# Eating & Drinking Dysphagia Policy

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# Meath School

# Eating and Drinking Policy

## Types of eating and drinking difficulties:

## 1. Dysphagia/swallowing difficulties
## 2. Eating and drinking difficulties associated with sensory feeding difficulties
## 3. Eating and drinking difficulties associated with sensory processing difficulties
## 4. Picky eaters

**Introduction**
Children who attend Meath School may have eating, drinking and/or swallowing difficulties. These difficulties may be as a result of physical or motor, medical, emotional/psychological, and/or social factors.

## 1. DYSPHAGIA/SWALLOWING DIFFICULTIES

**Definition:** "Dysphagia describes eating and drinking disorders in children and adults which may occur in the oral, pharyngeal and oesophageal stages of the swallow. The 'normal' swallow needs the respiratory, oral, pharyngeal, laryngeal and oesophageal anatomical structures to function in co-ordination, which is dependent upon the motor and sensory nervous system being intact." (RCSLT, 2019)

Children in this category may have different types of dysphagia:

- Oro motor difficulties e.g. lip seal, tongue movement, ability to chew etc.
- Pharyngeal difficulties e.g. difficulty initiating the swallow, moving the food from the mouth to the oesophagus, difficulty with movement of the muscles in the neck to support the swallow.
- Oesophageal phase e.g. food getting stuck due to a blockage or irritation caused by reflux.

A swallowing difficulty i.e. dysphagia, is potentially life threatening, due to the risk of choking or aspiration pneumonia and needs to be monitored carefully. These may arise from neurological damage or disease, psychological difficulties, physical abnormalities or damage to the oral, pharyngeal or laryngeal structures.

Intervention may include individualised mealtime plans, oro-motor programmes and strategies, to support the child in the best way. It may also involve other professionals where appropriate e.g. Dysphagia trained SLT (DSLT), Paediatrician, Dietician, Occupational Therapist (OT).

# 2. SENSORY FEEDING DIFFICULTIES

**Definition:** These children have difficulty with feeding or drinking, as a result of an early negative experience and/or limited early experience with foods. For example: insertion of nasogastric tubes, endotracheal tubes, periods of severe vomiting/choking etc. These children may present with hypersensitivity or aversions to food/drink (Yang, 2017). *For example, a child with early cardiac condition may have been under pressure to eat in order to increase their weight before an operation, this type of scenario can lead to aversion of food e.g. if they are unable to eat more due to fatigue and increased respiration rate.* This type of eating difficulty can co-occur with dysphagia.

Children in this category:

- May have a psychologically based sensory feeding difficulty,
- Can include children with diagnosis of ASD, where they meet the criteria above.

Intervention may require a collaborative approach with the DSLT and OT. It may include individualised plans, groups and strategies, to support the child.

# 3. SENSORY PROCESSING DIFFICULTIES

**Definition:** Sensory processing difficulties can characterised by a child who will not tolerate certain foods or is completely averse to food. This type of difficulty is usually due to difficulties with sensory processing of touch and smell. They may also display strong food preferences. This can lead to rigidity and fixed behaviours around touching, tasting or eating food (Taylor et al. 2015). This type of difficulty can also impact on control e.g. overloading their mouth and a feeling of not being satiated (full), causing problems with portion control e.g. wanting more and more. Intervention and strategies are tailored for individuals with these difficulties.

Children in this category may have:

- No underlying conditions which affect their ability to swallow,
- A diagnosis of ASD or sensory processing disorder (Nadon, et al. 2011).

Support for this type of difficulty should be accessed through the OT. Intervention may include a collaborative approach with individualised plans and strategies from OT, to support the child in the best way.

# 4. PICKY EATERS

**Definition:** This may be a developmental phase for example, due to decreased appetite due to growth rate slowing down. Social aspects can also contribute to picky eating e.g. such as structure/routine around meal times. Support for this type of difficulty should be accessed through the OT and/or the Educational Psychologist. Intervention may include individualised plans and strategies from OT, to support the child in the best way.

## SERVICE PROVISION

### a) Minimum requirements for a Lead Dysphagia trained Speech and Language Therapist (DSLT)

- Completion of a recognised post graduate dysphagia course e.g. QUEST.
- Completion of appropriate competencies including observation and supervision in the clinical setting, which allows the therapist to work independently with pupils with eating and drinking difficulties i.e. RCSLT competency level: Foundation Dysphagia Practitioner [https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/dysphagia-training-competency-framework.pdf].
- Post qualification, regular supervision from a named Specialist/Consultant Dysphagia Practitioner should be given.
- Peer supervision groups with other DSLTs can/should be accessed.
- The Lead DSLT should seek support and guidance from the named Specialist/Consultant Dysphagia Practitioner if at any time they experience difficulties in a pupil's clinical management.
- Dysphagia trained therapist will work in accordance with the guidelines outlined by the RCSLT.
- Allocated time should be provided for the Dysphagia trained therapist to complete assessments, reports and liaison with relevant others.

### b) Potential people involved and their roles

**Pupil**

- The child must be involved with the assessment and intervention, with this being as clearly explained to them as possible.
- Their wishes should form part of the decision-making process.

