# GUIDE FOR SUPPORTING

# *Pediatric Feeding Disorders in Schools*

***Emily M. Homer, CCC-SLP, ASHA Fellow***

# *Meet Emily Homer*

*Emily M. Homer, CCC-SLP, ASHA Fellow, worked in St. Tammany Parish public school system for 42 years where in 1996 they established a step-by-step procedure for addressing swallowing and feeding. Ms. Homer currently consults with school districts, state departments of education, and school-based SLPs on establishing a district-approved team procedure for addressing PFDs. She was awarded Fellowship of the American Speech, Language and Hearing Association (ASHA), 2018 and the1999 Louis M. DiCarlo Award for this work. She is the author of Management of Swallowing and Feeding Disorders in Schools, by Plural Publishing and has presented nationally at ASHA Conventions, State conventions, and webinars. She has authored numerous articles in professional journals on the topic.*

# Statement from Emily Homer

The Guide for Pediatric Feeding Disorders in the Schools has been designed to provide State Departments of Education information and support for school districts in their state to establish and implement a team procedure for addressing swallowing and feeding disorders.

It is my hope that this guidebook empowers states, individual school districts and their professional staff  to embrace providing pediatric feeding disorder services to students. The procedure and forms shared in this book have been used successfully in school districts throughout the country for over 25 years.

This guidebook is available to State Departments of Education and individual school districts that they may adapt it according to their needs and vision. (see directions for customization).

I want to commend the members of the Arkansas Department of Education and Arkansas Easter Seal Outreach Program committee members whose generosity of time, hard work, and talent brought this document into being. They did a wonderful job!

I am committed to safe mealtimes for children at school and am available to assist in the establishment and implementation of a procedure for addressing swallowing and feeding. You may contact me by going to my website, emilymhomer.com. and completing the contact form.

# *Acknowledgements*


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# *Purpose of this Guide*

Safe swallowing and feeding are critical to providing adequate nutrition for life-sustaining activities. To keep all children safe and ready to learn, this document is intended to provide education professionals with guidance to meet the needs of students with pediatric feeding disorders within educational settings in Arkansas. The information provided utilizes a team approach for the implementation of high-reliability strategies resulting in consistent and safe feeding practices as part of building a safe, supportive, collaborative culture (Marzano, 2018). The guidance is presented at an introductory level and is intended for use by administrators, teachers, school nurses, related services, food service managers, and other school personnel. This document is not a substitute for the in-depth knowledge and training needed by personnel providing direct feeding and swallowing services, nor is this document regulatory.

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# MEET JOEL!

Joel, a student with extensive support needs, struggles to eat and drink at lunch. He sits in his wheelchair at the end of the cafeteria table, drinks thin liquids (IDDSI level 0), and eats a regular lunch tray cut up into bite sized pieces (IDDSI level 7). Due to fine motor and coordination challenges, he requires assistance from an adult for self-feeding. He uses an adapted spoon, plate with a lip, and a cup with a straw.

The paraprofessional notices Joel coughing and his eyes watering during lunch. She also thinks he has lost weight since the beginning of school. After mentioning her concerns to Joel's teacher, the school speech-language pathologist and occupational therapist are contacted for support. The speech-language pathologist observes Joel at lunch and notes signs of dysphagia and aspiration. Concerned with Joel's safety with swallowing and feeding, she convenes a team to meet that afternoon to develop an action plan.

# SECTION 1

## *General Information on Pediatric Feeding Disorders*

**PEDIATRIC FEEDING DISORDER (PFD)** is defined by the World Health Organization's International Classification of Functioning, Disability, and Health (IFC) as: impaired oral intake that is not age-appropriate, and is associated with medical dysfunction, nutritional dysfunction, feeding skill dysfunction, and psychosocial dysfunction.

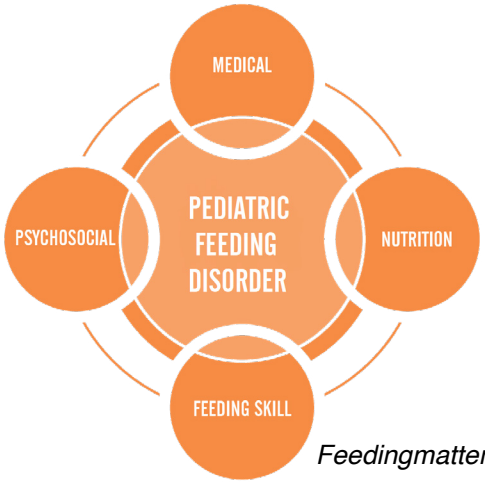
### *The term Pediatric Feeding Disorders & ICD Code for PFD is supported by:*

- The American Academy of Pediatrics
- American-Speech-Language-Hearing Association
- The American Occupational Therapy Association
- The National Coalition for Infant Health

*Feedingmatters.org*

## DIAGNOSTIC CRITERIA

A disturbance in oral intake of nutrients, inappropriate for a child's chronological age (vs. developmental age), lasting at least 2 weeks and associated with 1 or more of the following:




*Feedingmatters.org*

### *Medical Dysfunction*

- Cardiorespiratory compromise during oral feeding
- Aspiration or recurrent aspiration pneumonitis

### *Nutritional Dysfunction*

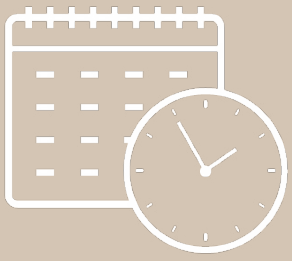
- Malnutrition
- Specific nutrient deficiency or significant restricted intake of one or more nutrients resulting from decreased dietary diversity
- Reliance on enteral feeds or oral supplements to sustain nutrition and or hydration

### *Feeding Skill Dysfunction*

- Need for texture modification of liquid or food
- Use of modified feeding position or equipment
- Use of modified feeding strategies

### *Psychosocial Dysfunction*

- Active or passive avoidance behaviors by child when feeding or being fed
- Inappropriate caregiver management of child's feeding and/or nutrition needs
- Disruption of social functioning within a feeding context
- Disruption of caregiver-child relationship associated with feeding



***Symptoms are classified as***

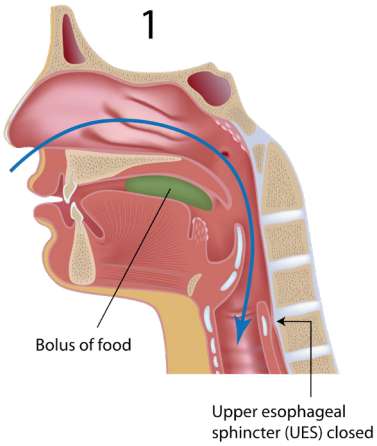
**ACUTE PFD**
duration less than 3 months
**-3 Months**

**CHRONIC PFD**
duration greater than 3 months
**+3 Months**

*Goday et al. 2019*

***The process of feeding and swallowing depends on highly complex and integrated sensorimotor systems and is considered one of the most intricate functions of the human body. It can be described in four phases.***

# PHASES OF SWALLOWING

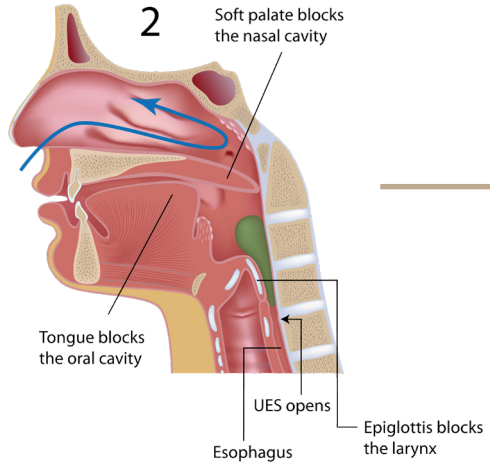



### *Oral preparatory*

This is a volitional phase during which food or liquid is manipulated in the mouth to form a cohesive bolus. This includes sucking liquids, manipulating soft boluses, and chewing solid food.

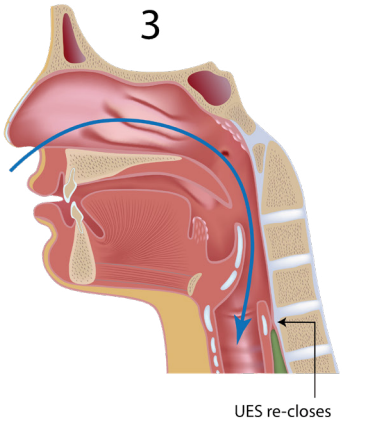
### *Oral transit*

This is a voluntary phase that begins with the posterior propulsion of the bolus by the tongue and ends with the initiation of the pharyngeal swallow.




### *Pharyngeal*

This phase begins with a voluntary pharyngeal swallow that, in turn, propels the bolus through the pharynx via an involuntary contraction of the pharyngeal constrictor muscles.




### *Esophageal*

This is an involuntary phase during which the bolus is carried to the stomach through the process of esophageal peristalsis.

***For schools, this includes students who:***

- Have dysphagia (oral preparatory, oral transit, pharyngeal or esophageal)
- Fail to master self-feeding skills expected for developmental levels or unable to use developmentally appropriate feeding devices and utensils
- Experience less than optimal growth
- Have behaviors (food aversions, food jags) that result in a limitation of the foods that they eat
- Need someone to assist them with eating at school (directives as to food choices, amount on spoon, food to drink ratio, pacing, etc.)

*Pediatric feeding disorders occur in all age groups, from newborns to school age, and can occur as a result of a variety of congenital abnormalities, structural damage, and neurological disease or disorder.*


## PREVALENCE OF CHILDREN WITH PFD:

**90%** Up to 90% of Children Diagnosed with Autism Spectrum Disorders

**80%** Up to 80% of Children Diagnosed with Developmental Delays

**26%** 26% of Premature Children

**25%** 25+% of Typically Developing Children (Picky Eaters)

**19.2-99.0%** 19.2-99% of children with Cerebral Palsy (Rates increase with greater severity of cognitive impairment and decline in gross motor function)

**50-80%** 50-80% of children with Down Syndrome

## Health Concerns most typically associated with PFD include the following:

- Choking
- Aspiration and aspiration pneumonia
- Undernutrition
- Dehydration
- Frequent illness and absences from school

## Students most at risk for PFD:

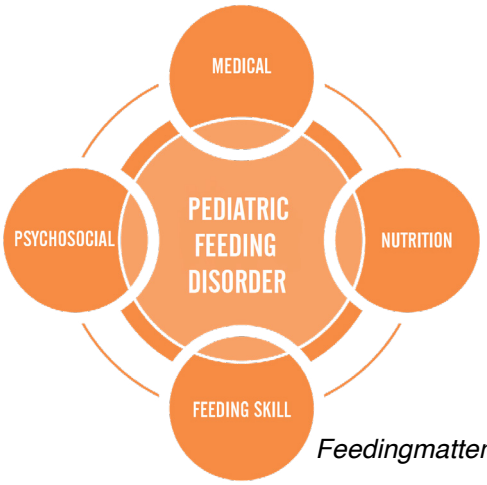
- Issues from birth: prematurity, low birth weight
- Developmental disabilities
- Complex medical conditions (history of cardiac or other surgeries)
- Neurological disorders (cerebral palsy, TBI, etc.)
- Neuromuscular disorders (muscular dystrophy, spinal muscular atrophy)
- Genetic syndromes (Down Syndrome, Hunter syndrome, Batten Disease, etc.)
- Structural abnormalities (cleft palate, paralyzed vocal cord)
- Sensory issues
- Psychosocial dysfunction or behavioral feeding concerns
- Autism
- Cognitive deficit
- Medication side effects (e.g., lethargy, decreased appetite)

Joel has a diagnosis of spastic cerebral palsy, which puts him at greater risk for PFD

When eating, children can display *sensory issues* that impact oral intake at school. Sensory issues include having decreased or increased sensitivity to:

- Texture
- Temperature
- Taste
- Visual presentation
- Sound
- Smell

# *Signs And Symptoms Of PFD* BY DOMAIN




*Feedingmatters.org*

### *Feeding Skills*

- Need for special preparation or texture of food (IDDSI levels)
- Unable to self-feed
- Extremely short mealtimes
- Extremely long mealtimes
- Need for specialized feeding equipment and utensils
- Need for positioning support during mealtimes
- Need for specialized strategies to eat
- Does not process food in the mouth (stuffs) due to sensory or motor deficits
- Difficulty chewing

***> Click for more information***

### *Nutrition*

- Unable to eat or drink enough to grow or stay hydrated
- Insufficient or too rapid of a change in weight or height
- Lack of a certain nutrient, i.e., iron, calcium, need for nutritional supplements
- Reliance on a particular food for nutrition
- Need for enteral feeds for nutrition-NG, GT, TPN
- Constipation
- Limited dietary diversity for age:
  - Too few fruits and/or vegetables
  - Limited or no protein source
  - Too few foods eaten on a regular basis

***> Click for more information***

### *Medical*

- Chronic respiratory concerns or acute illnesses such as pneumonia
- Coughing/choking during or after swallowing
- Drooling
- Poor oral motor functioning
- Nasal regurgitation
- Wet/gurgly airway sounds following eating or drinking
- Difficulty initiating swallowing

***> Click for more information***

### *Psychosocial Dysfunction*

- Refusal to eat:
  - all foods
  - food presented
  - with others
- Appears stressed, worried, fearful during mealtimes
- Behavioral challenges resulting in unpleasant mealtime
  - Child: disruptive behaviors
  - Caregiver: need to bribe, coerce, distract

***> Click for more information***

***The International Classification of Functioning, Disability and Health (ICF)*** is the international standard for framing disability and conceptualizing function as the interaction between health, the environment, and their personal factors (World Health Organization, 2013). Looking through the bio-psycho-social lens of the ICF-Framework yields critical information needed to inform the school team in determining a student-centered approach to swallowing and feeding concerns in school (ASHA, n.d.).

# *Joel*

CEREBRAL PALSY I 10 YEAR OLD MALE

### *Body Functions & Structure*

- Dysphagia-difficulty coordinating oral structures, delayed swallow
- Fine and gross motor coordination impairments, ataxia
- Fair head control
- Dysarthria-difficulty producing verbal speech

### *Activity Limitation*

- Holding and coordinating utensil use (speed, accuracy)
- Swallowing: safely receiving oral intake of liquid and solid food (coughs, watery eyes)
- Socializing with adults and peers

### *Participation Limitations*

- Self-feeding and eating at school
- Sustaining adequate hydration and nutrition for learning
- Interacting with peers and adults while eating at school, including expressing health and feeding concerns

### *Environmental Factors*

- Eats in the cafeteria during 30 minute lunch period
- Sits in his wheelchair at the end of the table with peers his age
- Eats level 7 diet and drinks level 1 liquids
- Uses special utensils and a straw to eat
- Paraprofessional to assist with feeding
- Paraprofessional has been trained to use feeding utensils

### *Personal Factors*

- Caregiver feeds regular diet at home and prefers to feed him rather than allow to self-feed
- Occasionally refuses to eat by shaking head “no” and has said he is afraid, will sometimes say he does not feel well
- Caregiver is not concerned with weight or feeding ability
- Has a little brother
- Loves to go to recess and will stop eating when students begin to leave for recess

# SECTION 2

## *Foundations for Addressing Pediatric Feeding Disorders in the School Setting*

There are four foundations for addressing swallowing and feeding that provide the basis for establishing safe eating at school for children with PFD.

1. Rationale
2. Administrative Support
3. Step-by-step Process
4. Interdisciplinary Team Approach

# FOUNDATION #1: RATIONALE

*Understanding the importance and necessity of addressing PFD in schools is essential.*

## FIVE REASONS SCHOOL DISTRICTS ARE RESPONSIBLE FOR PROVIDING THESE SERVICES:

1 Student safety: The school district has an obligation to provide a safe environment for students while they are at school, including during mealtimes.

2 Individuals with Disabilities Education Act (IDEA) and Section 504 regulations require districts to provide a free and appropriate public education (FAPE) to students with disabilities. Related services level the playing field for students with disabilities. Health, as a related service, is required to be provided when determined necessary for a free and appropriate public education (FAPE).

3 Case law implications: Two Supreme Court cases and several state cases support the responsibility of school districts for providing health services that allow students to stay in school and access their curriculum, when those services do not require a physician.

4 United States Department of Agriculture (USDA) School Food and Nutrition Service (FNS) regulations require that food service programs provide modifications for students with identified needs.

5 Code of Ethics for professional personnel in the schools including speech-language pathologists (SLPs), occupational therapists (OTs), physical therapists (PTs), and school nurses require that those professionals provide for the welfare of their clients and have or get the competency to provide services required as part of their scope of practice or job responsibilities.

