

## Chapter 1

# Preparing for a Patient Assessment

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Have you ever been rushed for time and thought to yourself, “I’ll go into my patient’s room and take a quick look at her swallowing abilities. I can always review the chart later”? If so, here are a few extreme examples of why you shouldn’t wait to review the chart:

- The patient goes limp after taking a drink and appears to have no pulse. Do you call a code? How would you know whether to call a code if you haven’t checked the patient’s resuscitation status on his chart?
- You take some foods from the department refrigerator and begin to assess the patient. A nurse walks in at the end of the session and is angry because you’ve just given a diabetic patient foods loaded with sugar.
- You begin feeding your patient from the test tray. Halfway through your assessment, the physician walks in, informs you that the patient is NPO for a procedure, and asks why you didn’t notice it in the chart.

Of course, there are many more reasons a thorough review of a patient’s medical history is essential before completing an evaluation.

- You’ll know what to expect from the patient.
- You may be able to determine which food consistencies to present in the bedside evaluation.
- You may also learn whether the patient’s physical condition will preclude full participation in the evaluation.

The information on the following pages is important to obtain BEFORE you evaluate a patient’s swallowing abilities.

## Interviewing the Patient

You may find critical information by asking the patient for a description of the problem. It may be necessary to reword your question in order to get the information. For example, you might ask a patient if he ever chokes when eating and he might answer, “No.” If you reword your question and ask if food or liquid ever goes down the wrong way, the patient may reply, “Yes.”



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## Principles of Biomedical Ethics

The field of biomedical ethics provides guidance about principles that guide decision making in our culture. A brief summary of some of the major principles is provided here, drawn from the text *Principles of Biomedical Ethics* by Beauchamp and Childress (1994).

### ► **Respect for Autonomy**

Patients have the right to make independent choices about their care. In order for patients to make autonomous choices, they should be free from controlling influences and actually have the capacity to make independent decisions. Often patients with dysphagia have had strokes with concomitant aphasia, making it difficult for them to make independent choices. When that is the case, you need to involve the patient to the extent he is able to participate and then rely on the family member(s) to assist in decision making. Beauchamp and Childress call these individuals “surrogate decision makers.” Several important court cases have involved decisions made by surrogate decision makers concerning continuing tube feeding (e.g., Karen Ann Quinlan, Claire Conroy, Paul Brophy, Terri Schiavo).

Your evaluation of receptive and expressive language provides crucial information about the patient’s ability to participate in decision making. Medical professionals must not assume that patients and family members cannot make complex decisions about their health. You must provide enough information and education to the patient and family to allow them to make an informed decision, rather than deferring the decision to a physician, nurse or other medical professional.

### ► **Nonmaleficence**

This principle asserts a primary principle of medical ethics: “Above all, do no harm.” Nonmaleficence means that one should not cause harm or impose risk of harm. It is closely tied to the next principle discussed, beneficence. Some ethicists consider them to be one principle.

Several concepts that provide more specific guidance about doing no harm are related to patients with dysphagia. One is the discussion of a distinction between withholding (i.e., never beginning) and withdrawing (i.e., stopping once it is started) medical treatment. Some argue that withholding is not maleficence, but withdrawing is. Family members may question the difference in removing a feeding tube once it is placed and never putting a tube in to begin with. The commonly-held belief now is that there is no distinction between withholding and withdrawing treatment.

Another concept addresses the difference between sustenance technologies and medical technologies (Beauchamp & Childress, 1994). This concept directly relates to dysphagia regarding withdrawing artificial feeding vs. withdrawing other life-sustaining technology (e.g., ventilator). Two early cases, Quinlan and Brophy, declared that medically-administered nutrition and hydration were not significantly different from other life-support techniques. This view is increasingly upheld by courts.

For patients who exhibit hemiparesis of the tongue and pharynx, a lateral head tilt to the patient's intact side may help. The bolus would be directed to the side of the oral cavity with greater muscle tone, which assists in oral control of the bolus.