**Parents/Carers**

- These individuals should raise any concerns about a child's eating or drinking difficulties with the class-based therapist or DSLT to initiate and contribute the referral process.
- Should have their views and ideas sought as part of an assessment, intervention and evaluation of any programme devised or implemented.
- Informed about any difficulties identified during the assessment process and the risks that these difficulties carry.
- Need to be informed of and understand that recommendations made will support to manage the risk of aspiration. Parents/carers must understand that non-compliance may increase risk of the child's of e.g. of choking, aspiration, silent aspiration – which could lead to aspiration pneumonia and death. Parents/carers should sign in writing to confirm their understanding of this as part of the process of the initial eating and drinking assessment report.
- They should be encouraged to take an active part in intervention so that skills can be generalised both in school and at home.
- In complex cases, parents/carers will be invited into school to observe a therapeutic session i.e. for eating and drinking, in order to have

strategies and consistencies modelled to them.

**Dysphagia trained speech and Language Therapist (DSLT)**

- Any DSLT working in school will use their skills and knowledge to assess pupils referred/on the caseload for swallowing, eating and drinking difficulties, particularly regarding safety.
- DSLTs will receive supervision as required from a more experienced therapist i.e. from the Lead DSLT/a Specialist or Consultant Dysphagia Practitioner.
- Co-ordinate assessment based e.g. oro-motor skills, mealtime observations and assessment of different food/fluids at different textures.
- To write or update Mealtime Plans (MTPs) as necessary.
- To devise interventions where appropriate e.g. to develop oro-motor skills, supportive strategies.
- To share MTPs with the child's class based SLT, parent/carers, catering staff and the Residential Team where appropriate.
- DSLT must inform parents and the team around the child of the associated risks of dysphagia and how they can support to minimise risk of aspiration by following recommendations made. This should be documented in the case notes.
- To write Eating and Drinking review summary reports when needed e.g. significant change is indicated, referral is needed or transition to a new setting is imminent.
- Contribute to: annual review reports i.e. summary paragraph in the 'Sensory and Physical' section (DSLT to monitor when the reports are due), outcome and set EHCP targets and transition planning where necessary.
- To give help, advice, support and training e.g. modelling textures according the most recent IDDSI guidance.
- Consult and liaise with relevant others on medical aspects of any difficulties e.g. GP, Paediatrician, Dietician etc, and keep the class-based therapist informed of any necessary information or changes.
- To support staff i.e. Head of Residential with school based menus in order to ensure that there are appropriate foods available/foods that can be appropriately modified for children with Dysphagia.
- To ensure that parents/carers understanding and acknowledge, that non-compliance with recommendations for the child, may increase the risk of choking, aspiration, silent aspiration – which could lead to aspiration pneumonia and death. This should be in signed acknowledgement by the parent/carer as part of the initial eating and drinking report process.

**Class based Speech and Language Therapist**

- To raise concerns with the DSLT about a child's eating or drinking difficulties to initiate the referral process.
- To liaise with class team and adults supervising any children in their class, keeping them updated about changes to the child's MTP.
- To carry out intervention programmes e.g. oro-motor skills, sensory food groups. To feedback to and report any concerns about recommendations and intervention to the DSLT.

**Occupational Therapist (OT)**

- To raise concerns with the class based SLT about a child's eating or drinking

difficulties to initiate the referral process.
- Use of skills and knowledge to assess and intervene with motor, perceptual and postural aspects of any eating/drinking/swallowing difficulties.
- To work collaboratively with the class team to support with assessment, creating a programme of intervention tailored for children with sensory based eating difficulties, environmental eating difficulties and fussy eaters.

**School Staff**
- To raise concerns with the class based SLT about a child's eating or drinking difficulties to initiate the referral process.
- Be involved throughout the decision-making process including observing, monitoring and implementing any intervention and strategies to support pupil's difficulties.
- To be aware of and monitor children for signs of aspiration.
- To read and follow recommendations made on the Eating and Drinking reports and MTPs when supporting children who are on the dysphagia caseload.
- To seek advice/support from the DSLT or class-based therapist if they are unsure about recommendations and strategies advised on MTPs and in reports.
- When supporting/feeding a child with eating and drinking difficulties it is recommended the member of staff should have had training from a DSLT within the last year.
- It is the member of staff's responsibility to follow the recommendations made by the DSLT.
- To report and safeguarding concerns via CPOMs or to a safeguarding lead.

**Catering Staff**
- To be kept informed by school staff, of the difficulties experienced by the pupils and given information about allergies, cultural/religious and other dietary restrictions in order to cater for these children as required.
- To adapt foods, where possible to the correct texture for specified children according to the IDDSI guidance and the DSLT's advice.

**GP/Paediatrician/Dietician**
- Consulted on medical aspects and for further referral by the DSLT, e.g. for videofluoroscopy (VFSS), ENT assessment, allergy testing, additional dietary information etc. Kept informed of any changes to the child's swallow, eating and drinking.