- ASHA: “individuals shall honor their responsibility to hold paramount the welfare of the persons they serve professionally.”
- AOTA: “an obligation to not impose risks of harm even if the potential risk is without malicious or harmful intent.”
- NASN: “school nurses actively promote student health, safety, and self-worth”
- APTA: “physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients and clients over the interests of physical therapist”

## FOUNDATION #2: ADMINISTRATIVE SUPPORT

*Implementing a district-approved swallowing and feeding procedure requires administrative support.*

The approval process will vary from school to school. Some important stakeholders to consider when seeking administrative support include:

- Superintendents
- Supervisor/Director of Special Education
- Supervisor/Director of Child Nutrition Programs
- Coordinators or lead therapists in the district including SLPs, OTs, PTs, and school nurses
- Principals

### THE ROLES OF ADMINISTRATION IN PROVIDING THESE SERVICES INCLUDE THE FOLLOWING:

- Approving a district-wide swallowing and feeding procedure that is used with all students with signs of PFD.
- Providing funds for instrumental swallow studies and equipment such as blenders, slow flow cups Nuk brushes, etc.
- Providing support when there are parental concerns in the form of meeting with parents, attending meetings with the school swallowing and feeding teams, and providing access to legal counsel when needed.
- Coordinating professional development for staff who need to update their knowledge and skills related to PFD.

# FOUNDATION #3: STEP-BY-STEP PROCESS WITH ACCOMPANYING FORMS

*For consistency across the district, the district team should consider a step-by-step process.*

## *Benefits of a Step-by-Step Process*

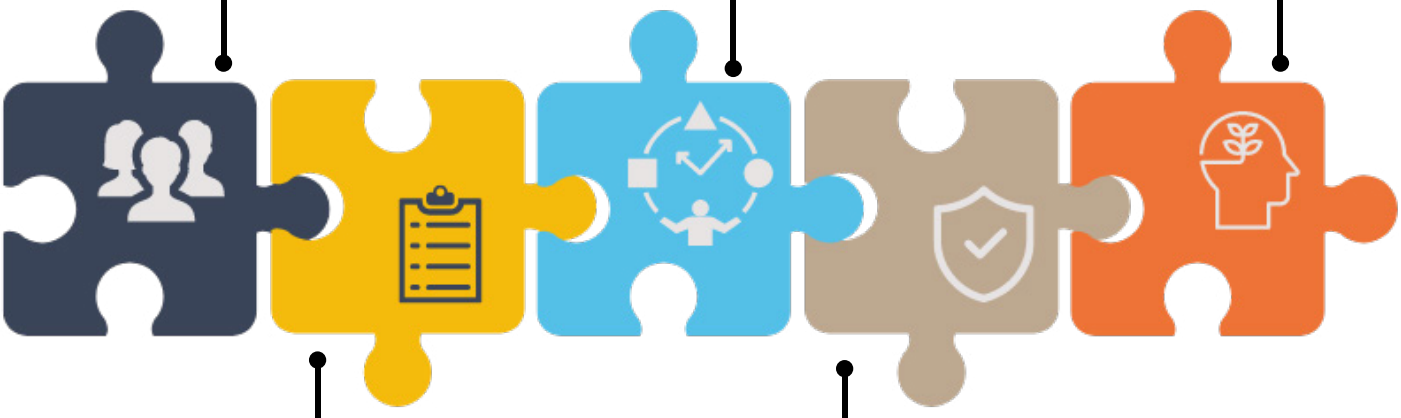
- Creates consistency throughout the school district
- Accountability of staff through clarification of roles and responsibilitie
- Documentation will ensure that the process is provided consistently
- Establish a safe mealtime environment for students with PFD

## ESSENTIALS OF A STEP-BY-STEP PROCESS

*Interdisciplinary approach with clarification of roles and responsibilities*

*Routinely monitor, train, and collaborate to ensure safety of every student identified as being at risk*

*Provide ongoing professional learning to classroom and itinerant staff*



*Documentation*
*(See attached examples)*

*Develop a safe eating plan unique to each student*

# *Essential Steps to a Swallowing and Feeding Procedure in the Schools and Personnel Responsible*

1. *Observation Request Form* is submitted to team leaders. After obtaining consent, an informal observation of the student eating is performed (SLP).

2. *Caregiver Interview form* is sent home in preparation for the interview that will be conducted by the SLP and school nurse.

3. *Interdisciplinary Assessment* is conducted and includes: general observations, oral motor observations, and swallow/food trials (SLP, OT, PT, school nurse).

4. *Safe Eating Plan* is established and classroom staff trained (SLP, OT, PT). Individualized Health/Emergency Plans are written by the school nurse (Nurse training).

5. *Cafeteria Procedure* is initiated and implemented (cafeteria manager and staff, SLP).

6. IEP meeting is held and physician release/ communication form is signed (teacher, parents, SLP, OT, PT, school nurse, principal).

7. Student is referred for an *instrumental evaluation* if indicated (SLP and OT).

8. *Safe Eating Plan* is revised, when indicated by results of the swallow study (SLP, OT, PT, school nurse), or whenever there is a change in the student's eating skills.

9. Consultation to maintain safety is scheduled and implemented (SLP, OT). Therapy to improve functional skills is initiated, when indicated (SLP, OT).

# *School Setting vs. Medical Setting*

*Team members who address swallowing and feeding in the schools often have experience in the medical setting. It is useful to know the differences between the two settings.*

*The following chart identifies distinctions and areas of potential overlap between the two settings.*

| MEDICAL SETTING | vs | SCHOOL SETTING |
|---|---|---|
| **High % of workload is dysphagia. This results in more experience and skills in the area of feeding and swallowing.** | *Frequency, experience* | **Small % of workload is dysphagia. This results in less experience in the area of feeding and swallowing.** |
| **Primarily acute care: Stroke, dementia, cancer, Parkinson's disease, and other adult-onset disorders, newborn/ infants, prematurity, neurologic involvement, anatomic and structural, genetic, and complex medical conditions** | *Diagnosis* | **Primarily chronic care: Neurological disorders (i.e. cerebral palsy), syndromes (i.e. Down syndrome), developmental delays, and behavioral feeding disorders** |
| **Hospitals, skilled nursing facilities, and outpatient hospital services.**<br><br>**Patients are typically seen for a limited amount of time and then discharged.** | *Setting and length of care* | **Students with disabilities are served from 3 years of age until 21 years in the school setting.**<br><br>**A student with dysphagia could receive services for as long as 18 years.** |
| **On-site medical support includes nurses, physicians (ENTs, neurologists, pulmonologists, gastrointestinal doctors), and dieticians.** | *Support staff* | **Minimal on-site medical support. The school nurse is typically the only medical personnel on a school campus. Communication with the student's physician requires permission from the parents.** |
| **Focus on health and returning to premorbid status. Once healthy or has recuperated, discharged.** | *Focus* | **Focus is on providing safe, efficient, and enjoyable mealtimes at school to ensure adequate nutrition and hydration to access the curriculum.** |

# FOUNDATION #4:
# INTERDISCIPLINARY TEAM APPROACH

*Collaborating as a team is essential to providing swallowing and feeding services in schools.*

***A team approach requires that all team members:***

- know the procedures for addressing swallowing and feeding.
- be aware of each person's role.
- collaborate and share information with other team members.

Each district has a unique composition and availability of resources. Therefore, team structure will vary from school to school. Despite this variability, the following professionals are recommended to form a core team. These knowledgeable staff members should establish a safe eating plan for students with PFD.

- Speech-Language Pathologist (SLP)
- Occupational Therapist (OT)
- Physical Therapist (PT)
- School Nurse

## *Roles and Responsibilities*

Each team member brings their own level of knowledge and expertise. The district and the individual professionals are responsible for increasing their knowledge and skills in swallowing and feeding as needed.

***All members of the swallowing and feeding team are responsible for:***

- referring students who are at risk.
- monitoring the student's swallowing and feeding.
- looking out for the safety and well-being of the students at school.

## *Team Leader*

Person designated to oversee the swallowing and feeding process. The speech-language pathologist takes on the role of swallowing and feeding team leader when dysphagia is a major concern. The occupational therapist may function as team leader, especially when concerns are primarily sensory. When a student is medically fragile the school nurse may function as team leader.

***The team leader:***

- receives input from all team members on a regular basis
- ensures that the procedure is followed with fidelity for each student, that team members ar kept informed and that the process is documented

# *Core Team Member* ROLES AND RESPONSIBILITIES

### *Speech-Language Pathologist*

- Serves as team leader, receives and completes the observation request, contacts other core team members, and begins the PFD procedure
- Initial identification of students at ris
- Coordinates assessment/treatment including the Interdisciplinary Observation (clinical evaluation)
- Attends Videofluoroscopic Swallow Studies/Modified Barium Swallowing Studies (VFSS or MBS
- Writes Safe Eating Plan
- Trains teachers, paraprofessionals and other designated feeders on the student's Safe Eating Plan
- Collaborates to develop oral motor, sensory-motor, and behavioral strategies to be integrated into the classroom/therapy program
- Treats oral and pharyngeal phase dysphagia. It is essential that the person making decisions regarding dysphagia (texture, liquid modifications, determining aspiration and choking risks, etc.) has the training an experience (including graduate-level coursework) to address it
- Consults, refers, and monitors esophageal phase dysphagia
- Refers the student and parents to other professionals as needed to rule out other conditions
- Monitors implementation of the Safe Eating Plan
- Responds to issues and concerns regarding the student's swallowing disorder
- Attends the IEP meeting

### *Occupational Therapist*

- May serve as team leader for sensory cases
- Initial identification of students at ris
- Conducts the Interdisciplinary Observation (clinical evaluation) with team members
- Participates in writing the Safe Eating Plan
- Trains staff designated as feeders on any adapted tools and sensory adaptations included in the Safe Eating Plan
- Monitors feeding and implementation of the Safe Eating Plan
- Collaborates to develop oral motor, sensory-motor, and behavioral strategies to be integrated into the classroom/therapy program
- Provides therapy and strategies to maximize student's independence in self-feeding
- Responds to issues and concerns regarding the student's swallowing and feeding disorder
- Brings knowledge of neuromuscular, positioning, sensory awareness, adaptive equipment, and environmental modification
- Refers the student and parents to other professionals as needed to rule out other conditions
- Attends the IEP meeting when possible or indicated

### *Physical Therapist*

- Addresses postural skills and mobility issues
- Addresses positioning and adaptive equipment needs related to mealtimes
- Attends the IEP meeting when possible or indicated

# *Core Team Member*
# ROLES AND RESPONSIBILITIES CONTINUED

### *School Nurse*

- Monitors the health of students at school
- Writes the individualized health plan (IHP) and trains personnel according to the student's medical diagnosis
- Trains classroom staff on the student's Emergency Plan for choking
- Monitors the student's weight to establish trends, if necessary
- Assists in contacting physicians as related to medical diagnosis and medications
- Consults with parents and teachers
- Shares medical information with team members as needed upon notification of swallowing/choking issues
- Refers the student and parents to other professionals to rule out other conditions
- Attends the IEP meeting when possible
- Periodically monitors lung sounds during meals when there is an aspiration concern
- Trains classroom staff and other team members on the signs of undernutrition and dehydration and what to do

### *Board-Certified Behavioral Analyst (member of Core Team when behavior is a major concern)*

- Studies changes the environment has on the student's eating behaviors
- Creates plans to manage behaviors that affect a student's feeding skills
- Works with the swallowing and feeding team to provide a comprehensive approach to behavior management that includes evaluation, data collection, interventions, and regular monitoring including mealtimes at school
- Consults with school swallowing and feeding team members on how to address feeding behaviors

**In addition to individual roles and responsibilities, team members may also be responsible for:*

- Educating families of children at risk for pediatric feeding and swallowing disorders
- Educating other professionals on the needs of children with feeding and swallowing disorders

# *School Staff* ROLES AND RESPONSIBILITIES

### *Classroom Teacher*

- Provides information on the student's progress during mealtimes
- Keeps the Individualized Health Plan and Safe Eating Plan in place of easy reference
- Oversees mealtime of the swallowing and feeding students in their classroom, the implementation of the Safe Eating Plan, and the trained feeders for each student
- Understands and can follow the student's emergency plan in the event a child is choking
- Recognizes changes in a student's feeding or swallowing and reports them to the team leader
- Contacts swallowing and feeding team leader as soon as there's a concern
- Follows through on oral motor exercises when recommended by the SLP

### *Classroom Paraprofessional or Assistant*

- Feeds student(s) according to their Safe Eating Plan
- Recognizes changes in student's feeding or swallowing and reports them to the swallowing and feeding team and/or the classroom teacher
- If indicated, records amount of food eaten and behaviors observed during mealtime
- Reports concerns about the student's feeding to classroom teacher and to the SLP

### *School Cafeteria Manager*

- Provides the recommended diet modifications to all school meals and snacks maintaining nutritional value according to USDA regulations
- Ensures that all food, including school trays and snacks, follows the guidelines and recommendations of the student's Safe Eating Plan
- Ensures that the equipment used to alter the texture of the student's food is adequately cleaned

### *Principal*

- Supports the professionals working with the students in their school
- Ensures that the district-approved team procedure is used with fidelity for al students with pediatric feeding disorders
- Serves as mediator with team members and parents
- Understands pediatric feeding disorders and the district procedure

# *District Administrator's* ROLES AND RESPONSIBILITIES

### *District Superintendent*

- Adopts a district-approved team procedure that is used for all students with the signs of a pediatric feeding disorder in the school district

### *District Supervisor or Director of Special Education*

- Ensures that the district-approved team procedure is used with fidelity for all students with the signs of pediatric feeding disorder in the school district
- Hires additional professional staff when needed (SLPs, OTs, PTs, Nurses)
- Provides funds for instrumental swallow evaluations (VFSS), when indicated, and equipment such as blenders, Nuk brushes, slow-flow cups, etc
- Reminds IEP teams that specialized feeding needs must be documented in the IEP when IDEA funds are used to support feeding the student
- Approves funds for professional development so that all team members can learn the procedure and their roles
- Approves funds for professional Core Team members to update their knowledge and skills in the area of swallowing and feeding
- Attends IEP meetings or parent meetings with the swallowing and feeding team when there are concerns
- Meets directly with parents to discuss their concerns
- Provides access to the legal team when those concerns cannot be resolved

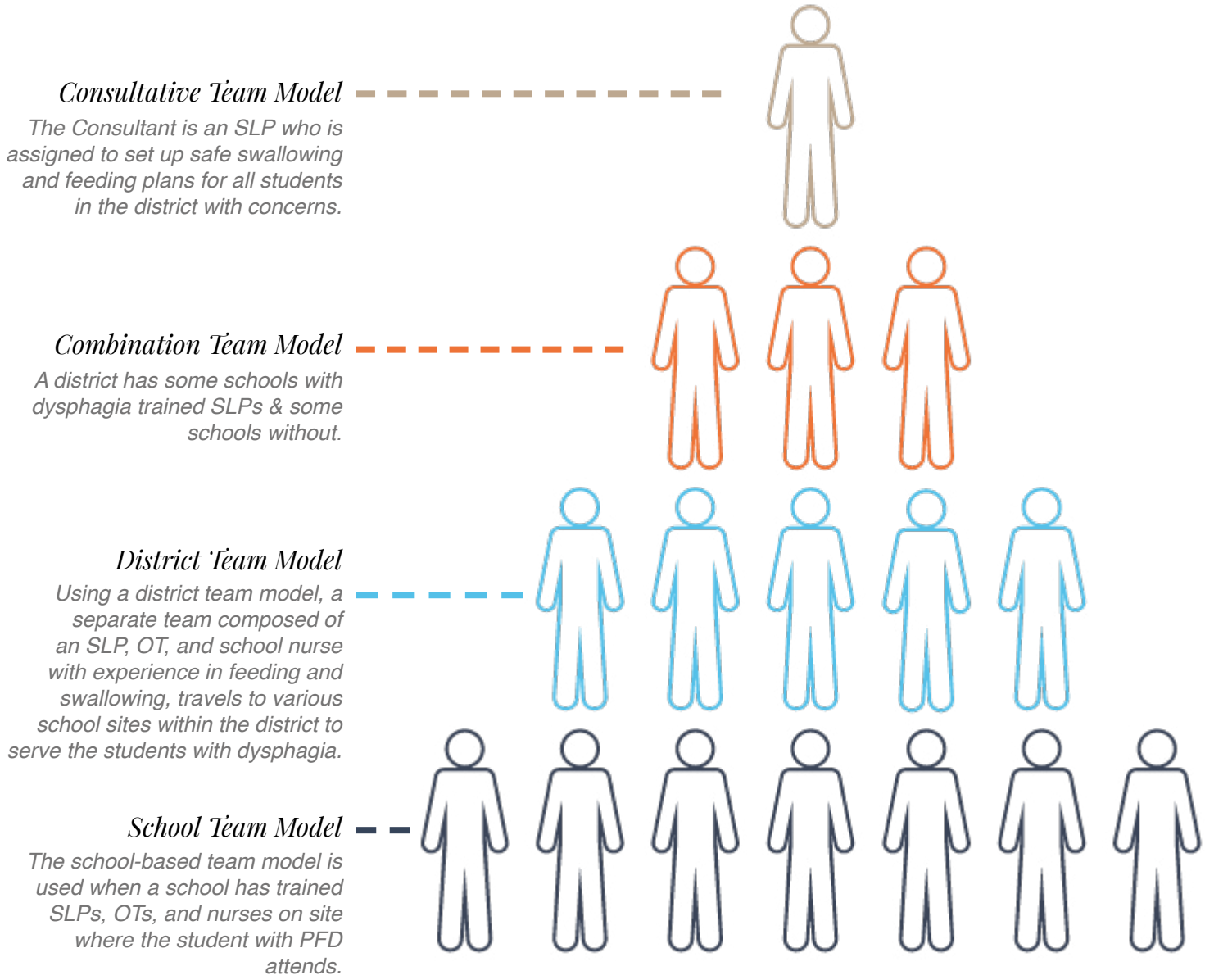
# TYPICAL ROLE OF THE *Parents/Caregivers*

- Shares knowledge of child's feeding habits, food preferences, and mealtime environment
- Provides medical information and history
- Participates in decision-making regarding mealtimes at school
- Shares cultural view as it pertains to food choices, habits, perception of disabilities, and beliefs about intervention (Davis-McFarland, 2008)
- Provides foods that meet the Safe Eating Plan recommendations when the student brings a lunch from home
- Implements swallowing and feeding goals at home
- Provides access to the medical team by signing a release of information for each treating physician or provider

# Team Models

There are many team models that can be used in a school district to address swallowing and feeding. The team model that is adopted will depend upon the make-up of the district and experience of school staff.