## 5. Oral Sensitivity Training

Patients who aren't eating by mouth may show reduced sensitivity to material in the oral cavity. If a patient's oral cavity is very dry from mouth breathing and having no liquids, it is inappropriate to initially present food to the patient without first completing some oral sensitivity training. Be sure the patient is positioned upright and then use a toothette or a swab to moisten the oral cavity. Adequate saliva is essential for a patient to be able to form a good bolus. If the patient is able to complete such a maneuver, you may even have him swish and spit some liquid from his mouth.

## 6. Sour Bolus\*

Some patients may benefit from presentation of a very sour bolus, like lemon juice. This technique can significantly improve the onset of the oral and/or pharyngeal phases of the swallow. For the patient who is NPO, lemon glycerine swabs provide a source of sour stimulation, though studies have not been completed to judge the impact on swallow. Note that when lemon glycerin swabs are used for oral hygiene, they are considered ineffective. In fact, the lemon reduces oral pH below the normal level and dehydrates the oral tissues. According to Trenter-Roth and Creason (as cited in Coleman, 2002), the acid conditions in the mouth can irritate, cause pain and decalcify teeth, increasing the risk of dental decay (Trenter-Roth & Creason, 1986).

## 7. Carbonation and Other Chemesthesis

Pelletier and Dhanaraj (2006) found that moderate sucrose, high salt and high citric acid elicited significantly higher lingual swallowing pressures compared to pressures generated with water. High salt and citric acid elicit chemesthesis mediated by the trigeminal nerve. Therefore, they hypothesize that chemesthesis may play a crucial role in swallowing physiology. If true, trigeminal irritants like carbonation may be beneficial to individuals with dysphagia.

## 8. Food Placement

Patients usually do best if food is placed at the midline of the tongue. Some patients do better if food is placed on the stronger side, especially if it is food that needs to be chewed.

## 9. External Pressure to the Cheek\*

Placing pressure on the affected cheek may also assist a patient with oral cavity weakness. The benefits for the patient are that the pressure decreases the amount of material falling into the weaker lateral sulcus and helps the tongue action in the formation of a cohesive bolus.

This tactile cue also reminds the patient to check the buccal pocket or lateral sulcus for material that could have fallen there. This technique compensates for decreased muscle tone.



Here are some questions you should ask yourself before beginning to use a technique you learned at a conference or heard about from a colleague if there is no published research to support it.

***Does the technique make sense, given what you know about the physiology of the swallow?***

For example, if a presenter told you that having the patient forcefully open and close the jaw would reduce pyriform sinus residue, you would quickly argue that jaw movement has nothing to do with laryngeal movement (which is largely responsible for reducing pyriform sinus residue).

***Is there a possibility of harm to the patient?*** Will the technique cause the patient any undo discomfort? For example, would a technique utilizing hot pepper sauce increase saliva flow and increase risk of aspirating bacteria-laden secretions?

***If there is no efficacy data published, why not?*** Just having a presenter or colleague tell you that a technique works doesn't mean you should try it. Our Code of Ethics states that "individual statements to colleagues about professional services, research results and products shall adhere to prevailing professional standards and shall contain no misrepresentations" (Principle IV. D, ASHA, 2003). If the researcher/clinician has been using the technique/protocol and is so confident of its efficacy that s/he is willing to teach others how to do it, then that individual has an obligation to submit the data for critical peer review.

***If it seems to work for your patients, is that enough proof for you?*** Remember the placebo effect. If you are excited about a new technique and tell the patient how wonderful it is and how well it will work, that alone can have an effect on the patient. In addition to the placebo effect, just judging efficacy by how well it works for several patients does not help you determine what other variables you have failed to control that might be accounting for the change.

***Are you taking time away from treatment with a more traditional technique that has been shown to be effective?*** If you spend time in therapy having the patient hold a bag of ice, as you believe increasing sensitivity in the hand increases the speed of onset of the swallow, are you not taking time away from use of thermal-tactile stimulation, which has some support in the literature?

***What do you tell a patient when you decide to use what must be considered an experimental approach?*** You should disclose to the patient that the technique you are using does not yet have any published efficacy data to support it. The Code of Ethics again provides guidance to us in Principle I:

- D. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed.
- E. Individuals shall evaluate the effectiveness of services rendered and of products dispensed and shall provide services or dispense products only when benefit can reasonably be expected.
- F. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.