The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

SWALLOW SCREENING FOR TRACHEOSTOMISED ADULT PATIENTS

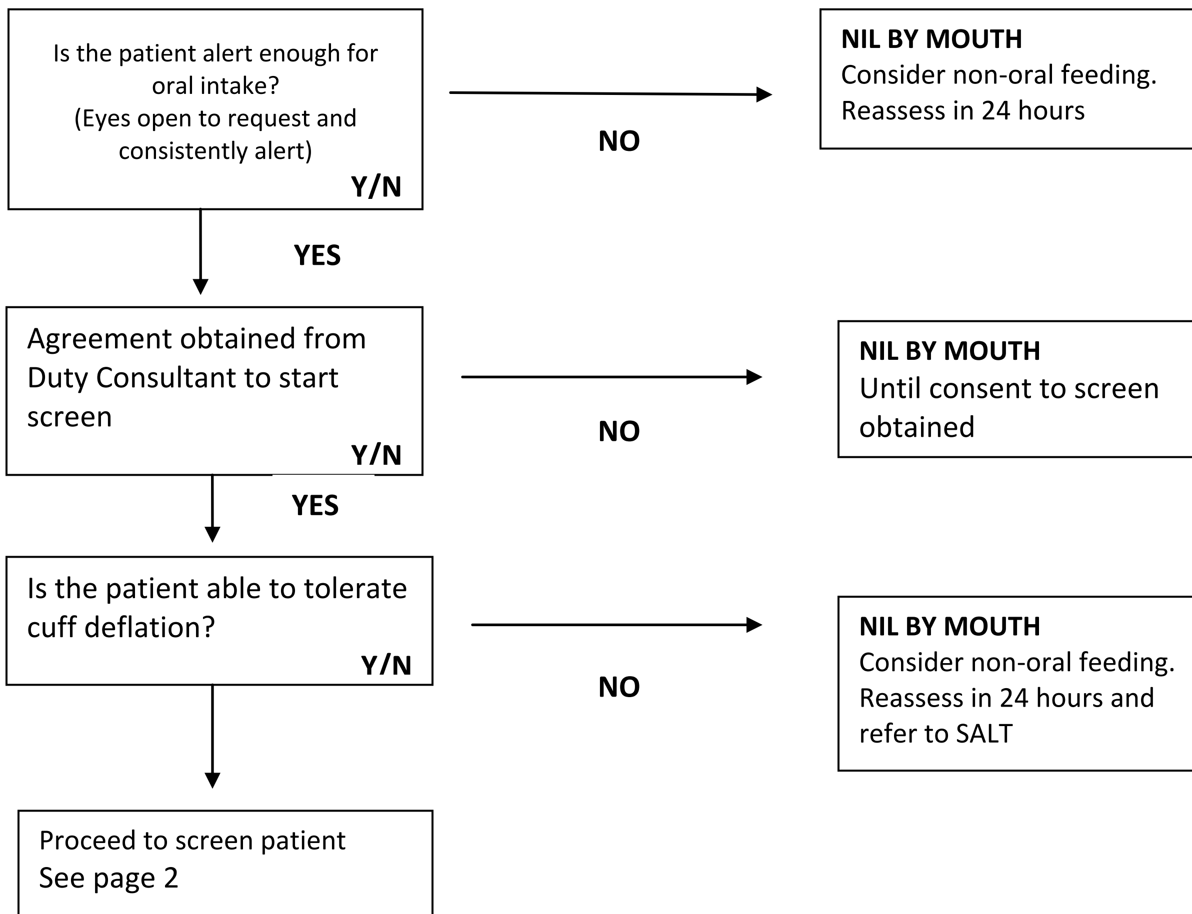
For use with tracheostomised patients who have been nil by mouth before starting oral intake

PLEASE AFFIX PATIENT LABEL

PRE-SCREEN CHECKLIST

Question	Y	N
Does the patient have neurological impairment?	Y	N
Has the patient undergone head or neck surgery?	Y	N
Has the patient previous known dysphagia e.g. modified diet or fluids	Y	N

If answer yes to any of the above DO NOT proceed with screen and refer to Speech and Language Therapy (SALT)



SCREENING TOOL

IF AT ANY STAGE YOU ARE CONCERNED OR NEED ADVICE, PLEASE REFER TO SPEECH AND LANGUAGE THERAPY ON EXTENSION 24324 (RVI), 38270 (FRH Neuro) or 31644 (FRH ENT).

FLUIDS (using water)

1st tsp ☐

2nd tsp ☐

Sips up to 50ml ☐

Give patient glass of water ☐

Please indicate any difficulties (can be more than one)

Coughing ☐ Choking ☐ No attempts to swallow ☐ Wet/gurgly voice after drinking ☐

Breathlessness/respiratory difficulty ☐ Drooling ☐ Drinks come back out of nose ☐

Evidence of fluids on tracheal suctioning ☐ Other (please specify) ☐ ________________________________

PASS ☐ - continue to diet section of screen – see below

FAIL ☐ - stop screening if ticked at least one of the boxes above, place NBM and refer to SALT. Refer to Dietitian

DIET

Item	Pass	Fail
Yoghurt (at least ½ pot) - puree	PASS ☐ continue screen	FAIL ☐ stop, NBM; refer to SALT
Bread (at least ¼ slice) - soft	PASS ☐ continue screen	FAIL ☐ **Puree diet**; refer to SALT
Biscuit (at least 1 biscuit) - normal	PASS ☐ continue screen	FAIL ☐ **Soft diet;** refer to SALT

Please indicate any difficulties (can be more than one)

Excessive chewing ☐ Inadequate chewing ☐ Food left in the mouth ☐

Food spat out ☐ Eating at inappropriate speed ☐ No attempts to swallow ☐

Coughing ☐ Choking ☐ Wet/gurgly voice after swallowing ☐

Feeling of food sticking in the throat ☐ Breathlessness/respiratory difficulty ☐

Evidence of food on tracheal suctioning ☐ Other (please specify) ☐__________________________________

Outcome of screen: **NBM** ☐ **Oral Intake** ☐

Diet texture (please circle) Puree Soft Normal

If there is any deterioration in the patient's condition, please repeat screening assessment.

Nurse completing screen (print name): ____

Date and time screen completed: ____

Ward: ____

Please file in medical notes

PLEASE REFER ANY COMMUNICATION PROBLEMS IMMEDIATELY TO SPEECH & LANGUAGE THERAPY