## TEAM MODELS
## FROM LEAST TO MOST SLPS
## *Trained in PFD*



### *Consultative Team Model*

*The Consultant is an SLP who is assigned to set up safe swallowing and feeding plans for all students in the district with concerns.*

### *Combination Team Model*

*A district has some schools with dysphagia trained SLPs & some schools without.*

### *District Team Model*

*Using a district team model, a separate team composed of an SLP, OT, and school nurse with experience in feeding and swallowing, travels to various school sites within the district to serve the students with dysphagia.*

### *School Team Model*

*The school-based team model is used when a school has trained SLPs, OTs, and nurses on site where the student with PFD attends.*

# *Team Models* BREAKDOWN

## *Consultative Team Model*

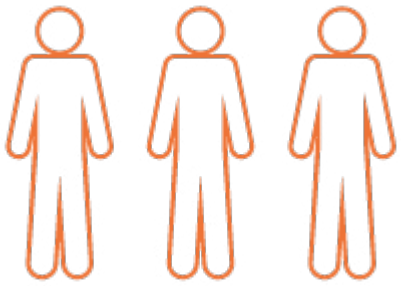
The Consultant is an SLP who is assigned to set up safe swallowing and feeding plans for all students in the district with concerns. The consultant works with the school-based SLP, OT, PT, nurse, and classroom staff to: identify concerns, establish safe feeding plans, train school-base personnel, and work with cafeteria staff. The school-based personnel assists with the monitoring and day-to-day management of the students. The Consultant visits the sites on a regular basis and is available as needed to address the school team's concerns.

### *Benefits:*

- SLP responsible for setting up safe feeding plans is extremely knowledgeable
- Consultant sees many students with swallowing and feeding disorders which increases experience and expertise

### *Challenges:*

- May only serve swallowing and feeding students so a new position may be required
- Consultant is itinerant and may not be available when needed
- Relies on school-based OTs, PTs, and nurses to participate on the team



## *Combination Team Model*

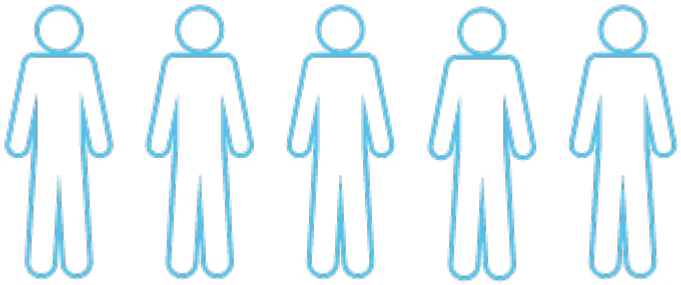
A district has some schools with dysphagia-trained SLPs and some schools without. When possible, teams are school-based, which allows the person most knowledgeable to be on campus. For schools where this is not possible, a district team serves the students with dysphagia while working closely with school personnel.

### *Benefits:*

- Professionals with the knowledge and skills can use them to address swallowing and feeding at their schools
- Moves district toward the goal of the school-based team

### *Challenges:*

- Takes additional administrative attention to coordinate schools that use a district team and those that are school-based



## *District Team Model*

Using a district team model, a separate team composed of an SLP, OT, and school nurse with experience in feeding and swallowing, travels to various school sites within the district to serve the students with dysphagia. This team works collaboratively with the school-based personnel (including teacher, administrator, SLP, OT, and nurse). The team trains school staff to follow the Safe Eating Plan and to report concerns and changes to the core team.

### *Benefits:*

- This model works well in small districts or districts with few dysphagia trained SLPs
- The core team members have a larger swallowing and feeding caseload and as a result, develop more experience and knowledge
- This model makes ongoing training and staff development easier to achieve

### *Challenges:*

- Could underutilize professionals on campuses with the knowledge and skills to address PFDs
- Trained professionals are not based on campus and as a result, communication and access to the team can be difficul

## *School Team Model*

The school-based team model is used when the school has trained SLPs, OTs, and nurses on site where the student with PFD attends.

- The SLP, OT, and PT, etc. that work with the students in therapy, also provide swallowing and feeding services
- Each school in the district is assigned a swallowing and feeding team leader (typically the SLP) to oversee the team process
- The school-based team evaluates the student's swallowing and feeding, establishes a safe feeding protocol, trains classroom staff, and monitors student's feeding

### *Benefits:*

- Facilitates regular monitoring of students
- Allows for more involved dysphagia therapy
- Team members available to interact frequently with other school staff as well as parents/guardians
- Professionals with the most knowledge of dysphagia are on campus in the case of an emergency
- Team members are very familiar with the students and staff at the school

### *Challenges:*

- Requires many dysphagia trained therapists
- Professional development is more difficult due to a larger number of member
- Small swallowing and feeding caseloads prevent team members from becoming more experienced in the area of PFD

# SECTION 3

## *Students Eat Safely: Follow the Forms Swallowing and Feeding Procedure for School-based Services*

Once the school district recognizes the need to address swallowing and feeding using a team model, they are ready to establish a step-by-step procedure.

*The following procedure outlines the essential components of a team procedure that, when implemented with fidelity, establishes and maintains safe mealtimes at school for students with swallowing and feeding disorders. See the Team Procedure Checklist as a quick reference and record of when each step was completed.*

>CLICK for Team Procedure Checklist

# STEP 1: Observation Request Form

>Click for Observation Request Form

When there is a concern about a student's swallowing or feeding skills, an observation request should be sent to the PFD team.

The PFD team should determine the process and point of contact for initial requests. The completed Observation Request Form is sent to: _____.

The team member should then discuss the concern with the referring person and obtain consent from the legal guardian. Once consent is granted, an informal observation of the student during a mealtime at school should be completed.

***

**Add the name and contact information for the person responsible for tracking swallowing and feeding cases in the district. The PFD team leader assigns a PFD team member to the referral.**

Step 2

# *STEP 2: Caregiver Interview Form*

> ***Click for Caregiver Interview Form***

The assigned team member should call the caregiver to discuss concerns about their child's safety during mealtime and obtain the child's medical and social history using the Caregiver Interview Form.

## *The purpose of this step is:*

- to acquire medical information including history of medications, history of swallowing and feeding issues, and current health status.
- to gather information about the student's current feeding practices at home.
- to identify the caregiver's concerns about their child's mealtimes.
- to inform the caregiver of the district's procedure and goal of safe and efficient mealtimes at schoo for their child.
- to inform the caregiver of the school team's concerns about their child's mealtimes at school.
- to include the caregiver as part of the problem-solving team.

The team member should recognize that feeding a child can be an emotional subject for caregivers. They should avoid alarming or scaring the caregiver and remember they are the expert on their child. Their experiences and opinions should be considered throughout the process.

# STEP 3: Interdisciplinary Assessment

> Click for Interdisciplinary Assessment Form

## PREPARING FOR THE INTERDISCIPLINARY ASSESSMENT

***Prior to beginning the Interdisciplinary Assessment, the PFD team should prepare by doing the following:***

Step 3

### Review

Review Caregiver Interview Form as a team.

### Contact

Contact the Child Nutrition Director regarding the various foods and liquid modification that may be needed during the observation

### Explain

Explain to the student's designated feeder (classroom staff) what their role may be.

### Assess

Observe the student's current feeding position and determine the optimum position for eating at school. This is usually completed by the school physical therapist or occupational therapist to determine if the student is having difficulty maintaining their postural stability (e. g. leaning to the side or having trouble staying upright). Are they lying down, reclined, or eating with their neck in extension? Is the positioning of the feeder affecting the student? Positioning should be one of the first areas observed and is an ongoing component of supporting the student.

### Observe

Observe the child eating in their typical environment. If necessary, determine the location (classroom, cafeteria, etc.) that will be the most conducive for observing specific feeding and swallowing skills

>>Click here for a more in-depth evaluation of oral motor skills

# Oral Motor Observations

Step 3

***Tongue lateralization***
*Is the tongue moving from side to side or just pumping up and down?*

***Tongue elevation***
*Is the child able to elevate their tongue?*

***Food Residue***
*Have student open mouth to see if there are food particles in the oral cavity or on the tongue.*

- *Does the student do a lingual sweep to collect leftover food?*
- *Is there awareness of food left on the lip, tongue, cheek, palate, or gum?*

***Straw drinking***
*Watch the student drink from a straw, if able. Look for lip closure, cheek tension, tongue retraction, spillage, etc.*

***Tongue thrust***
*Do you observe a tongue thrust when the student chews, swallows, or is at rest?*

***Spontaneous swallow***
*Does the child swallow on their own, or do they need to be prompted to swallow?*

***Oral Resting Posture***
*How is the oral resting posture? The tongue should contact either the bottom or top teeth but retracted inside the oral cavity with the tongue tip resting on the alveolar ridge. Jaw should be maintained in a high but not completely closed position.*

***Lip closure***
*Can the student achieve lip closure when eating?*

# Trials of Liquid Modification

If the student exhibits overt signs of aspiration when drinking liquids, a referral should be made for a VFSS (Videofluoroscopic Swallow Study). As the family works to schedule the exam, the PFD team should consider adjusting the manner of intake, as appropriate, to optimize the students safety. Suggestions include:

- Consideration of appropriate positioning
- Increasing supervision at mealtimes
- Small, single sips only (no consecutive swallows)
- Liquids presented via spoon rather than straw
- Use of various adaptive feeding equipment

Step 3

Notify the parents by both calling and writing, to inform them the team has observed clinical signs of aspiration with oral intake and they should request their child's physician refer for a formal swallowing evaluation (VFSS).
If approved by the physician, it is requested that they refer to Arkansas Children's Hospital or Arkansas Children's Northwest for the VFSS procedure, as these are facilities with the most expertise regarding pediatric feeding disorders.

## The Swallow/Food Trials

***The purpose of these trials is for the school team to determine the safest and most efficient way for the student to eat at school.***

- Evaluate the safety of the student's current diet by beginning with the foods the student eats at school and what the parents report that the student eats at home. Foods can be obtained from the student's lunch brought from home or lunch the school provides.
- As the student eats their meal, the team observes, makes notations, and suggests modifications, adaptations, and strategies that improve th student's ability to eat safely and efficientl . This includes, but is not limited to, solid food modifications, positioning, pacing, cueing, utensils, an feeding equipment.
- When a concern is observed (such as gurgly voice, inadequate chewing), modify the meal to determine the safest way for the student to eat or drink. Recommended food and liquid modification should follow the Internationa Dysphagia Diet Standardization Initiative (IDDSI).(See IDDSI for more information and training modules)
- It should also include observations and notations of the student's activity and participation ability and their body structure and function.

***Upon completion of the observation, if the student warrants being followed by the PFD team, recommendations should be placed on the Safe Eating Plan and a conference to address swallowing and feeding concerns should be scheduled.***

# STEP 4:
# Safe Eating Plan Form

>> ***Click for Safe Eating Plan Form***

## FIRST COMPONENT

A Safe Eating Plan should be drafted based on the information gathered during the Caregiver Interview and Interdisciplinary Observation. The plan should include information the staff will need in order to feed the student safely and efficientl .

Step 4

*The Safe Eating Plan should include the following information:*

- Student information
- Team leader contact information
- Brief medical history including the initial concern
- Special considerations
- Feeding recommendations
  - Positioning
  - Equipment
  - Diet/Food preparation
  - Sensory concerns
  - Utensil selection
  - Spoon placement
  - Cup drinking
- Feeding plan techniques/precautions
  - Placement of feeder
  - Specific needs to monito

>> ***Click for Trained Feeders Form***

## SECOND COMPONENT

The second component of the Safe Eating Plan is staff training, one of the most important roles of the team. It is recommended that two to three feeders be trained for every student. It is required that staff receive training on the Safe Eating Plan before feeding the student. The goal of training is for designated feeders to follow the student's plan with fidelit . Staff training should be documented on the Trained Feeders Form. Periodic monitoring by the PFD team is required to ensure the Safe Eating Plan continues to be implemented correctly.

## *Possible Team Member Training Responsibilities*

**SLP**
Food and liquid modification, special precautions, and consideration

**OT**
Adaptive feeding equipment and sensory considerations

**Nurses**
Emergency plan and student's IHP (individualized health plan), recognizing and reporting undernutrition and dehydration

**PT**
Optimal positioning for eating

**Behavior Specialist**
When behavioral concerns are present

Step 4

### *Training should include the following:*

- Provide an overview of the student's Safe Eating Plan
- Demonstrate how to safely feed the student
- Observe the staff feeding the student
- Provide coaching and feedback to designated feeders
- Preparation of meal according to IDDSI recommendations

(See: Coming to the Table for Caregiver Tips)

### *Individualized Health Plan (IHP) and Emergency Plans*

Individualized Health Plan (IHP) and Emergency Plans are written by the school nurse on district forms and are part of the student's IEP. The IHP includes the student's medical conditions and the actions being taken by the nursing program.
The Emergency Plan is written for students who may, at any time, require emergency procedures for things such as choking during mealtimes. Staff should be trained on the IHP and Emergency Plans.

**Note: The Safe Eating Plan should be revised and altered whenever there is a change in the student's feeding status or additional information is obtained. Each time the plan is revised, the staff must be trained on the new plan and the caregivers should be notified of the changes. See Step 8.**

*The School Nurse will need an updated script for thickener each year.*

# *STEP 5:*
# *School Meal Modification Form*

>> ***Click for Prescription for School Meal Modification Form***

Step 5

*Many students with Safe Eating Plans receive a school meal for breakfast and/or lunch. The Child Nutrition Program falls under the jurisdiction of the United States Department of Agriculture (USDA).*

The U.S. Department of Agriculture's school meal programs aim to provide all participating children, regardless of background, with the nutritious meals and snacks they need to be healthy. Consistent with federal law and program regulation, this includes ensuring children with disabilities have an equal opportunity to participate in and benefit from the programs, which are the National School Lunch Program (NSLP), the School Breakfast Program (SBP), the Fresh Fruit and Vegetable Program (FFVP), the Special Milk Program (SMP), and the afterschool snack component of the NSLP.

