X8036 10/11

Patient Label

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

DYSPHAGIA SWALLOW REFERRAL

FAX THIS REFERRAL TO SLT Dept - 07 571 6098
Please include FRONT COVER of Assessment to Discharge Planner

Referred by:	Ward:
Date:	Time:
This patient also needs to be seen for communication assessment: YES / NO	

REFERRALS RECEIVED BY 8.30AM WILL RECEIVE PROMPT ATTENTION
NATIONAL STANDARDS RECOMMENDS THAT PATIENTS WILL BE SEEN WITHIN 2 DAYS OF REFERRAL

Please answer all questions before referring a patient for swallow assessment:

IS THE PATIENT AWAKE AND ALERT? CAN THEY BE SAT UPRIGHT?

YES

- ☐ Seat as upright as possible [A]
- ☐ Note if they can cough to command [B]
- ☐ Have you noticed them swallow their saliva [C]
- ☐ Trial 1 x sip of water & observe

Cause for Concern:

- ☐ No attempt to swallow
- ☐ Water leaks straight out
- ☐ Coughing / choking
- ☐ Wet / gurgly voice
- ☐ Breathing changes

Any Concerns?

- ☐ Place patient Nil by Mouth and send this to SLT
- ☐ Use oral hygiene tool

No Concerns

Give ½ glass water and observe. If no concerns, begin normal fluids and pre-admission diet

Observe First Meal:

If any concerns place NBM and refer to SLT. Continue to monitor and repeat screen if deterioration occurs

NO

REPEAT SCREEN IN 24 HOURS

Regular Oral Hygiene

Keep Nil by Mouth

If still NO in 24 hours:

- ☐ Discuss enteral feeding with the medical team
- ☐ Continue NBM
- ☐ Regular Oral Hygiene
- ☐ Referral to Oral Hygiene Tool

** Refer to Rationale overleaf*

Dysphagia Screen Rationale

A. Alert?

Is the patient able to maintain alertness? A patient needs to be alert to their environment to be fed. They need to be able to indicate they are ready to receive food into their mouth, (e.g. opening their mouth, licking lips etc.). They also need to be able to stay alert long enough to swallow any food/fluid that is given.
The patient needs to be able to follow 1-step commands to pass this question. E.g.: close your eyes / open your mouth. If the patient is too confused or unable to respond, then answer "no".
Rationale: A patient needs to be aware and attentive to the feeding process due to the voluntary components of swallowing. A patient should not be offered food or fluids if they are not alert enough to swallow it safely.

Can be maintained in upright position?

A patient needs to be able to sit upright (90% flexed at hip) independently for about 20 - 30 min. Ideally the patient should sit in a chair, otherwise the back of the bed needs to be as high as it will go. Pillow can be used to keep the patient in this position, but please check with Physio/OT guidelines first. The patient needs to be able to keep their head facing forward, not extending back or to the side.
Rationale: incorrect positioning can lead to increased difficulties with swallowing as head and neck position influence the anatomy of the oral, pharyngeal and laryngeal cavities. Adequate trunk alignment is important for good respiratory support to enable effective coughing.

B. Can cough strongly on request?

Instruct the patient to take a deep breath and cough as hard as they can. The cough should be loud. If they are only able to throat clear, hawk, or forced expiration (no voicing) then answer "no".
Rationale: There needs to be a reasonable amount of force to expel material from the airway. Voicing is required because when you cough your vocal folds come together strongly. The meeting of the vocal folds is one of the 4 levels of airway protection.

Chest clear? Medical team has documented.

You are not expected to listen to the patient's chest, but please check the medical notes to see that there is no chest infection documented.
Rationale: Aspiration pneumonia can be the result of reduced airway protection and other types of pneumonia can reduce the effectiveness of airway protection mechanisms e.g. reduced ability to cough and expel material from the airway.

C. Coping with own saliva? |

Is the patient drooling a lot, and not swallowing their saliva at regular intervals? If their voice or breathing sounds wet and bubbly, their saliva may be pooling around their airway. Saliva can be aspirated if it is pooling in the pharynx, and will often take with it pathogens from the oral cavity.
Rationale: If a patient is unable to control and swallow their own saliva, then it is unlikely they will be able to do this with any food or fluids that you give to them.

Can swallow saliva on request?

Place your fingers above and below the Adam's apple (the Cricoid cartilage of the larynx). Ask the person to swallow and feel the movement of the larynx. It should move quickly up and slightly forward. In an adequate swallow, the larynx should move about 2-2.5 cm (about 1-2 finger widths).
Rationale: Good laryngeal movement is a good indicator of an adequate pharyngeal stage of swallowing.

Signs and Symptoms

Obvious Aspirators	Choking Changing Colour Coughing Excessively Wet & Gurgly Voice Drooling
Subtle Aspirators	Throat clearing/weak cough Multiple Swallowing Watery Eyes Increased SOB Food pocketed in mouth
Silent Aspirators	®LL Consolidation Weight loss Hx pneumonia Temperature Spikes Decreased SpO_2 Saturation

Please refer to the **Nurses Dysphagia Module** on **Moodle** for full training.