screen elements
- Need for modification of electronic medical record(EMR) tool for clarification

Stroke Swallow Screening Tool Elements

- Select an approved diagnosis
- Assess for lethargy
- Assess for oxygen saturation $>90\%$ on RA and RR < 24
- Assess for difficulty managing secretions
- Assess for recent swallowing difficulties
- Sit the patient up in a 90 degree position and assess ability to hold cup independently
- Give the patient 3 oz (90 ml) of water and instruct to drink it all
- Wait 1 timed minute; assess for choking, coughing, or drooling





Outline of New Process

- Completion of stroke swallow CBL
- Overview of the anatomy and physiology of swallowing and swallowing difficulties and rationale for dysphagia screening
- Post-test completion (Passing grade = 100%)
- Sign up for a competency assessment class
- Submit CBL transcript when attending class
- Complete competency assessment with two qualified observers (one actor and one assessor)



Simulation Scenario Development

- Eight scenarios were developed which include:
 - Stroke diagnosis
 - Patient vital signs and Oxygen saturation
 - Actor cards with scripting for symptoms and communication to assure consistency
- Two scenarios in which the patients pass but have language impairments
- Six scenarios in which the patients fail (one for each potential fail point in the screen)





General Overview and Debriefing

- Each session began with a general overview of the stroke swallow screen
- Review of elements/steps
 - Stroke diagnosis
 - Lethargy
 - Oxygenation on room air
 - Difficulty managing secretions
 - Recent swallowing difficulties
- Following the steps sequentially
- Each scenario was followed by debriefing, discussion, and clarification of misconceptions



Debriefing:

- Simulation generated discussion and helped the nurses understand the rationale behind each element of the screen
 - Focus was placed upon points commonly confused by nurses
- Clarification and discussion of gray areas was beneficial
- Managers and staff were quickly won over by the process



Findings:

- Some experienced nurses were shocked at the amount of water given to the patient and that a full timed minute must go by before passing the patient
- Some nurses were failing patients for aphasia, confusion and facial droop even though they were not elements of the screen
- Many nurses believed patients automatically failed if they were on oxygen



Findings:

- RNs did not necessarily appreciate that layering a stroke on other co-morbidities increases the risk of aspiration
- Patients who are “awake” were perceived as being less sick and less likely to have dysphagia
- Every group walked away with some clarification of the hows and whys of the swallow screen
- All staff gave positive feedback regarding the process



Scenario #1

For the RN:

Ischemic Stroke

BP 170/89 HR 98 Afib RR 12 pOx 97% RA

For the Actor:

Has word-finding difficulty and R HP 3/5 L 5/5. Alert and follows commands. Holds cup of water and sits up to 90 degrees. Drinks water without difficulty.

Standard Pt behaviors:

1. Alert
2. Uses wrong words
3. Speech hesitant
4. Right side weak-holds cup with left hand
5. Sits up at 90 degree angle
6. Drinks all water with no difficulty
7. No drooling or gurgled speech

PASS. SLP consult for aphasia

Scenario #2

For the RN:

Intracerebral Hemorrhage

BP 160/90 HR 98 RR 20 Pulse Ox 96%

For the Actor:

Alert with left sided weakness with slurred speech. Initially swallowed water without difficulty, but after 30 seconds, clears throat and or coughs. Sounds gurgled when asked to speak.

Standard Pt behaviors:

1. Alert and oriented
2. Slurred speech
3. Right sided weakness
4. Drinks water without difficulty
5. After 30 seconds displays one or more of the following behaviors:
 - a. clears throat
 - b. speech sounds gurgled when asked to speak
 - c. coughs
 - d. wipes at mouth

FAIL Consult SLP for Speech Language Pathology Evaluation



Summary and Future Direction

- Simulation-based dysphagia screening competency assessment utilizing standard patient scenarios is an effective strategy that enhances nurse engagement and allows for real time discussion and remediation
- Future study will focus on the effect of this process on improving the dysphagia screening metric