The Child Nutrition Program directors and managers should be provided with a copy of the Safe Eating Plan. The PFD team should train the Child Nutrition Program directors and managers on the International Dysphagia Diet Standardization Initiative (IDDSI) to meet the recommended modifications and any student specific needs as outlined on the Safe Eatin Plan. It is the responsibility of the Child Nutrition Program operators to ensure all meal modifications are carried out during school meals

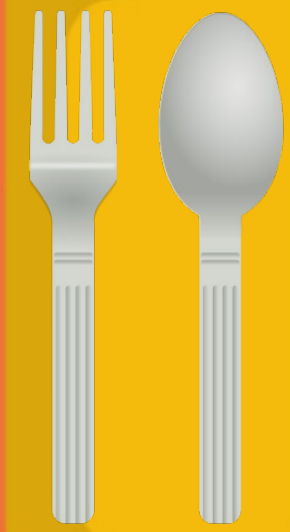
## *Training Resources*

For instructions on how to modify foods and thicken liquids, the Complete IDDSI Framework should be used. It will be a valuable resource for PFD teams to utilize when training others.

## *Preparing the Student's Meal Tray*

The team leader and cafeteria manager should review the monthly meal menu, crossing out food items that the student should not have and substituting them with nutritionally equal foods that meet the student's plan.

*Ex: if the child receives minced and moist solids, raw broccoli will be scratched off and substituted with string beans.*



Step 5

Meal modification is a funding and nutrition issue based on federal regulations. The USDA provides the following guideline: In a disability situation, meal modifications outside the meal pattern are reimbursable, provided the request is supported by a medical statement signed by a state licensed healthcare professional. The medical statement must include the signature of an individual who is authorized to write medical prescriptions under state law. This may include a doctor, a nurse practitioner, dentist, or a physician's assistant. Food and Nutrition Service guidance refers to individuals authorized to sign the medical statement as "State licensed healthcare professionals."

Step 6

# STEP 6: The IEP Conference

>>*Use your school district's IEP Form*

Once the team has established a safe eating plan, an IEP meeting must be held. Typically, the child's special education teacher or case manager schedules the meeting, inviting PFD team members (OT, PT, SLP, nurse), parents, and a school administrator. Other team members may need to be included such as the behavioral specialist, nutrition director, or the school psychologist

***Note: In the interest of student safety, the Safe Eating Plan should begin immediately, once it has been established and appropriate school personnel are trained.**

## *The IEP meeting includes:*

- discussion of findings from the PFD team
- review of the Safe Eating Plan.
- review of the Emergency Plan and/or Individualized Health Plan with the committee.
- determine if an instrumental evaluation is indicated (VFSS) and if so, discuss obtaining a prescription from the physician.

The student's Present Level of Academic Achievement and Functional Performance (PLAAFP) should describe the swallowing concerns, in order to establish goals in the IEP.

**It should include:**

- Description of the swallowing concerns, including: oral and pharyngeal phase dysphagia, oral sensory motor disorders, etc.
- Review of the medical history regarding swallowing and feeding
- Indicate actions that will be taken including recommended diet modification

***The presence of the safe eating plan should be documented on the special factors page of the IEP.***

# *STEP 7: Instrumental Evaluation Referral (VFSS)*

## >> *Instrumental Evaluation Referral (VFSS)*

If the IEP team determines a videofluoroscopic swallow study (VFSS) or additional clinical feeding evaluation is needed to facilitate safer feeding in the school environment, the IEP team should assign roles and responsibilities to aid in facilitating these evaluations.

### *These steps include working with the guardian to:*

- Obtain a prescription/referral for the necessary appointments
- Schedule the appointment(s)

To initiate this process, a member of the PFD team should contact the LEA or other district employee responsible for assisting with medical referrals.

Inform the individual that a swallow study (VFSS) or clinical feeding evaluation is requested.

Provide a signed release of information so necessary communication can occur prior to and after the evaluation.
>>Authorization to Release Health Information to Schools
>>En Espanol Authorization to Release Health Information to Schools

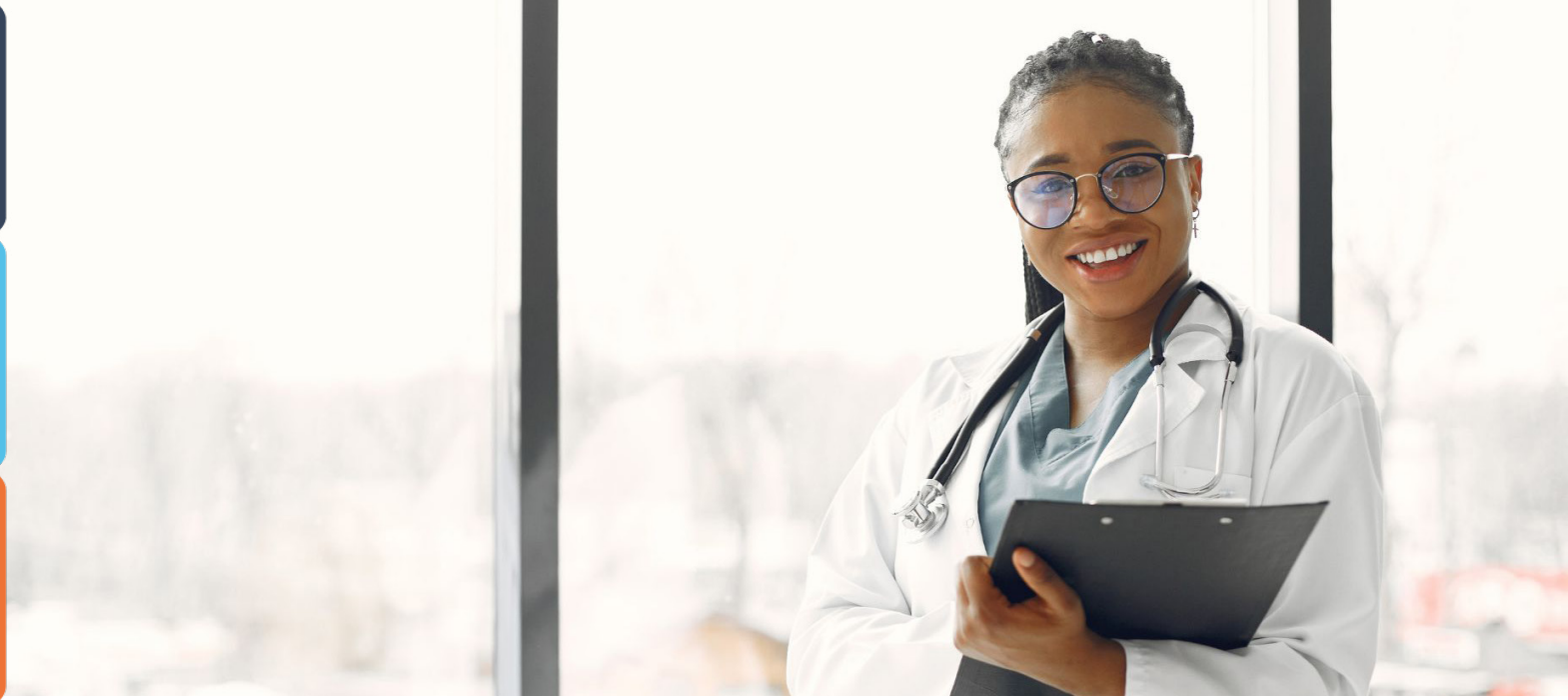
This individual will facilitate scheduling the evaluation, making sure the team leader and any needed team members can attend. The team leader may need to obtain permission from the school principal and the SLP Coordinator or Related Services Coordinator in order to attend the study.

Step 7

Once the appointment has been scheduled and a release of information has been signed, the team leader is free to contact the hospital based SLP to discuss concerns. This person should also complete the Pre-Instrumental Evaluation Information Form and send a copy to the hospital SLP. By providing the hospital SLP information prior to the appointment, specific concerns can be addressed. This will help ensure information is obtained from the study that will help guide the PFD team.

## *Training Resources*

See the “medical” box in Signs and Syptoms by Domain in Section 1.



# Contacting a Physician

Collaborating with the student's physician(s) is extremely important but can be challenging in the school system. In compliance with the Family Educational Rights and Privacy Act (FERPA), the school team needs a release of information form signed by the parents to talk to physicians, private therapists, or dieticians. The school nurse often assists in working with the physicians and parents to obtain necessary information to facilitate safe feeding at school.

## *The district team should contact the student's physician when:*

- the team is concerned about a child's nutritional intake and/or hydration and health status.
- the student receives part or all their nutrition or hydration via enteral or parenteral tube feeding.
- the student has a medically complex condition.
- the team needs additional medical history information.
- the team needs to request a script for a VFSS or clinical feeding evaluation.
- the student appears to be undernourished, lethargic, complains of chest pain, is coughing phlegm, etc.

***Note: It is always recommended that the school team work closely with the student's physician(s), however, a prescription from a physician is not necessary to conduct the Interdisciplinary Swallowing and Feeding Observation or to write and implement a Safe Eating Plan.***

Step 7

# *STEP 8:*
# *Revision of Safe Eating Plan*

>> ***Safe Eating Plan***

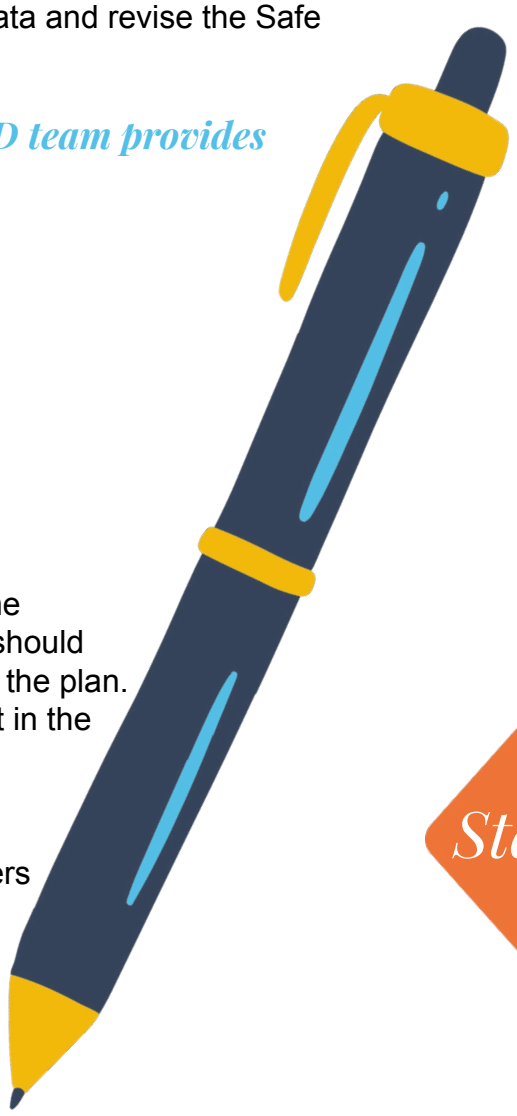
## *Revisions to the Safe Eating Plan are indicated when:*

- the VFSS report indicates the current plan is no longer appropriate.
- a child has a serious illness.
- a child has changes that are not part of a typical growth pattern.
- there is a change in skill level.

Guided by the team leader, the PFD team should review data and revise the Safe Eating Plan based on the student's needs.

## *After any changes to the Safe Eating Plan, the PFD team provides training that should include:*

- revisions to food and liquid consistencies.
- special precautions and considerations.
- adaptive feeding equipment.
- sensory considerations.
- positioning for eating.



**THE SCHOOL NURSE** should train staff on revisions to the Individualized Health Plan and Emergency Plan. Parents should sign the Emergency Plan indicating that they are aware of the plan. The Safe Eating Plan and Emergency Plan should be kept in the classroom in the same location for easy access.

**THE TEAM LEADER** should ensure the Safe Eating Plan is followed and monitored by the appropriate team members (i.e. SLP, OT, PT, Nurse).

Step 8

# *STEP 9: Student Support*

All students with Safe Eating Plans must receive regular consultative support from the PFD team to maintain safety during mealtimes. Consultative support is considered a supplementary aid and service or service “on behalf of the student” (IDEA, 2004). Services on behalf of the student are documented on the Supplementary Aids and Services page of the IEP. Consultative support includes progress monitoring student safety and performance.

## *As part of consultation, the PFD team member should engage in a continuous cycle that includes:*

- Review data collected (weight, swallowing issues, self-feeding attempts)
- Observe mealtime
- Monitor any equipment needs
- Adjust Safe Eating Plan
- Provide training and support, answer staff and caregiver questions
- Review performance and data

In addition to consultative services to monitor the Safe Eating Plan, students with PFD may also receive direct services for therapeutic intervention.

## *Direct services may include:*

- Interventions to target oral motor and swallowing needs
- Interventions to support self-feeding needs

The IEP team or school team determines the type, amount, and duration of services that are indicated. Some students will need weekly monitoring to ensure that they are being fed correctly and that the plan is appropriate. Other students will not need to be monitored that often. Monitoring should be done a minimum of once per month. All services, including consultation, should be documented.

Step 9

# SECTION 4

## *Day Care and Preschool Procedures*

Early Childhood Special Education services are provided to children ages three to five years. To receive services, a child must be evaluated and meet the criteria within one of ten preschool eligibility categories.This evaluation determines if the child qualifies for IDEA special education services in the schools.

# PRESCHOOL STUDENTS

Part of the multidisciplinary evaluation includes a thorough medical and case history interview with the caregivers.

***Best practice would include:***

- questions relating to the student's feeding history.
- current feeding situation.
- any medical history related to swallowing and/or feeding.

If the caregivers report a history of PFD, the evaluators will then make a recommendation to the district or educational cooperative's pediatric feeding disorders team or appropriate personnel.

*Referral for support is the first component in the Essential Step by Step Process.*

Once the child is referred to the PFD team, the setting where the child receives services will affect the process followed to establish safe and efficient mealtimes. If the student requires PFD services, different scenarios are possible. Each setting may utilize a slightly different process.

# *Scenarios for Preschool Students who Require PFD Services*

## SCENARIO 1:

***Student receives services at the school district site:***

During the comprehensive evaluation, the caregivers indicate that there are feeding concerns. After completing the evaluation, the IEP team decides that the student's feeding skills have an adverse educational impact, and therefore, PFD services will be provided at the school district site. (See: Feeding Matters, general info on PFD,etc. )

## SCENARIO 2:

***Student receives services at Head Start:***

The student attends a Head Start Program and qualifies for PFD services. This depends on how the Head Start Programs are administrated. In some districts they are part of the school district's school sites, and the procedure is followed in the same manner as if the student were attending a district school. In other situations, Head Start is a separately administrated program and therefore is treated the same as the private preschool program or daycare center.

## SCENARIO 3:

***Student receives services by the district SLP at a preschool or daycare site:***

The student requires support in the area of swallowing and feeding, and receives therapy at a preschool or daycare site. When this student has swallowing and feeding concerns in addition to speech and language, occupational therapy, etc. then the school team works with the caregivers and center to provide a safe eating environment for the student at the preschool center or daycare. The procedure is adapted and used in this setting, however, the ultimate responsibility for the student's safety during mealtimes at the preschool or daycare lies with the school district, as the early childhood special education (ECSE) program is responsible for the implementation of the IEP.

# *Example:*

The student is in a private preschool that is served by the local school district and qualified for speech therapy services on the evaluation.

***Caregivers are notified:***
The Caregiver Interview form is completed during the child's eligibility evaluation, so the designated preschool SLP, who also serves as the team leader, called the caregivers and set up a time to meet. At this meeting, they discuss the information on the form completed by the caregivers and inform them of the district's process and goal of the procedure (safe, efficient, and enjoyable mealtimes for this child at school).

***Preschool Director is notified:***
The preschool director is informed that the student has swallowing and feeding concerns which could result in the need for food modification and monitoring during mealtimes.

***The Interdisciplinary Observation is scheduled and conducted at the preschool:***
The student is observed during a typical mealtime at school by the SLP, OT (when possible), and PT (if indicated). Information is gathered on the need for special seating, utensils, food or liquid modification, monitoring, and precautions

***The Safe Eating Plan is written, and the preschool staff are trained:***
Once the Interdisciplinary Observation is completed the team writes a Safe Eating Plan and discusses with the preschool director which staff members at the preschool are responsible for feeding the student and need training. These classroom staff members are trained as well as the school director on the student's Safe Eating Plan. The IEP team determines who, how, and where the food is prepared then trains the appropriate personnel on how to prepare the student's food.

***IEP meeting is held and swallowing and feeding information is added:***
An IEP meeting is held to discuss the PFD and the student's Safe Eating Plan. This meeting includes members of the district swallowing and feeding team or appropriate personnel, the preschool director, caregivers, and classroom staff.

***Implementation of the Safe Eating Plan is monitored by the PFD team or appropriate personnel:***
The SLP, OT, and/or nurse who provide services to the preschool periodically monitor the student's mealtime and discuss with the teachers, caregivers, and the director the implementation of the student's Safe Eating Plan. This gives each of them a chance to express concerns, make changes, or to ask questions.

