

Massey Bedside Swallowing Screen (Modified)

To be completed on all TIA/CVA patients prior to administering oral medication, food or fluids.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Patient is alert and follows commands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. No evidence of dysarthria (speech slurred/garbled) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. No evidence of aphasia (trouble speaking or understanding words) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If Yes to 1-3, continue screen. If No to any items in 1-3, stop screen and keep NPO.

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| 4. Able to clench teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Able to close lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Face is symmetrical with movement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Tongue is midline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Uvula is midline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If Yes to 3 or more, continue screen. If No to 3 or more items in 4-8, stop screen and keep NPO.

- | | | |
|--|------------------------------|-----------------------------|
| 9. Gag reflex is present | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Voluntary cough present | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Able to swallow own secretions (no drooling) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Swallow reflex is present | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes to 9-12, continue screen. If No to any item in 9-12, stop screen and keep NPO.

Position Patient Upright:

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| 13. Give 5 mL of water via teaspoon: | | |
| a. Chokes with swallow | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Voice sounds gurgly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Coughed after water | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Water dribbles out of mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If No to 13 a-d, proceed. If Yes to any, keep NPO and consult Speech Therapy.

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|---|------------------------------|-----------------------------|
| 14. Give 60 mL of water via cup (no straw): | | |
| a. Chokes with swallow | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Voice sounds gurgly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Coughed after water | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Water dribbles our of mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If No to 14 a-d, administer oral medication and diet as ordered. If Yes to any, keep NPO pending swallow evaluation.

Signature: _____ Date: _____ Time: _____

Exempla
HEALTHCARE
LUTHERAN MEDICAL CENTER



PATIENT INFORMATION

M0383716 REG CL: V052199494
TEST, BARBARA L
68 09/08/40 F ADM: 03/24/09
ADMIT FOR TEST ONLY
SP

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EL-EF-NR-3163-0707

