ABSTRACT
The assessment of a stroke patient’s ability to swallow plays an important role in the management, recovery and patient outcome in stroke. Nurses in the Neuroscience unit encounter this situation daily in caring for stroke patients. This nursing assessment is integral in providing adequate nursing care to prevent complications such as aspiration pneumonia.

INTRODUCTION
In effort to strengthen the reliability of nursing dysphagia screening assessment, Neuroscience Nurses utilized simple questionnaires to assess nursing awareness and appropriate use of current dysphagia screening. Empowering nurses’ utilization of a reliable dysphagia screening tool has a positive impact on patient outcomes, including decreased complications and length of stay.

OBJECTIVES
The purpose of this study was to evaluate the bedside nurses knowledge of the dysphagia screening tool and improve the current dysphagia screening process implemented for stroke patients.

METHODS
The study was conducted in the Neuroscience Center, a 48 bed mixed neuroscience unit with 12 Neuroscience Progressive Care beds and Comprehensive Stroke Center. The study reviewed the medical records of 18 patients diagnosed with TIA or stroke. Medical record review focused on initial dysphagia screening upon admission to the Emergency Department and Neuroscience Center. The medical record review examined the appropriate timing and utilization of dysphagia screening, timing of diet orders, factors affecting appropriate timing of diet orders and appropriate feeding restrictions. In addition, the nurses’ knowledge of the dysphagia screening tool was gathered through the questionnaire responses.

RESULTS
The nursing questionnaire revealed most nurses are aware of the initial dysphagia screening tool (attached with the stroke protocol) is initiated in Emergency Department. Nurses report being unable to initiate bedside dysphagia screening upon admission to Neuroscience Center; this indicates a lack of awareness and appropriate utilization of dysphagia screening at the bedside.

CONCLUSIONS
Further nursing education is needed on how to appropriately assess the patient’s ability to swallow with utilization of the dysphagia screening tool at the bedside. This affirms the need to establish a standardized, reliable, nurse-driven bedside dysphagia screening tool that nurses can easily administer.

FUTURE DIRECTIONS
Collect further data regarding Swallow Screening Tools that shows reliability and validity. Include peer review, collaborate with Speech and Language Therapy Department, Clinical Nurse Specialist and Nurse Research Scientist. Provide educational programs for nurses on topics such as swallow screening at the bedside. Coordinate education sessions with Speech Therapy and Clinical Nurse Specialist.

REFERENCES