

***\*\*Patient needs to be alert enough to eat/drink and well positioned. If patient is not alert, continue with regular mouth care and liaise with consultant about how short-term medication, nutrition and hydration needs will be met, then re-screen once alert enough\*\****

Screen to be completed within 72 hours of having had surgery, but ideally on admission. Please ensure this screen is then placed in medical notes.

***Trauma Dysphagia Screening Tool***

***For all patients with Femoral or Spinal Fracture***

Patient Sticker

|  |  |  |
| --- | --- | --- |
|  | Y | N |
| Acute chest infection or history of recurrent chest infections | **□** | **□** |
| Acute delirium | **□** | **□** |
| History of unexplained weight loss or high MUST score  | **□** | **□** |
| Rockwood Frailty Score of 5 or above | **□** | **□** |
| Acute O2 requirement/respiratory support e.g. nasal specs/mask, high-flow O2 etc. | **□** | **□** |
| Complex chest injuries | **□** | **□** |
| Poor mouth care  | **□** | **□** |
| Schizophrenia  | **□** | **□** |
| Learning Disability | **□** | **□** |
| Moderate-severe heart failure  | **□** | **□** |

**IF ANY OF THE ABOVE CONSIDER SPEECH & LANGUAGE THERAPY (SLT) REFERRAL**

|  |  |  |
| --- | --- | --- |
|  | Y | N |
| Hard collar, C1-C7 spinal fracture, or anterior cervical spinal surgery   | **□** | **□** |
| Pre-existing oro-pharyngeal dysphagia  | **□** | **□** |
| Patient/staff/family have raised swallowing concerns e.g. coughing whilst eating/drinking, choking, wet/gurgly voice during/after eating drinking | **□** | **□** |
| Previous or current respiratory or neurological comorbidity e.g. stroke, Parkinson’s, dementia, COPD etc  | **□** | **□** |
|  |  |  |

**IF ANY OF THE ABOVE ARE PRESENT, EVIDENCE WOULD STRONGLY RECOMMEND SLT REFERRAL**

**ACTION:**

|  |  |
| --- | --- |
| Normal Diet + Normal Fluids |  |
| Monitor and re-screen as indicated e.g. if clinical status changes or swallowing concerns arise. |  |

**NO SLT REFERRAL INDICATED**

|  |
| --- |
| Patient has no red or amber markers |
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|  |  |
| --- | --- |
| Referred as ‘Service Order’ on Careflow EPR | **□** |
| Why not referred……………………………… | **□** |

y

If suspected oesophageal dysphagia, discuss with gastroenterology department as appropriate.

**IF REFERRING TO SLT, DISCUSS THE FOLLOWING WITH CONSULTANT OR REGISTRAR WHILE AWAITING SLT ASSESSMENT. DOES PATIENT HAVE CAPACITY? No □ Yes □**

**PATIENT HAS CAPACITY, AND DISCUSSED OPTIONS WITH THEM. □ BEST INTERESTS DISCUSSION WITH NOK □ CONSIDER DIETITIAN AND PHARMACY INPUT AS REQUIRED. TICK OPTION THAT IS AGREED ON AND INFORM NURSING STAFF:**

a) NBM – with artificial nutrition as medical team advise (NGT/NJ/TPN/IV fluids etc). Mouth care every two hours **□**

d) Normal Diet + Normal Fluids **□**

c) Water + Level 6 Diet (Soft & Bite Sized) **□**

b) If previously on modified diet and fluids, continue with these recommendations. **□**

**DATE: TIME: SIGNED & DESIGNATION:**