# *Early Intervention Program*

When discussing school-based swallowing and feeding services, it's important to understand the Early Intervention (EI) program for children aged 0 to 3. Recognizing its function, differences from school-based programs, and strategies for transitioning to school-based services is crucial for the student, caregivers, and school staff.

Early intervention provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. The goal of EI is to maximize a child's potential by providing experiences in natural environments that capitalize on rapid brain development occurring in the first 3 years of life (Bruder & Greer, 2017).

# *Early Intervention Program and the Public School Program*

Students in the Early Intervention program who qualify for IDEA services, including PFD, are typically scheduled for an Individualized Education Plan (IEP) prior to their 3rd birthday. This IEP meeting is often the parent's first experience with the public-school program, so it is extremely important that it be a positive experience.
It is common for the EI teachers and therapists to attend the IEP conference or to communicate prior to the meeting of the IEP team. This communication with the EI providers can either result in a positive transition to the public-school setting or a negative one.

***Facilitating communication and a smooth transition from EI to public-school services is critical. The EI team should:***

- collaborate with the school team to set up a process for communication prior to the IEP conference.
- operate as part of the team to establish a continuum of special education services for the student.
- listen to what the school team is proposing.
- encourage discussion with the caregivers about the importance of the following:
    - Keeping an open mind about how the services will be provided, pointing out that they will be different from the EI services provided.
    - Understanding the differences and then helping the caregivers to adjust to the changes that are occurring.
    - Encouraging caregivers to share with the school team important information about their child's mealtimes.

# *Comparison of Early Intervention and School-based Services*

| EARLY INTERVENTION PROGRAM | VS | SCHOOL-BASED PROGRAM |
|---|---|---|
| Services are provided in the child's natural environment, often the home. | ⟷ | Services are provided in the child's Least Restrictive Environment. |
| Services are often individual or consultative in nature. | ⟷ | Services may be individual, group, or consultative in nature. |
| The focus of the program is to enhance the capacity of families to meet the special needs of their children with disabilities. | ⟷ | The focus of the school-based program is to provide support and services needed for the child to be successful in an educational setting. |
| Sections of the law reference the inclusion of the caregivers in all aspects of the Individualized Family Service Plan (IFSP). | ⟷ | Caregivers are a valuable and required member of the IEP team. This team collaborates to make decisions based on the child's needs. |
| Services are caregiver directed where the caregiver assumes the lead. | ⟷ | District team collaborates with the caregivers as part of the decision-making team along with educators, therapeutic staff, and administration. |
| Students typically eat their meals at home with their caregiver and in a familiar environment. | ⟷ | Students eat in the school cafeteria in a group setting. |
| Caregivers and family members assist the student with meals. | ⟷ | Student's mealtimes are typically monitored by school staff. Students may not always be fed or monitored by the same person every day. |

*Providing PFD services to students in preschool who require those services can assist the child in having a positive school experience and set the stage for their educational experiences. Working with caregivers, school staff, and administrators can result in a smooth transition and positive experience for all involved.*

# SECTION 5

## *Training Considerations*

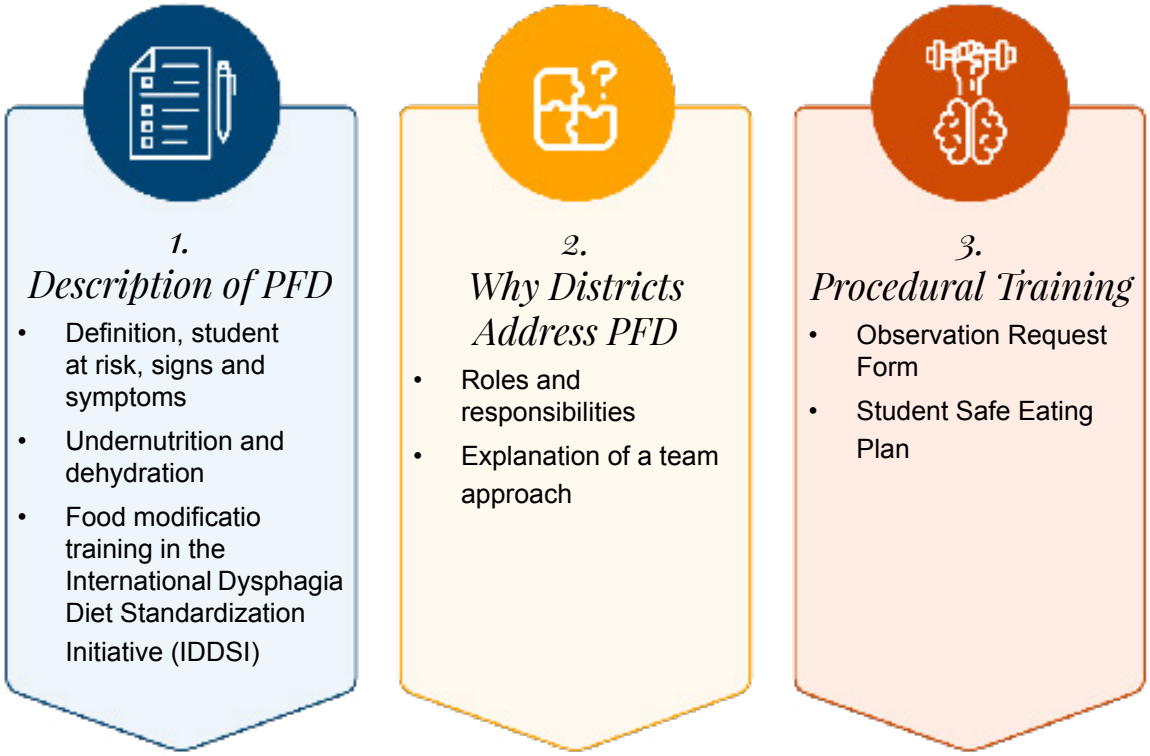
The PFD team should consider the training needs of their system. Considerations include:

- Procedural training for all team members by the core team members.
- Safe Eating Plan training for designated feeders by the core team members.
- Cardiopulmonary resuscitation and Heimlich Maneuver training for classroom staff, designated feeders, and cafeteria monitors (outside training or training by a certified nurse)
- Undernutrition and dehydration training for core team members, classroom staff, and designated feeders by the school nurse.
- Food modification training on the International Dysphagia Die Standardization Initiative (IDDSI) for cafeteria managers and staff by the food service program (with consultation from the SLP).
- Updating knowledge and skills of core team members: SLP, OT, PT, and school nurse

# The Core Team

The Core Team is responsible for supporting the training needs of their district including creating and disseminating content. Training information should be data driven and based on a needs assessment from information including surveys, analysis of student data, school needs, and stakeholder input.  The core team should use the content within this guidebook as the foundation for training staff.

Training considerations include:

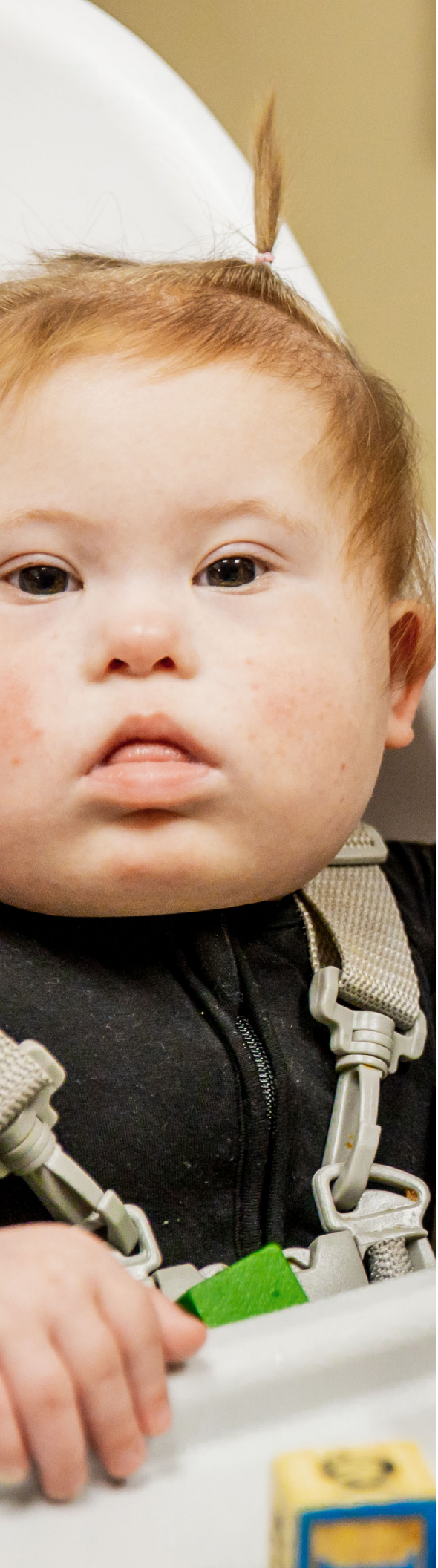



**Medical training such as CPR and the emergency rescue procedures for choking (Heimlich maneuver) should follow local education agency policy.*

In the school setting it can be challenging for SLPs and OTs to update knowledge and skills. Many SLPs in the schools have taken graduate level coursework for dysphagia but have not applied it in practice and may feel unprepared to address it. Pediatric swallowing and feeding disorders in the schools are often complex and require an individual student approach (a student with food refusal is different from a student with cerebral palsy who has oral phase issues). There are things that related service providers can do to increase their knowledge and skills and become more comfortable addressing PFDs.

*Note:*

Remember the caregiver is an important member of the student's team. The caregiver should be included in initial and subsequent trainings on the student's plan.



# STRATEGIES *That Add to Clinician Confidence*

## *1: Set a Goal*

Each therapist can set an individual goal and establish a plan for updating their skills and increasing their knowledge.

*This can be done by:*

**Identifying the skills that need to be updated or strengthened and begin there.**

- Use the Dysphagia Competency and Verification Tool (DCVT) for SLPS (Urban & Hazelwood, 2019, DCVT)
- Specialized Knowledge and Skills in Feeding, Eating, and Swallowing for Occupational Therapy Practice
- Person-Centered Focus on Function: Pediatric Feeding and Swallowing

Highlight the skills you are comfortable with and work on the ones that you need to hone. Seek out professional development trainings, mentors, or articles to learn more about the areas of concern.

## *2: Individual Learning*

- Read current research, journal articles, and attend lectures and webinars when possible.
- Observe other professionals in your district who are experienced with identifying and treating PFD.
- Research and prepare a presentation for district therapists to teach them more about a specific topic
- Buy a dysphagia textbook that is currently used in graduate speech pathology programs. These can be a great reference source.
- Seek out other books that address specific areas of PF identification and treatment

# 3: Access to Professional Development

Talk to district supervisors about providing access to professional development including web-based training and mentoring. According to the Council for Exceptional Children, it is the district's responsibility to ensure that professionals who work for them have the certification, knowledge, and skills needed to work in their area. "The major functions commonly assigned to administrators of special education programs include the following: …Conducting programs for staff development, such as in-service or continuing education (CEC Policy Manual, 1997)."

There are many training websites that offer coursework on pediatric swallowing and feeding with some being specific to school aged children. Seek out these websites. ASHA now has a series of courses designed specifically for school based SLPs addressing Pediatric Feeding Disorde . See ASHA Learning Pass.

# 4: Use the Staff You Have

There may be some SLPs and OTs in the district who have the knowledge and experience to address swallowing and feeding. List the SLPs in your schools who have worked with dysphagia in the medical setting. Assign them as mentors to other SLPs who have the coursework but minimal experience. It is often necessary for the school district to adjust the mentor's caseloads to allow time to work with PFD team members. By utilizing mentors who already have the knowledge, skills, and experience to address dysphagia to guide those who need their skills updated, the district is building capacity and expanding the staff that can work independently.

Having a mentor can be one of the most effective ways for an SLP or OT to develop the skills needed to address swallowing and feeding disorders.

# 5: Learn about Each Student with a PFD on Your Caseload

Learn as much as you can about the type of swallowing and feeding disorders of the students who are assigned to your caseload. Research the following:

- The signs of a feeding disorder you have observed.
- The specific swallowing and feeding signs that are typical of the population you are serving
- What you can do to address each sign.

Specialize in that child's swallowing and feeding disorders.

For example: if the student has Down's Syndrome, research swallowing and feeding concerns with that population.

# SECTION 6

## *School Services for PFD*

All students with a Safe Eating Plan receive ongoing monitoring and consultation or services on behalf of the student administered by the SLP, OT, PT, and school nurse. In addition, some children's services will require direct intervention to maintain safety and improve a student's functional eating skills.

The district must provide a safe eating environment for the student and services that ensure that students access their curriculum, thus providing a free and appropriate public education (FAPE). Once a student is identified as having a PFD and a Safe Eating Plan is established, the IEP team determines the type of intervention needed. Under IDEA, a student can receive services on their behalf including monitoring and consultation, as well as direct intervention (IDEA, 2004). All students with a Safe Eating Plan receive ongoing monitoring and consultation or services on behalf of the student administered by the SLP, OT, PT, and/or school nurse. In addition, some students will require direct intervention to maintain safety and improve functional eating skills.

## THINGS TO CONSIDER

***From a medical perspective:***

- Is the child gaining weight and growing?

***From a nutrition perspective:***

- If the child is lacking in vitamins and minerals, can a daily comprehensive multivitamin be given?

***From an educational perspective:***

- Is the child able to attend school?
- Do they eat what their caregiver packs them for lunch (which may be modified)
- Is the child safe at school? At risk for choking?
- Are there problems with attention during academic tasks?

## MONITORING AND CONSULTATION WILL INCLUDE:

1. Monitoring the implementation of the Safe Eating Plan and the student's feeding and swallowing skills.
2. Sharing information and training PFD team members including teachers, paraprofessionals, child nutrition staff, and caregivers.
3. Coordinating services of PFD team members and informing team members when there are changes.
4. Providing feedback to designated feeders to direct them toward safe and efficient feedin practices.
5. Resolving conflicts when they occu , throughout the process.

*Guidelines for beginning a feeding intervention program.*

Mealtimes and food experiences in general should be pleasant and stress free.  Joan Arvedson (2017) states that "stress does not help to get a child to eat more." Goals should focus on adequate nutrition and hydration for health and growth and functioning in the school setting. It may be necessary for the mealtime environment initially to be quiet and distraction free. The school may need to provide a quiet place for the student to eat and then work toward eating in the cafeteria.

# BEGINNING OF THE SCHOOL YEAR PROCEDURES

*The following procedure will ensure safety from day one. Each district will have a different organizational structure for which team members complete these steps based on their resources and system. When possible, the PFD Coordinator will fulfill this role. The following steps might be considered:*

- Distribute a roster of students assigned to each PFD team leader. See PFD Student Data Form
- Student location is verified, the previous plan is reviewed, and the classroom staff is trained on the safe eating plan from the previous year.
- The student is observed during a school meal on the first day of school to ensure that the plan is still appropriate.
- The Safe Eating Plan is adjusted, rewritten, and classroom staff retrained if necessary.
- Copies of the Safe Eating Plans are shared with appropriate school personnel.

