

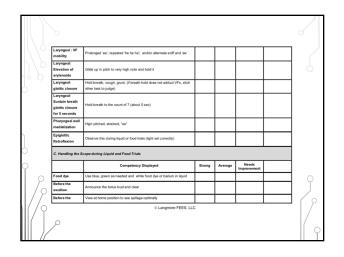


FEES COMPETENCIES TO ATTAIN DURING TRAINING								
Name:	Date:							
A. Technical Skills (assessed during FEES course)								
	Competency Displayed	Strong	Average	Needs Improvement	Assessors Initials			
	Handles scope with care; doesn't 'kink" the flexible part							
	Able to administer topical anesthesia and decongestant correctly							
	Able to pass with correct hand position on left or right side of patient							
	Anchors with finger on the face without obstructing patient's eyes or mouth							
	Able to pass along the floor of nose at reasonable speed							
	Able to move from nasopharynx (VP port) to home position w/out touching the lateral walls or base of tongue with good speed							
	Able to maintain a good view in home position and to return to home position frequently							
	Able to scan the entire HP to view anatomy, secretions, residue, or medical pathology							



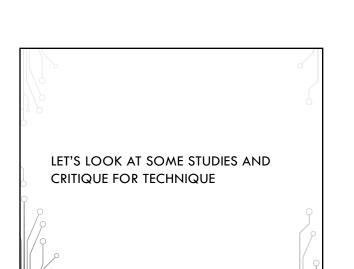
	Able to pass to the laryngeal vestibule and view the subglottic shelf w/out the epiglottis, AE folds, or arytenoids				
	Able to pass quickly to the laryngeal vestibule, scan the vestibule for penetration or aspiration and withdraw quickly				
	Able to pass to the laryngeal vestibule and touch the arytenoids for sensory testing, without touching the other structures.				
	Able to withdraw the scope completely w/ the thumb released, smoothly and at a comfortable speed				
B. Anatomic- Phy	siologic Assessment: Ability to elicit the non-swallow tasks by dem	onstration a	nd observe t	he response	
	Competency Displayed	Strong	Average	Needs Improvement	Assessor's initials
Velopharyngeal closure	Repeated 'puh puh', 'fifty fifty', etc.				
Base of tongue	"Paul is tall", etc.				
Handling of Secretions and swallow Frequency	Observe inside/outside laryngeal vestibule				
Laryngeal: breathing rate, pattern if abnormal	Observe with good view				
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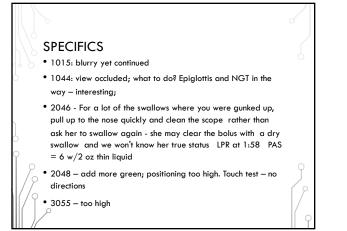






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Swallow			
During the Swallow	Withdraw the scope a little if barium used		
After the swallow	Pan around to view all residue;		
After the swallow	Wait for spontaneous clearing swallow		
After the swallow	Move down to vestibule quickly to view penetration/ aspiration; withdraw as soon as appropriate		
After the swallow	If optimal view not obtained at any time, repeat the trial		
<u>Notes:</u>			
	a		







PRACTICE SCORING VIDEOS: MOSTLY ICU PATIENTS/ EXTUBATED

*1010 – ASPIR 10.39 – PENETRATION; LPR *2018 – DELAY AND WEAK *2033 – PERSISTING PENETRATION *3040 – ASPIR DUR DELAYED COUGH *4019 – LONG DELAYS *8004 – DELAY ASPIR THIN

DYSPHAGIA DUE TO INTUBATION?

• Evidence from ICU intubated/extubated patients with no premorbid dysphagia: Clinical Trial from Denver; publication by Scheel; Brodsky study

COMMON PATTERNS OF DYSPHAGIA IN THE ICU -- IF NO PREMORBID DYSPHAGIA

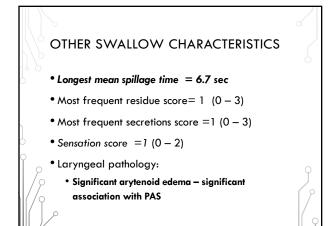
Scheel et al, 2015 (Ann Oto Rhin Laryn)

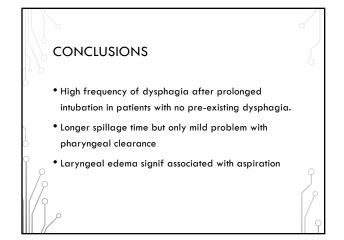
• 59 patients FEES within 72hrs of extubation (3 days)

• Descriptive study: what were patterns/ frequency of aspiration/ predictors of aspiration

RESULTS

- Penetration / Aspiration
 - If <24 hrs post-extubation: 36% penetrated; 22% aspirated
 - If >24 hrs post extubation: 60% penetrated/aspirated
 - When did aspiration occur?
 - Before or during swallow
 What does this suggest??





CLINICAL TRIAL JUST COMPLETED

- Mark Moss, MD = PI. U Col (Pulmonologist)
 - Boston Med Ctr, U Colorado, Yale, Stanford participated
- Bedside clinical eval results compared to FEES (done 1 hour after bedside exam). How sensitive? Do we need FEES?
- Initial results = YES, FEES adds info not seen in the BSE