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Age: 70 years Sex: M
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*National Simulation Health Service*
*Patient Admission Details*

*(Affix Patient Label Here)*

URN:

Family Name:

Given Name(s):

Address:

DOB: Sex:

## ADMISSION DETAILS

Date of Admission:

Admitting Details: 70YO ♂ PRESENTING WITH URINARY FREQUENCY, FEVER AND CONFUSION ?UTI

## PATIENT PERSONAL DETAILS

| Title: | MR | Surname: | PARKER | First Name: | JAMES |
|---|---|---|---|---|---|
| Other Names: | EDWARD | Preferred Name: | JIM | | |
| Address: | 15/238 DANIEL STREET | Suburb: | NEWTOWN | | |
| Home Phone: | 1825 6167 | Mobile Phone: | N/A | Work Phone: | N/A |
| Religion: | NIL | | | | |
| Primary Language: | ENGLISH | | | | |
| Occupation: | RETIRED | | | | |
| Medicare Number: | 5138 4627 127 | DVA Number: | N/A | Pension: | 4629 15373 |
| Private Health Fund: | AHM | Membership Number: | 2349 165784 3211 | | |

## MEDICAL HISTORY

Medical Conditions: DIABETES MELLITUS TYPE 2; BILATERAL MILD-MODERATE HEARING LOSS; RECURRENT CHEST INFECTIONS; PREVIOUS SMOKER ~ 30 YEARS – STOPPED AT AGE 50.

Current Medication: METFORMIN HYDROCHLORIDE 500MG B.D.

Allergies: NIL KNOWN

## CONTACTS

### First Emergency Contact

| Name: | MRS BETTY PARKER | Relationship to Patient: | WIFE | | |
|---|---|---|---|---|---|
| Home Phone: | 1825 6167 | Mobile Phone: | N/A | Work Phone: | N/A |

### Second Emergency Contact

| Name: | MR CHRISTOPHER PARKER | Relationship to Patient: | SON | | |
|---|---|---|---|---|---|
| Home Phone: | 0419 567 216 | Mobile Phone: | 0419 567 216 | Work Phone: | 0419 567 216 |

### General Practitioner (GP)

| Doctor Name: | DR CHRISTINE DAVIES | Practice: | UPTOWN GENERAL MEDICAL PRACTICE |
|---|---|---|---|
| Address: | 16/1440 THOMPSON STREET | Suburb: | UPTOWN |
| Work Phone: | 1081 2222 | Mobile Phone: | AS PER PRACTICE PHONE NO |

*National Simulation Health Service*

# PROGRESS NOTES INPATIENT

*(Affix Patient Label Here)*

URN:
Family Name:
Given Name(s):
Address:
DOB: Sex:

| DATE & TIME | *Add signature, printed name, staff category, date and time to all entries.*<br>MAKE ALL NOTES CONCISE AND RELEVANT<br>Leave no gaps between entries |
|---|---|
| DD/MM/YY | NURSING: 70yo ♂ admitted this am with UTI, dehydration and delirium. Presented with |
| XX:XXhrs | urinary frequency, fevers and confusion. PMHx: T2DM (managed with medication); mild- |
| | mod hearing impairment; recurrent chest infections; previous smoker ~30 years. SHx: Wife |
| | (Betty) very supportive. Lives at home – independent with all ADLs prior to admission. |
| | 3 sons live close by. Retired carpenter. ------------------------------------------------------------------ |
| | ATOR – fluctuating LOA. Assistance required for all cares. Limited oral intake. |
| | Occasional coughing on thin fluids and taking a long time to chew as per AIN report. IV line |
| | insitu. Meds given as charted. Bloods taken. Need to monitor oral fluids/intake. |
| | (JAMES) RN ---------------------------------------------------------------------------------------------------- |
| DD/MM/YY | NURSING: Fluctuating LOA. Confusion noted. Moist cough and low grade fever. |
| | Contacted MO to review. CXR requested by MO. CXR indicated R) lower lobe changes. |
| XX:XXhrs | Discussed with MO re: occasional coughing when eating and drinking ?aspiration. |
| | Swallow to be reviewed by speech path. Meds given as charted. (LEE, RN)----------------------- |
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National Simulation Health Service

# PROGRESS NOTES
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*(Affix Patient Label Here)*

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National Simulation Health Service

# PROGRESS NOTES
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*(Affix Patient Label Here)*

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National Simulation Health Service

# PROGRESS NOTES
# INPATIENT

*(Affix Patient Label Here)*

URN:

Family Name:

Given Name(s):

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DOB: Sex:

VFSS report on following page – do **not** insert in medical file.

Give to students on Day 4 afternoon before watching VFSS video. Ask students to file in medical file under *Investigations*.