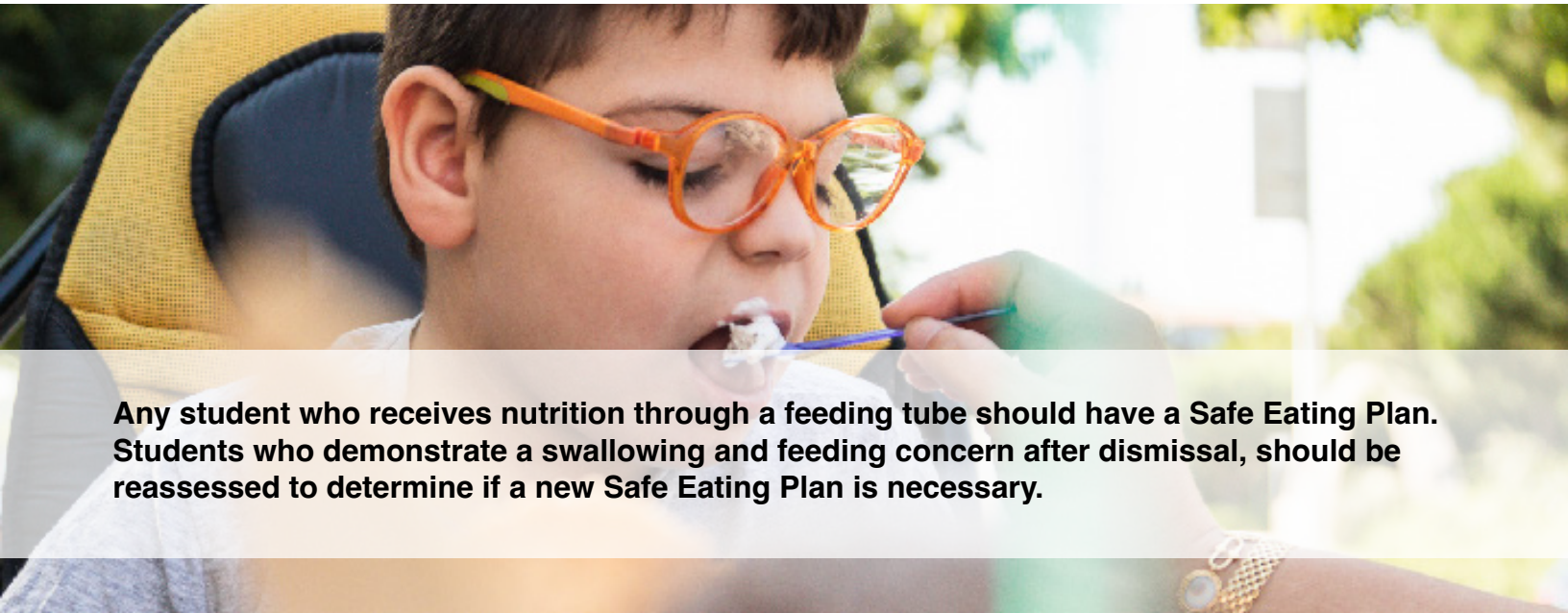
*Transfer Procedure During the School Year*

During the school year, when a student transfers to a new location, a process should be followed to ensure that the student's swallowing and feeding concerns are immediately addressed. The school team should ensure the student's Safe Eating Plan is included in the student's educational file. School transfer form example

*Dismissal Procedure*

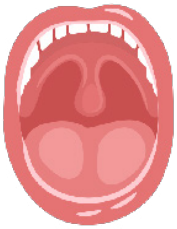
A student is dismissed from support provided by the PFD team when data indicates the student no longer needs a Safe Eating Plan. The district should follow IEP team procedures where applicable. Some indicators for dismissal may include:

- Eating a variety of foods and textures appropriate for developmental age.
- Eating a normal consistency diet (IDDSI level 7 for solids, level 0 for drinks).
- There are no longer health risk concerns for undernutrition due to the inability to swallow safely, chew, self-feed, etc.
- Special instructions are no longer needed for safety during school meals.



**Any student who receives nutrition through a feeding tube should have a Safe Eating Plan. Students who demonstrate a swallowing and feeding concern after dismissal, should be reassessed to determine if a new Safe Eating Plan is necessary.**





# ORAL PHASE DYSPHAGIA

There are times when a student has oral motor or sensory motor disorders which warrant treatments to improve the oral preparatory and oral transit phases and functional eating skills. These therapeutic interventions may be established in SLP or OT sessions for the purpose of strengthening oral motor skills and desensitizing sensory issues. Following the establishment of a treatment plan by the SLP or OT, exercises to improve oral motor and sensory motor deficits may be implemented by trained classroom staff and caregivers under the training and monitoring of the SLP and/or OT.

***To be effective:***

- exercises should be specific to the child s weaknesses.
- exercises should be done frequently and repeatedly with fidelit .
- caregivers and classroom staff are trained to assist the student with the exercises throughout the day.
- data should be taken regularly to drive the treatment plan and monitor progress.

***Points to remember when implementing a treatment plan for oral phase dysphagia and sensory motor disorders:***

- Therapy should be based on clinically observed deficits in the child and should focu on specific skills that are functional and meaningful such as spoon feeding, biting chewing, etc. (Edwards, 2013).
- Oral motor skills should be trained in the order they normally develop (Sheppard, 2005).
- Oral motor program should be intensive and systematic with the goal being to progress to a more normalized diet.

***According to Sheppard (2008) primary eating milestones are:***

- Eating from a spoon
- Drinking from a cup
- Sipping from a straw
- Biting
- Chewing
- Self-feeding

>> ***Click here for ASHA's Feeding and Swallowing Milestones***

# *Oral Phase* STRUCTURES *and Their Roles*

1. **LIPS**
Must close on a spoon, straw, or cup for efficient intak

2. **TONGUE**
Lateralizes to place a bolus on the lateral chewing surfaces and then returns the bolus to midline

3. **JAW**
Horizontal, vertical, and rotary jaw movements are necessary for effective biting and chewing

4. **CHEEKS**
When cheeks have normal tone, they remain tight against the gums, keeping the bolus from falling into the lateral sulci

# *Therapeutic Activities to Consider*

***Spoon feeding***

***Biting***

***Lip closure***

***Chewing***

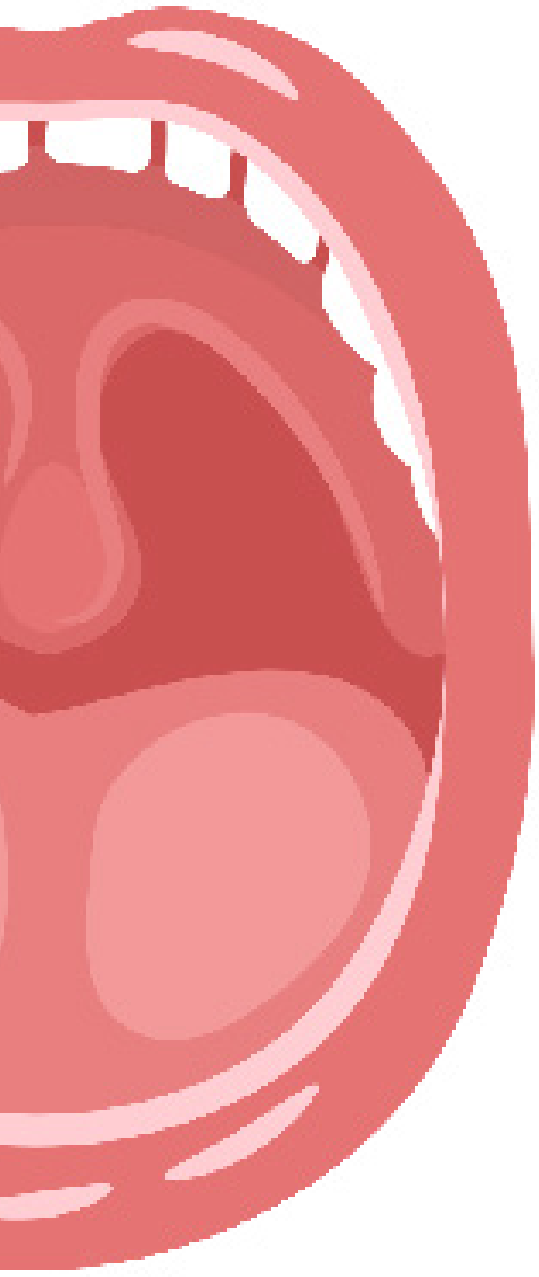
***Drink to bite ratio***

***Swallowing before taking another bite***

***Appropriate amount placed on eating utensil***

***Adequate amount of chewing before swallowing***

***Alternating a variety of foods at each meal***



## PHARYNGEAL PHASE DYSPHAGIA

Children with pharyngeal phase dysphagia are primarily supported in school through a modified diet. Some children may benefit fro therapeutic interventions to address swallowing. The PFD team will need to determine if the student's nutritional needs are adequately being met at school. For students with pharyngeal phase dysphagia, it is essential that all feeders are trained in safe feeding strategies, signs of aspiration, and a safety plan. If feeding interventions are required at school, the school team should work with medical providers on interventions relevant for school.

## PROGRESSIVE DISORDER AND MEDICALLY FRAGILE

When a child has a progressive disorder or is medically fragile, the focus of the PFD team changes. The goals turn to maintaining skills and adapting as the student regresses or when an illness interferes with safe eating. It becomes even more important that the school team work closely with the caregivers and physicians to monitor the student's swallowing and feeding skills and to adjust to the changes in the student's condition.

The school PFD team closely monitors the student's safe eating plan to make sure that it remains appropriate, revises it when there are changes in the student's skills, and trains designated feeders on the new safe eating plan. The nurse is a major team member not only monitoring the student's health at school but also communicating with caregivers and physicians to keep them informed of how the student is doing at school.

### *Medical Instability*

There are times when a student experiences persistent illness or develops an acute illness that affects their ability to eat safely. In these cases, observe the student's swallowing and feeding skills and ask the following questions:

- Can the student continue to eat safely at school?
- If so, what changes need to be made to the plan?
- Does the student need an alternative method of receiving nutrition?

# TRANSITIONING TO OR FROM TUBE FEEDING

### *General information*

There are many ways that children may receive enteral nutrition. The nasogastric tubes (NG), jejunostomy tubes (JEJ, PEJ or RIJ tubes), and the percutaneous endoscopic gastrostomy tubes (PEG tube) are among the most common. All use a high-calorie liquid food mixture containing protein, carbohydrates (sugar), fats, vitamins, and minerals.

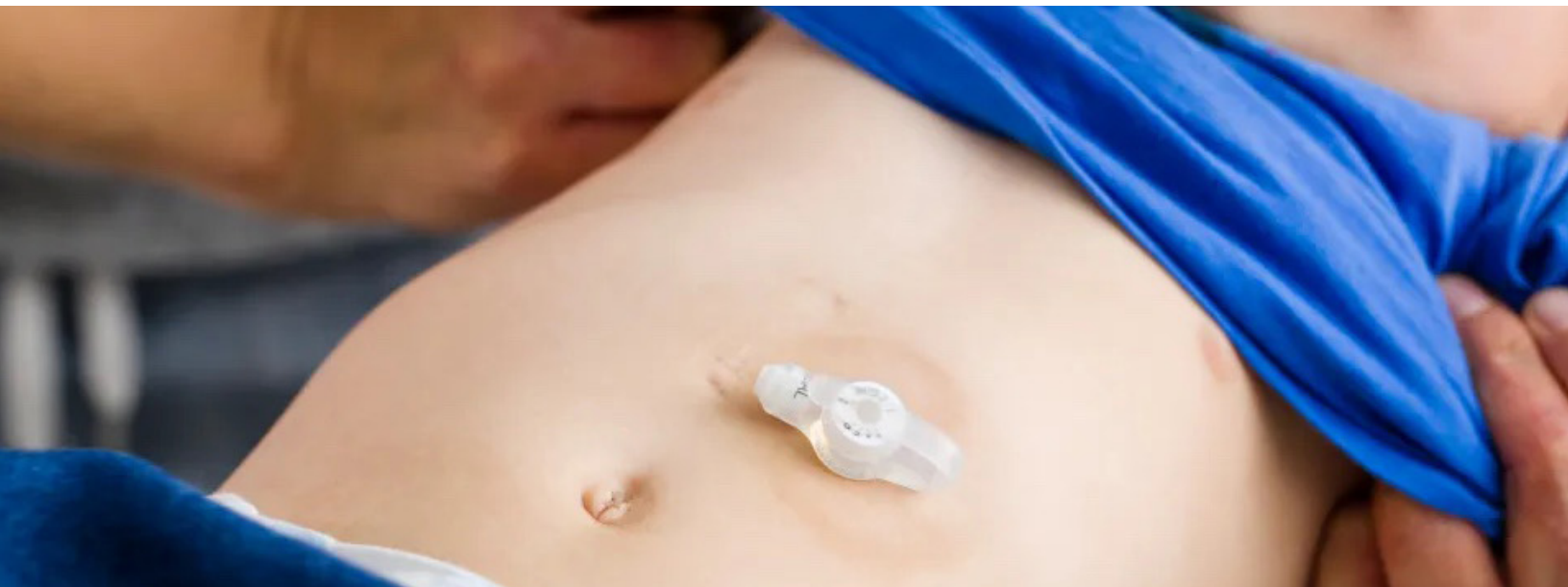
### *When does a child need tube feeding?*

- the child is unable to sustain nutrition orally due to oral motor deficits or aversion but has a saf pharyngeal swallow.
- The student is at a high risk for aspiration that cannot be addressed with food modifications positioning, or feeding strategies.
- The child is too sick to eat normally and too fragile to risk surgical insertion of the PEG. Nasogastric tube is typically used in this case but is often a temporary solution.

### *The school's role in transition*

The decision to move a student from oral feeding to tube feeding is often very difficult and emotional. This decision is made by the caregivers and the child's physicians; however, the school team plays an important role in supporting or seeking a decision. The school team serves as an information source to the student's physician, reporting their observations during school meals, strategies, and modifications attempted and the results. Regardless of caregive 's or physician's decisions, the school district must always focus on the safety of the student at school and cannot feed the student in a way that the school team determines is unsafe.

When a student is moving from enteral nutrition to oral feeds, ongoing consultation and collaboration with the student's medical team and caregivers is recommended. A medical prescription is necessary stating that the student is safe to return to oral feeding at school. While the school district does not have total responsibility for this transition, the school PFD team can assist and facilitate the transition process during school feedings.



# BEHAVIORAL FEEDING DISORDERS

### *General Information*

A behavioral feeding disorder or PFD with a psychosocial factor is when a child has a response to foods, liquids, and/or mealtimes that interferes with their ability to function in normal, daily living activities both at home and in the school setting. The child may have a medical condition which makes eating painful or unpleasant or a sensory-motor disorder. The school team may observe aversions to food and mealtimes and an effort to escape the situation.

**These children may exhibit the following behaviors during mealtimes:**

- Oral defensiveness
- Oral hypersensitivity
- Picky eating
- Feeding aversion
- Feeding jags (eats only one thing)
- Limited eating (only eats a certain amount)
- Food refusal
- Vomiting and gagging

Children in the school setting with behavioral or sensory-motor disorders must be approached differently than those with a strict safety concern. Behavioral disorders rarely occur on their own and often have other accompanying disorders which can affect a student's feeding status.
They are treated by the core team members, the SLP, OT, PT, and school nurse, with the addition of a behavioral specialist when appropriate.

To successfully address the behavioral feeding disorder, it is necessary to identify the underlying causes of the behaviors being observed at school. The school team should work with caregivers and physicians on identifying any medical issues such as esophageal dysfunction, dysphagia, respiratory concerns and so on, that may be affecting the student's eating. If oral, pharyngeal, and/or esophageal dysphagia is suspected it is important to go through the district procedure to identify the specific concerns and address them. Students with developmental delays, health impairments, and autism are at high risk for choking during meals.

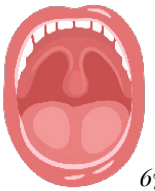
Students presenting with the behaviors listed above may have sensory motor issues. The school team should identify any sensory issues that the child is exhibiting and provide intervention when data indicates an adverse educational impact. Finally, because these children are high risk for undernutrition and dehydration, the team should determine if the student has adequate nutrition and hydration to access their curriculum. The school nurse can play an important role in identifying nutritional concerns, communicating with caregivers and physicians, and working with the PFD team to increase the student's nutritional intake at school.

### *General treatment goals:*

According to Fischer et. al. (2005), general treatment goals should focus on decreasing behavioral problems at meals. Areas that may be addressed are:

- Increasing oral intake or the variety of oral intake.
- Advancing texture.
- Increasing the structure and routine of mealtimes.
- Choosing and targeting specific behaviors for increase or decrease/ extinction. Thus, detailed behavioral programs are designed to address individual behaviors as well as to further the general goals of treatment.





