WEST GTA Stroke Network

Dysphagia Screening Do's and Don'ts When Using the STAND Tool

- **Dysphagia: Difficulty swallowing**
- **SLP: Speech-Language Pathologist**
- **NPO: Nothing by mouth**
- **STAND: Screening Tool for Acute Neurological Dysphagia**

Do's

Complete dysphagia screening on all stroke patients before any oral intake (medications, food, liquid).

Make patient NPO and refer to SLP if patient fails dysphagia screening.

Repeat dysphagia screening only if patient failed due to reduced level of alertness (and alertness has subsequently improved).

Monitor patients at meals and report any difficulties to SLP (if involved), or request referral to SLP if not involved.

Don'ts

Do not continue screening tool if you answer "yes" to: *Patient has been evaluated by a SLP during this admission.* Refer to the SLP documentation.

Do no use STAND to "upgrade" patient currently on a modified diet. If the patient is on a modified diet, presume patient has dysphagia and defer to SLP.

Do not repeat STAND if patient has already failed (for any reason other than reduced level of alertness).

Do not use STAND if patient pulls out naso-gastric tube. Refer to SLP for assessment.

Canadian Stroke Best Practices

www.strokebestpractices.ca

The Canadian Stroke Best Practice Recommendations state that:

- Appropriately trained professionals should complete initial swallowing screening for all stroke patients using a validated screening tool to ensure patients are screened as early as possible ideally on day of admission.
- Abnormal results from the initial or ongoing swallowing screens should prompt referral to a speech-language pathologist for more detailed assessment and management.
- Patient family and caregivers should receive education on swallowing, prevention of aspiration, and feeding recommendations.