National Simulation Health Service

# VIDEOFLUROSCOPY SWALLOW STUDY (VFSS) REPORT

URN:

Family Name:

Given Name(s):

Address:

Sex:

## Patient History

70yo male admitted with UTI and dehydration. PMHx: Type 2 Diabetes Mellitus, history of smoking (approx. 30 years, 10 cigarettes per day, quit age 50); recurrent chest infections. SHx: Lives independently with wife.

Current diet: Minced and moist diet and mildly thick fluids.

## Reason for VFSS Referral

Oropharyngeal dysphagia identified on clinical bedside examination. Inconsistent coughing post swallow. Febrile and right lower lobe changes on CXR on a background of recurrent chest infections ?aspiration.

## Previous VFSS studies

Nil

## Oromotor

All movements symmetrical. ROM adequate. Generalised weakness. Weak cough ? effectiveness. Voice quality – NAD. Natural dentition.

## VFSS Findings

**Trialled on**

1. Thin fluids, small sips
2. Thin fluids, larger bolus size
3. Mildly thick fluids
4. Bread
5. Diced fruit
6. Puree
7. Mildly thick fluids AP view with pan to stomach

Fluids

Sips of thin fluids - Adequate lip seal. Adequate soft palate movement and closure. Impairment in bolus containment on thin fluids as the bolus is seen to spill into the pharynx. Thin trials revealed delayed swallow initiation from level of pyriforms. Incomplete epiglottic deflection observed across trials. Adequate cricopharyngeal opening during the swallow however residue noted in pyriforms post swallow due to reduced pharyngeal clearance. Minimal residue in valleculae post swallow on small sips. Silent penetration of fluids during the swallow to the level of the vocal cords which is later seen to be aspirated. Trials of larger bolus size (large mouthfuls) revealed increased diffuse pharyngeal residue. Silent penetration during the swallow with subsequent aspiration post swallow. Prompted cough ineffective in clearing aspirated materials. Noted delayed small throat clear post one trial. Not effective. Pharyngeal residue mostly cleared with spontaneous and prompted clearing swallows.

Trials of mildly thick fluids revealed more timely swallow initiated from the level of valleculae. Mild valleculae residue post swallow partially cleared with spontaneous clearing swallow. No aspiration observed on sips of mildly thick fluids.

Penetration Aspiration Scale rating - Thin fluids: 8 (material enters airway, passes below vocal folds and no effort is made to eject)

Solids

Bread trial revealed lengthy oral stage and incomplete mastication. Sips of mildly thick fluids were required for bolus formation and to assist oral propulsion of bolus and swallow initiation (from the level of valleculae). Mild oral residue observed post swallow. Reduced pharyngeal stripping, hyolaryngeal excursion and epiglottic deflection resulting in residue in the valleculae and posterior pharyngeal wall requiring multiple secondary clearing swallows plus effortful swallow to

National Simulation Health Service

**VIDEOFLUROSCOPY SWALLOW STUDY (VFSS) REPORT**

URN:

Family Name:

Given Name(s):

Address:

Sex:

clear. Partially masticated bread seen in the pharynx with an open airway. No penetration +/- aspiration during the swallow however pharyngeal residue of poorly masticated solids put patient at high risk of choking.

Improved mastication, oral transit and propulsion observed on trials of diced fruit. Swallow initiated at base of tongue. Again, reduced pharyngeal clearance characterised by residue in valleculae and minimal coating on posterior pharyngeal wall. Improved from soft diet trials. Prompted secondary clearing swallow largely effective. Similar amounts of pharyngeal residue noted on puree trial.

Penetration Aspiration Scale rating - Solids: 1 (material does not enter the airway) – though residue places patient at risk post-swallow on soft diet.

AP - View

Symmetrical flow. No issues noted by radiologist regarding oesophageal stage.

## Impressions

Moderate oropharyngeal dysphagia characterised by reduced oral control and bolus formation, delayed swallow initiation, reduced pharyngeal efficiency and compromised airway protection. Requires modified fluid and diet consistencies plus strategies to optimise safety.

Requires ongoing speech pathology for dysphagia management and guide upgrades as appropriate. If dysphagia persists, recommend consideration of cause given medical history.

## Recommendations

1. Sips of Mildly Thick fluids and Minced and Moist diet
2. Secondary clearing swallows
3. Swallow rehabilitation in the community targeting oral control (oromotor training), swallow initiation (sensory stimulation), pharyngeal clearance (Masako exercise).

## Plan

1. Referral to community speech pathologist
2. Repeat VFSS 2-4/52. If no improvement consideration needed regarding cause of dysphagia.
3. Letter to GP to monitor chest status
4. Discuss findings with patient and wife prior to discharge

| **SPEECH PATHOLOGIST:** | **RADIOLOGIST:** |
|---|---|
| [signature] | [signature] |