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# Forms

# Team Procedure Checklist

Student: _____ School: _____
SLP: _____ OT: _____
Nurse: _____

| DATE | PROCEDURE |
|---|---|
| **Step 1: Observation Request** | |
| | Observation Request Form completed by: |
| | Informal Observation of the student eating, completed by: |
| **Step 2: Caregiver Interview** | |
| | Caregiver Interview Form sent home |
| | Interview with caregiver:<br>☐ Phone ☐ Virtual ☐ In-person ☐ Unable to meet |
| **Step 3: Interdisciplinary Assessment** | |
| | Interdisciplinary team completes the mealtime assessment |
| | Team meets to discuss outcome of the assessment and next steps |
| **Step 4: Safe Eating Plan** | |
| | Safe Eating Plan written |
| | IHP/Emergency Plan established and signed by parent |
| | Cafeteria staff trained on mealtime modifications as needed |
| | Classroom staff trained on Safe Eating Plan and Emergency Plan |
| | Safe Eating and Emergency Plans initiated |
| **Step 5: School Meal Modification** | |
| | Prescription for School Meal Modification obtained |
| | Safe Eating Plan is given to Child Nutrition director and staff |
| | Child Nutrition staff trained on IDDSI (as needed) and the student's Safe Eating Plan |

| DATE | PROCEDURE |
|---|---|
| **Step 6: IEP Conference** | |
| | IEP meeting held<br>*Persons attending:<br>☐ Teacher ☐ SLP ☐ OT ☐ PT ☐ Administrator<br>☐ Nurse ☐ Parents ☐Other:<br>_____<br><br>*Issues addressed:<br>☐ Emergency Plan ☐ Medical History ☐ Referral to Physician<br>☐ Release of Information ☐ Safe Eating Plan discussed ☐ Referral for VFSS<br>☐ Information from IEP sent to Food Service for recommended changes<br>☐ Other:<br>_____ |
| **Step 7: VFSS Referral (as needed)** | |
| | Script for instrumental evaluation requested from physician, when indicated |
| | Script received and VFSS appointment set up |
| | Pre-VFSS Form sent to hospital SLP |
| | VFSS conducted<br>*attended by:<br>_____ |
| **Step 8: Safe Eating Plan Revised (as needed)** | |
| | Addendum to IEP to include new information |
| | Safe Eating Plan revised to reflect recommendations from the VFSS |
| | School staff and caregivers trained on the new Safe Eating Plan |
| | New Safe Eating Plan is initiated |

# Observation Request Form

Date form completed: _____ Classroom teacher: _____

Student: _____ Completed by/title: _____

Date of birth: _____ School: _____

**BACKGROUND INFORMATION:**

**Medical Diagnosis:** _____

**History of swallowing or feeding concerns:** ☐ YES or ☐ NO

If YES, please choose from the following:

| | |
|---|---|
| ☐ Repeated respiratory infections<br>☐ History of recurrent pneumonia<br>☐ Weight loss/history of undernutrition | ☐ Receives nutrition through tube feeding<br>☐ Other: |

**OBSERVED BEHAVIORS:**

Consult with speech-language pathologist, occupational therapist, and staff assigned to support the student during mealtimes to answer questions below.

| | |
|---|---|
| ☐ Requires special diet or diet modification (i.e. baby foods, thickener, soft food only)<br>☐ Poor upper body control<br>☐ Poor oral motor functioning<br>☐ Maintains open mouth posture<br>☐ Drooling<br>☐ Nasal regurgitation<br>☐ Food remains in mouth after meals (pocketing)<br>☐ Swallowing solid food without chewing<br>☐ Overstuffing<br>☐ Effortful swallowing or difficulty initiating swallow | ☐ Food and/or drink escaping from the mouth or trach tube<br>☐ Slurred speech<br>☐ Eyes watering/tearing during mealtime<br>☐ Wet breath sounds and/or gurgly voice quality following meals or drinking<br>☐ Coughing/choking during meals<br>☐ Unusual head/neck posturing during eating<br>☐ Hypersensitive gag reflex<br>☐ Mealtime takes more than 30 minutes<br>☐ Needs assistance with mealtimes |

**ADDITIONAL ADVERSE BEHAVIORS OBSERVED:**

| | |
|---|---|
| ☐ Avoids food textures, colors, tastes, etc.<br>☐ Feeding jags (eats only one thing)<br>  ☐ Limited eating (only eats a certain amount)<br>☐ Maintains open mouth posture<br>  ☐ Spitting up or vomiting associated with eating and drinking | ☐ Gags easily<br>☐ Food refusal<br>  ☐ Feeding aversion<br>  ☐ Self-injury during meals |

**ADDITIONAL INFORMATION OR COMMENTS:**

**SECTION COMPLETED BY PFD TEAM MEMBER:**

Informal observation conducted by: _____

**Notes:**

☐ **Concerns Verified**: **Initiate Step 2: Caregiver Interview in PFD Procedures**

**Next Steps:**

# Caregiver Interview Form

☐ In person meeting ☐ Virtual meeting ☐ Phone
Student: _____ Gender: _____ Date of Birth: _____
Name of caregivers: _____ Phone: _____
Address: _____

_____

**Do you have any concerns about your child's feeding and/or mealtimes?** ☐ YES ☐ NO
If yes, please describe:

| |
|---|
| |

## MEDICAL INFORMATION

**Name of primary care physician:** _____
**Is your child followed by any of the following physicians?**

☐ Gastroenterologist Name and Phone #: _____
☐ Neurologist Name and Phone #: _____
☐ Pulmonologist Name and Phone #: _____
☐ Other: _____ Name and Phone #: _____
**Current Height:** _____ **Current Weight:** _____
**Indicate if your child has any of the following allergies?**

☐ Food: _____
☐ Environmental: _____
☐ Asthma: _____

**Bowel Habits:**
Frequency of Bowel Movements: _____times per (check one): ☐ Day ☐ Week
Consistency: ☐ Hard ☐ Soft ☐ Loose ☐ Watery
**Sleep patterns:** ☐ Normal ☐ Wakes at night ☐ Snores ☐ Mouth breathing
**Medications taken on a regular basis (please include dosage and frequency):**

| Medication | Dose | Prescribing Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please check if your child has had any of the tests below:**

☐ Swallow study (VFSS) Date: _____ Results: _____

☐ Upper GI (Barium Study) Date: _____ Results: _____

☐ Gastric emptying Date: _____ Results: _____

**Does or has your child ever had GERD (gastroesophageal reflux disorder)?** ☐ YES ☐ NO

If yes, please list the symptoms and treatments:

**Has your child had other esophageal conditions such as eosinophilic esophagitis, or gastrointestinal disorder?** ☐ YES ☐ NO

If so, when and current treatment:

**Does your child currently have frequent respiratory infections?** ☐ YES ☐ NO

**Does your child have a history of pneumonia?** ☐ YES/when? _____ ☐ NO

**Has your child ever been diagnosed with undernutrition?** ☐ YES/when? _____ ☐ NO

Explain how this was addressed:

Was it resolved? ☐ YES ☐ NO

**Was, or is your child fed through a feeding tube?** ☐ YES ☐ NO

If yes, then when? _____ How long? _____

What was the reason for the tube feeding?

☐ Aspiration ☐ Undernutrition ☐ Other: _____

**Hospitalizations (month, year, reason):**

**Current Medical Problems:**

**Does the child visit the dentist on a regular basis?** ☐ YES ☐ NO

When was your child's last visit to the dentist? Date: _____

Dentist Name: _____

Is there any significant dental history that may affect your child's eating habits? ☐ YES ☐ NO

If yes, please explain:

Tooth brushing: ☐ with assistance ☐ independent

## CURRENT FEEDING PRACTICES

**Describe a typical family meal:**

**What are your child's food preferences?**

Likes:

Dislikes:

**What kinds of food does your child eat?**

☐ Regular Liquids ☐ Thickened liquids ☐ Pureed ☐ Mashed ☐ Ground
☐ Chopped ☐ Bite-sized pieces ☐ Table foods (whatever your family is eating)

**Does your child self-feed (e.g., holding utensil, scooping, bringing food to mouth)?**

☐ YES, independently ☐ YES, with assistance ☐ NO

**Does your child enjoy mealtime?** ☐ YES ☐NO

**Are mealtimes stressful for the child and/or caregiver?** ☐ YES ☐ NO

**How do you know when your child is hungry?**

**How do you know when your child is full?**

**Frequency and duration of meals:**

**Check all that apply:**

☐ Choking during a meal ☐ Vomiting ☐ Coughing during and/or after a meal
☐ Chronic ear infections ☐ Gagging ☐ Chronic respiratory problems
☐ Difficulty chewing ☐ Tongue thrust ☐ Gurgly or "wet" voice
☐ Biting on utensils ☐ Food refusal ☐ Sensitive to being touched around the mouth
☐ Avoidance behaviors during feeding
☐ Drooling: ☐ constant ☐ frequent ☐ occasional

**Does your child take any nutritional supplements?** ☐ YES ☐ NO

If yes, specify: _____

**Do certain foods/liquids appear to be more difficult for your child to eat?**

**How is your child positioned during feeding?**

☐ Regular chair at table ☐ Booster seat ☐ Highchair
☐ Sitting in a wheelchair ☐ Tumble form chair ☐ Held on lap
☐ Adaptive chair, type: _____
☐ Other: _____

**What utensils are used?**

☐ Bottle ☐ Sippy cup ☐ Open Cup (no lid) ☐ Straw
☐ Spoon ☐ Fork ☐ Toddler utensils

**Other adaptive equipment:**

**Additional Comments or Concerns:**

_____ _____
**CAREGIVER SIGNATURE** **DATE**

_____ _____
**CAREGIVER'S NAME PRINTED** **PHONE #**

_____ _____
**INTERVIEWED BY** **DATE**

# Interdisciplinary Assessment Form

**Student:** _____ **Age:** _____ **Date of Birth:** _____ **Date of Observation:** _____
**School**: _____ **Diagnosis:** _____
**SLP:** _____ **OT:** _____ **Classroom Teacher:** _____
**Nurse:** _____ **Parent:** _____ **PT:** _____

**General Information**
During this consultation, the student was (check all that apply):
**Level of Alertness:** _____
**Level of Awareness:** _____
**Mode of Communication:** _____

**Seating:** ☐ Wheelchair ☐ Tumble form ☐ Rifton Chair ☐ Other: _____

**Positioning:** ☐ Upright ☐ Semi upright ☐ Reclining <30º
☐ Other: _____

**Head control:** ☐ Adequate ☐ Poor ☐ Excessive head/neck hyperextension

**Facial:** ☐ Asymmetrical ☐ Jaw extension ☐ Open mouth posture

**Abnormal reflexes observed:**

**Notes**:

**Observation of Liquids Presented:** ☐ **N/A**

1. Method of Presentation (ex: straw, etc.): _____
2. Oral Presentation (lateral vs. midline): _____
3. Pacing and Cueing Description: _____
4. Manual Support**:** _____

**Instructions:** Write in the name of the liquid presented in the blocks labeled liquid 1, liquid 2 and liquid 3. Check all that apply.

| | Liquid 1: | Liquid 2: | Liquid 3: |
|---|---|---|---|
| Consistency of Liquid | | | |
| Temperature | | | |
| Taste (Sour, Sweet, etc.) | | | |
| Tongue Thrust/ reduced retraction | ☐ | ☐ | ☐ |
| Bite on cup | ☐ | ☐ | ☐ |
| Anterior loss | ☐ | ☐ | ☐ |
| Limited jaw opening | ☐ | ☐ | ☐ |
| Limited upper lip closure over cup | ☐ | ☐ | ☐ |
| Delayed swallow | ☐ | ☐ | ☐ |
| Coughing following drink | ☐ | ☐ | ☐ |
| Gurgly, wet quality (check those that apply) | ☐ Before ☐ During ☐ After | ☐ Before ☐ During ☐ After | ☐ Before ☐ During ☐ After |
| Liquid residue in oral cavity | ☐ | ☐ | ☐ |
| Throat clearing | ☐ | ☐ | ☐ |
| OTHER: | ☐ | ☐ | ☐ |

**Observation of Foods Presented** ☐ **N/A**

1. Method of Presentation (ex: spoon, etc.): _____
2. Oral Presentation (lateral vs. midline): _____
3. Pacing and Cueing Description: _____
4. Manual Support: _____

**Person assisting with meal:** _____ **Location/Setting:** _____ **Positioning:** _____

**Utensils/Adaptive equipment used:** _____

**Instructions:** Write in the name of the food presented in the blocks labeled food 1, food 2 and food 3. Check all that apply.

| | **Food 1:** | **Food 2:** | **Food 3:** |
|---|---|---|---|
| Consistency of food presented: | | | |
| Temperature: | | | |
| Taste (Sour, savory, etc.) | | | |
| Poor lip closure | ☐ | ☐ | ☐ |
| Drooling | ☐ | ☐ | ☐ |
| Reduced lip action to clear material | ☐ | ☐ | ☐ |
| Poor bolus formation/movement | ☐ | ☐ | ☐ |
| Decreased anterior/posterior movement | ☐ | ☐ | ☐ |
| Food residue in oral cavity | ☐ | ☐ | ☐ |
| Absence of chewing | ☐ | ☐ | ☐ |
| Absence of rotary jaw movement (munching) | ☐ | ☐ | ☐ |
| Bites on spoon or utensil | ☐ | ☐ | ☐ |
| Delayed swallow initiation | ☐ | ☐ | ☐ |
| Cough or throat clear following swallow | seconds | seconds | seconds |
| Cued swallow | ☐ | ☐ | ☐ |
| Fatigued easily | ☐ | ☐ | ☐ |
| Gagging before/during/after meal | ☐ | ☐ | ☐ |
| OTHER: | ☐ | ☐ | ☐ |

**Behavioral Observations** ☐ **N/A**

**Instructions:** Briefly describe how the food was presented and what happened under each presentation. Check + if the behavior was observed and – if the behavior was not observed. Ex: sweet, crunchy

| Interfering Behaviors | Liquid #1 | Liquid #2 | Liquid #3 | Food #1 | Food #2 | Food #3 |
|---|---|---|---|---|---|---|
| Throwing food/utensils | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Screaming/crying | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Self-injury | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Flopping (falling to the floor) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Leaving the area | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Closing mouth/head turn | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Talking with food in mouth | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Spitting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Overstuffing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Aggression (biting, scratching, head butting, punching attempting to hurt feeder) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| OTHER: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Sensory Questionnaire and Observation** ☐ **N/A**

**Instructions:** Observe and interview teachers, parents etc. and indicate if each statement applies. Add comments to explain further.

| **Sensory Questionnaire/Observation** | **Check all that apply** | **Additional comments:** |
|---|---|---|
| Avoids eating certain food textures (crunchy, soft, chewy, liquid) | ☐ | |
| Avoids eating foods of certain temperatures (warm like oatmeal, cold like ice, room temperature) | ☐ | |
| Eats primarily one color of food | ☐ | |
| Eats only certain tastes (salty, sweet, sour, spicy, bland) | ☐ | |
| Does not notice food left on his/her face | ☐ | |
| Reacts emotionally when asked to hold utensil/cup | ☐ | |
| Limits self to specific food items - list | ☐ | |
| Gags when introduced to a new food or texture | ☐ | |
| Gags easily when eating or when using utensils | ☐ | |
| Resists tactile exploration of food or other activities (sand, mud, play doh, etc.) | ☐ | |
| Enjoys playing with food but does not eat it | ☐ | |
| Resists grooming, face washing, tooth brushing | ☐ | |
| Mouths, licks, or chews non-edible items | ☐ | |
| Routinely smells things (food or non-food items) | ☐ | |
| Hypersensitive to noises in the environment | ☐ | |
| Overstuffing | ☐ | |

**Modifications Attempted During Interdisciplinary Observation**

Dietary Modifications: _____

Adapted Equipment Modifications: _____

Positional Changes: _____

Behavioral Interventions: _____

Other: _____

**Summary and Recommendations:**

| |
|---|
| |

1. _____
2. _____
3. _____

**Date Parent Informed:** _____

**Date Team Informed:** _____

**Parent/Team Additional Notes:**

| |
|---|
| |

**Referral/Recommendation for:**

☐ VFSS ☐ Physician Consultation ☐ Release of Information ☐ Behavioral Specialist Referral
☐ Safe Swallowing and Feeding Plan ☐ Training ☐ IEP team meeting scheduled

_____ _____

Signature of Person Completing Form Date

# Safe Eating Plan

Student: _____ Date of Birth: _____
School: _____ Date of Plan: _____
Teacher: _____ PFD Team Lead: _____
PFD Team Lead Contact Info: _____

**CASE HISTORY AND PRESENTING CONCERNS:**
Diagnosis: _____
Findings from VFSS and/or Interdisciplinary observation:

_____
Seizure Disorder: ☐ Yes ☐ No

**FEEDING RECOMMENDATIONS**:

**Seating and Positioning:** _____
Positioning of the feeder to the student:

☐ Feeder directly across from student ☐ Feeder slightly to the side of student
☐ Feeder next to the student ☐ Other:

**Utensil selection (type in specific recommendation):**

☐ Special spoon/fork
☐ Special cup
☐ Special bowl/plate
☐ Other: _____

**Tube Feeding:**

☐ Tube fed only/nothing by mouth
☐ Tube and oral fed

**Diet/Food Preparation (according to the IDDSI):**

Food Consistency:

☐ Liquidized ☐ Pureed (pureed) ☐ Minced and moist (mech. ground)
☐ Soft and bite sized (chopped) ☐ Regular (regular)

Liquid Consistency:

☐ Extremely Thick (pureed) ☐ Moderately thick (honey)
☐ Mildly thick (nectar) ☐ Slightly thick ☐ Thin

Sensory Modifications:

☐ Temperature: _____ ☐ Taste: _____
☐ Texture: _____ ☐ Color: _____

**Other recommendations:**

**Feeding Plan Techniques/Precautions:**

Amount of food per bite (be specific to amount and size): _____

Spoon presentation and placement: ☐ Left Lateral ☐ Right Lateral ☐ Midline

Keep the student in an upright position for _____ minutes after the meal.

Offer a drink after _____ bites.

- Amount of liquid required: _____

Typical volume consumed during the meal: _____

Other mealtime management precautions:

**Monitoring during mealtimes:**

☐ 1:1 feeder to student ☐ 1:2 feeder to student ☐ 1:3 feeder to student

**Swallowing and Feeding Plan Training**

I, the undersigned, have read and been trained on implementing the swallowing and feeding plan for _____. I agree to implement the swallowing and feeding plan as specified.

| Name | Position | Date |
|---|---|---|
| | | |
| | | |
| | | |

**I understand that I am responsible for the implementation of this student's Safe Eating Plan.**

**Teacher Signature:** _____ **Date:** _____

# Trained Feeders

Student: _____ Classroom Teacher: _____

PFD Team Leader: _____ School: _____

**Use this form to document the date, supervision, and names of feeders trained. Document comments as necessary. An example is provided.**

**Indicate the level of supervision and monitoring required during meals at school using the following key:**

1:1 Student needs maximum monitoring during meals. One student to one trained adult.

2:1 Student needs monitoring during meals but is somewhat independent. Two students to one trained adult.

3:1 Student self feeds and needs to be monitored during meals to maintain pacing, food choices, drink to food ratio, etc. Three students to one trained adult.

| Date | Level of Supervision | Feeder #1 | Feeder #2 | Feeder #3 | Comments |
|---|---|---|---|---|---|
| *Example: 08/31/2023* | *1:1* | *Ms. Smith* | *Ms. Adams* | *Mr. Owens* | *Initial training on Safe Feeding Plan* |
| *Example: 12/01/2023* | *2:1* | *Ms. Smith* | *Ms. Adams* | *Mr. Owens* | *Training on **Revised** Safe Feeding Plan* |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# School Meal Modification Form

Student's Name: _____ Age: _____ Grade/Classroom: _____
School: _____ Parent's Name: _____
Parent's Email: _____ Telephone: _____
Address: _____
Steet or P.O. Box City Zip

**List the Medical Condition that results in special nutritional or feeding needs:**

_____

## DIET PRESCRIPTION (mark all that apply)

**Food Intolerance:** _____

**Eliminate ALL foods that may contain any form of:**

- ☐ Eggs-pure form only
- ☐ Milk-beverage form only*
  *Substitute (please check): ☐ Juice or ☐ Water
- ☐ Milk AND dairy only*
  *Substitute (please check): ☐ Juice or ☐ Water
- ☐ Eggs proteins
- ☐ Fish
- ☐ Milk proteins
- ☐ Nuts
- ☐ Peanuts
- ☐ Shellfish
- ☐ Soy-pure form only
- ☐ Soy
- ☐ Wheat-whole form only
- ☐ Wheat
- ☐ Other: _____

**Consistency: Foods**

- ☐ Regular
- ☐ Soft and bite-sized
- ☐ Minced and Moist
- ☐ Pureed/Extremely thick
- ☐ Liquidized

**Consistency: Drinks**

- ☐ Thin
- ☐ Slightly thick
- ☐ Mildly thick
- ☐ Moderately thick
- ☐ Extremely thick

**Any Other Specific Dietary Need:** _____

| Specific Foods to Omit | Specific Foods to Substitute |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

***Please note: if juice or water must be substituted for liquid milk, it must be noted on diet prescription form or student will be charged for juice or water.***

I certify that the above-named student needs special meals prepared as described above because of the student's chronic medical condition:

Office Address: _____
Office Fax: _____ Office Telephone: _____

_____ _____
Licensed Physician/Recognized Medical Authority Signature Date

# Instrumental Evaluation Form

Date form completed: _____

Name: _____ Date of Birth: _____ CA: _____

Diagnosis: _____

Referring SLP: _____

## BRIEF MEDICAL HISTORY:

**Positional concerns and adaptive equipment currently used at school:**

| |
|---|
| |

**Current diet recommendations:** _____

**Results of Interdisciplinary Observation Performed at School:**

| |
|---|
| |

**Oral Phase:**

| | |
|---|---|
| ☐ Drooling<br>☐ Pocketing:<br>☐ Lateral sulcus<br>☐ Anterior sulcus<br>☐ Not clearing the oral cavity before swallow<br>☐ Anterior loss/poor lip seal | ☐ Excessive chewing<br>☐ Hyper/hypo sensitivity<br>☐ Difficulty with bolus formation<br>☐ Other: |

**Pharyngeal Phase:**

| | |
|---|---|
| ☐ Coughing/choking:<br>☐ Before ☐ After ☐ During swallow<br>☐ Repetitive swallows<br>☐ Wet/gurgly voice quality after swallow | ☐ Delay in triggering swallow<br>☐ Decreased/absent laryngeal elevation<br>☐ Expectorating food<br>☐ Other: |

**Information that the school system would like to receive from the instrumental evaluation:**

1. _____
2. _____
3. _____

We have included an Authorization for Release of Confidential Information. If you have questions, please contact:

Name: _____ Phone: _____

Email: _____

# PFD School Transfer Form

Please complete this form on any student who will be moving or has moved to a new school. Put a copy of this form in the student's folder and send a copy of this transfer form to the pediatric feeding disorders team administrator. Complete a different form for each student who is transferring to a different school.

Date: _____

Name of Student: _____ Date of Birth: _____

Current School: _____

Current PFD Team Leader: _____

School Transferring to: _____

Receiving PFD Team Leader: _____

*Note: Use the Pediatric Feeding Disorder Team Assignment Form to determine who the PFD Team Leader is for the receiving school.

# Appendix

# FEEDING DOMAIN

Some students with PFD require specialized equipment to eat safely and independently at school. There are many types of assistive technology (AT) tools available to help students. It is important to have a team consider AT tools for feeding. Here are some common pieces of feeding equipment

***Need for special preparation or texture of food (IDDSI levels)***

- Unable to self-feed
- Extremely short mealtimes
- Extremely long mealtimes
- Need for specialized feeding equipment and utensils
- Does not process food in the mouth (stuffs) due to sensory or motor deficits

***Maroon spoon helps ...***

- Control bite size
- Remove food from utensil (poor lip closure)
- Acceptance of utensil (oral hypersensitivity)

***Scoop plate helps...***

- Scoop food onto utensil
- Reduces spillage

***Easy Hold Silicone Strap helps...***

- Grip utensil

***Did you know...***

The Obi Robot is an adaptive eating device for anyone with upper extremity strength and mobility limitations. It can be customizable for accessibility by using switches allowing the user to control what they eat and when!

- Need for positioning support during mealtimes
- Need for specialized strategies to eat weighted or built-up utensil helps
  - Grip utensil
  - Steady utensil
  - Some adapted utensils can be off-set or angled to help with self-feeding

***Long drinking straws help...***

- With limited arm mobility

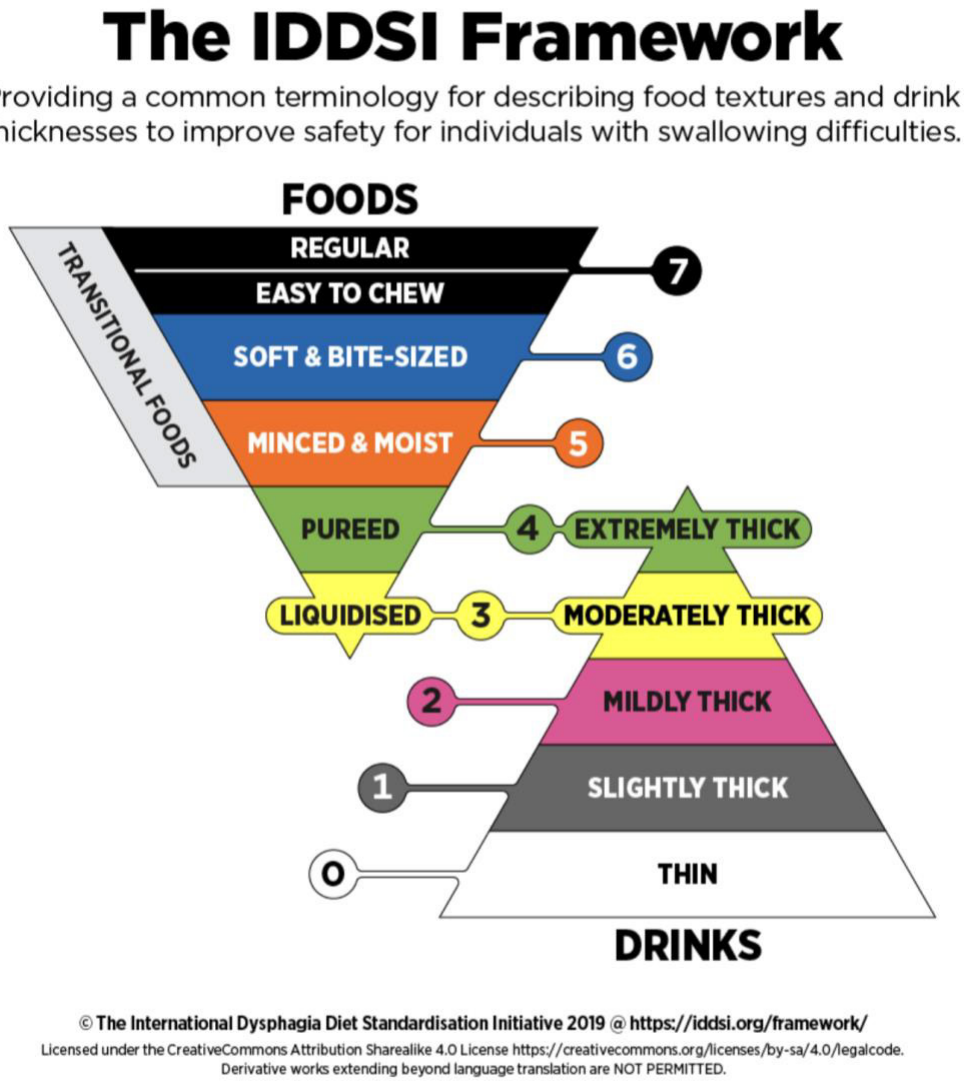
***Flexible "nosey" cup***

- Prevents tilting head too far back
- Reduces aspiration risk

***Cups with two handles help***

- With motor impairments
- Prevent spillage

If you're unsure of what equipment will best meet the oral motor, feeding, and drinking needs of a student, check out the Easterseals Feeding Kit to trial a few options.




IDDSI, has full support of:

- Academy of Nutrition and Dietetics (AND)
- American Speech-Language and Hearing Association (ASHA)
- Association of Nutrition and Foodservice Professionals (ANFP)

Questions your school might consider:

- Are we using the 8 levels and labels for foods and liquids (0-7)?
- Do the foods and liquids follow the preparation recommendations for that level?
- Have we looked at our menu to determine if foods need to be moved to a different level, removed, or prepared a different way?
- Do staff know how to identify and prepare modified foods and liquids?

For more information: [Website | The IDDSI Framework | Testing Methods ]

# MEDICAL DOMAIN

## *Signs and symptoms of aspiration*

- Aspiration occurs when something foreign (food, liquid, saliva, etc.) enters the level below the true vocal folds.
- Clinical signs and symptoms of aspiration during oral intake may include the following:
  - Coughing or choking
  - Wet/gurgle vocal quality
  - Facial color changes
- Chronic aspiration may be characterized by the following:
  - Recurrent episodes of pneumonia
  - Chronic cough
  - Poor weight gain and growth
  - Unexplained fevers
- Students may aspirate without signs or symptoms. We refer to this as silent aspiration

## *When to refer and how*

- When clinical signs and symptoms of aspiration are present during drinking or eating, it is necessary to refer the student for an instrumental evaluation (Videofluoroscopic Swallow Study, VFSS) to obtain information about the safety of the pharyngeal phase of swallowing.
- When characteristics of chronic aspiration are present, a VFSS may be necessary to rule out underlying aspiration when other medical factors have been ruled out.
- If the SLP determines that the feeding problem is due to an oral motor deficit, sensory deficit, and/or behavioral in nature, an instrumental assessment (VFSS) is not necessary if clinical signs or symptoms of aspiration are not present.
- If the IEP team determines an additional clinical feeding evaluation is needed to facilitate safer feeding in the school environment, a VFSS referral should be requested.
  - ACH: Swallow Study or Functional Feeding Evaluation? Instrumental assessment requires an order from the physician to the referral site.

## *Prepping for the VFSS*

- The goal of a VFSS and/or clinical feeding evaluation is to determine a Safe Eating Plan.
- When possible, the school SLP should communicate with the medical SLP before the instrumental exam.
  - If this is not possible, a communication tool should be used to share observations and concerns regarding the student's feeding and swallowing.
  - The Students Eat Safely Form should be sent with the student on the day of their appointment.

- Based on the results of the evaluations, changes to diet and/or manner of intake precautions may be recommended for the school team and family to carry out.
- The Safe Eating plan should be adjusted accordingly. The SLP should then work closely with the cafeteria manager to ensure the meal follows these recommendations.
  - The SLP and food service manager should review the monthly meal menu together in order to eliminate unsafe food items and develop substitutions.

## *Types of Assessment: Clinical vs. Instrumental*

### ***Clinical Evaluation***

- A clinical swallowing assessment may be required for different reasons at different times during the process of evaluating and managing PFD. A clinical swallowing assessment provides an opportunity to use information gathered during the feeding observation to generate hypotheses with respect to the child's swallowing concerns, to trial and test the effectiveness of dysphagia management strategies and to guide decision-making as to whether further swallow evaluation via instrumental assessment is required (Arvedson & Lefton-Greif, 1998).
- The clinical evaluation alone cannot confirm or rule out aspiration or determine abnormal swallowing physiology (Calvo, Conway, Henriques, & Walshe, 2010). A thorough clinical evaluation does provide valuable information necessary to make appropriate intervention recommendations (Beecher & Alexander, 2004) including the need for instrumental evaluation.

### ***Instrumental Evaluation***

- An instrumental assessment of swallowing examines both the presence of and causes for the swallowing concerns, including, but not limited to, silent aspiration.
- As described by Arvedson and Lefton-Grief (1998), instrumental assessments are employed in conjunction with the clinical assessment and may be used to:
  - Examine the anatomy and physiology of the oral cavity and pharynx during swallowing.
  - Provide further information on the oral, pharyngeal and esophageal phases of swallowing to guide diagnosis of dysphagia and subsequent clinical decision making.
  - Evaluate the effectiveness of strategies on increasing swallowing safety and efficiency.

Arvedson, J. C., & Brodsky, L. (2001). *Pediatric swallowing and feeding : assessment and management*. Delmar Publishers.

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Kingsnorth, S., Wincentak, J., Provvidenza, C., Townley, A., Hoffman, A., Perlin,

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# IDENTIFYING UNDERNUTRITION AND DEHYDRATION

| Undernutrition | Dehydration | What to do |
|---|---|---|
| ● Loss of appetite and lack of interest in food and/or fluids ● Weight loss (i.e. loose clothing) ● Tiredness or low energy levels ● Reduced ability to perform everyday tasks (i.e. attending to tasks, playing at recess) ● Reduced muscle strength (i.e. not being able to walk as far or as fast as usual) ● Changes in mood – malnutrition can be associated with lethargy and depression ● Poor concentration ● Poor growth ● Recurrent infections, increased recovery time, poor wound healing, increased risk of infection<br><br>● Difficulty keeping warm<br>● Dizziness | • Thirst • Dry, sticky mouth • Decreased urine output • Dark yellow urine • Dry and cool skin • Few or no tears when crying • Sleepiness, dizziness, lightheadedness • Complaints of headache and muscle cramps • Rapid heartbeat and rapid breathing • Involuntary muscle contractions and loss of consciousness • Drop in blood pressure • Short-term muscle damage • Constipation | ● Contact the school nurse who will take responsibility for determining if there is an issue and then communicate it to the parents. ● The swallowing and feeding team should help to determine a safe way for the student to receive adequate nutrition and hydration while at school.<br><br>● Educate school staff and parents to recognize the signs and symptoms of undernutrition and dehydration. ● Use the procedure and the Safe Eating Plan to adjust the student's diet and encourage added nutrition and hydration according to the physician's guidelines. ● Keep a daily log to determine food and liquid intake. ● School nurse weighs the student<br><br>regularly and works directly with caregivers and physicians |

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