## c) Quality Standards

These should be in line with the current guidelines; in the case of the speech and language therapists these are outlined within RCSLT guidelines, and any subsequent guidelines related to Paediatric Dysphagia e.g. IDDSI guidance.

## d) Safeguarding

All individuals involved with children who have eating and drinking difficulties should continuously monitor for and report signs which could indicate a safeguarding issue. Any concerns should be reported on CPOMs and/or to a Safeguarding Lead at school. Some examples may include: recurrent chest infections, food refusal and reports of inappropriate food textures/fluids being given. These may indicate that further training

is needed with individuals, that further assessment is needed or but may also indicate a safeguarding issue.

## SERVICE PROTOCOL

This section will outline how the service should be delivered, and at what stages different aspects take place. It should also outline what can be provided and what cannot (see Appendix A for the Eating and Drinking Care Pathway).

**It is important to be aware that Dysphagia assessment and intervention cannot be offered unless there are trained staff available who meet the level of competence outlined in this policy. When this is not the case, advice should be sought from the community Speech and Language Therapist working with the pupil on entry or a Specialist/Consultant Dysphagia Practitioner associated with the school e.g. from Dawn House School or a private therapist.**

## SERVICE DELIVERY

i) Eating and drinking difficulties and history are asked about when parents/carers make their initial visit to the school.

ii) Further discussion with the parents/carers takes place with the parents/carers when the child comes for their assessment visit. Information is passed on to the relevant class team before their first meal in school. A Speech and Language Therapist will observe the child during meals on the assessment day if there are any concerns from parents or any previous feeding difficulties. Further discussion with the parents/carers may then take place.

iii) A full case history is taken from the parents/carers by the assessment centre team. This includes any relevant information regarding eating and drinking. This information is passed to the Head Teacher and Head of Therapies. It is their responsibility to inform the DSLT, enabling provision to be put in place. Further information should be gathered by the class-based team on the child's first day at school.

iv) If there are concerns around eating and drinking difficulties for a child that is already school based, a referral form should be completed by the class-based therapist/parent/carer and handed to the DLST. A copy of the referral form should be stored in the child's therapy file in the dysphagia section by the class-based therapist and/or electronically on the school computer system by the DLST (on SharePoint: Meath/Therapy/SLT Admin/Dysphagia/Referrals).

v) Assessment should be carried out by a DSLT, with a post graduate qualification in Dysphagia. It may also involve others in the team, e.g. Occupational Therapist to provide advice on alternative equipment/seating. Appropriate consent should be gained from the child's parent/carer. The DSLT should explain to the child to support their understanding of the assessment to the best of their ability, using signing/symbols if necessary. Assessment should happen in a timely manner and should be prioritised appropriately where the referral form/discussion with the referrer indicates that the child is at a high risk of aspiration. Following assessment, the appropriate level of risk should be recorded (suggested

resource Appendix B). Where the child has a community-based Dysphagia speech and language therapist working with the child, advice will be sought.

vi) If a need is identified, an initial Eating and Drinking Report and MTP is completed by the DSLT, supported by the class-based Speech and Language Therapist as required. The Eating and Drinking Report and MTP will be added to SharePoint in the pupils individual file under their 'Dysphagia' folder, class SLT files and the child's main file in the front office. Reports should be shared with relevant people involved for example: parents, medical professionals, class-based SLT, head of residential. MTPs will also be printed and filed in Eating and Drinking files (1x in the dining room, 1x in the staff room). Copies are also given to the relevant teams around the child e.g. residential, class based SLT to share with the class team, parents/carers. Follow up summary reports after Eating and Drinking reviews will be written where appropriate for example, if significant change occurs or if requested/needed for a referral. Summary paragraphs regarding the child's eating and drinking should be added to the annual review reports. DSLT/OT should be involved in outcoming or updating EHCP targets related to eating, drinking and oro-motor skills.

vii) Oro-motor programmes and MTPs will be written and overseen by the DSLT and OT where appropriate. This will be monitored and carried out by the class-based Speech and Language Therapist/s and where appropriate, oro-motor programme targets can be added to the child's termly short term targets. DSLT will review both the MTP and any programme. For children with low risk of aspiration, they should be reviewed at least yearly, if possible in line with their annual review. For children with moderate/high risk of aspiration, reviews should happen once per term. Changes made to recommendations should be communicated to the class based SLT who would be responsible for disseminating this information. Class based therapists should approach the DSLT for advice if and when concerns arise before the child's review.

viii) Place mats in the dining room should indicate when a child has eating and drinking difficulties. These will act as a prompt for all staff. Place mats should indicate where more detailed information (MTPs) can be found i.e. in the red Eating and Drinking files. Following any new/updated recommendations in MTPs and Eating and Drinking Reports, Class based therapists will be responsible for disseminating the information, in order for place mats to be updated by a member of the class team. This information would also be shared with parents/carers as part of the review process.

IX) If necessary, referral to an outside agency, e.g. an external Specialist/Consultant Dysphagia Practitioner, would be made through discussion with parents/carers, speech and language therapist, GP/ Paediatrician etc.

X) Recommendations made by the DSLT are based on a 'snapshot' in time. This means that recommendations made are based on how the child presents on the date/s of assessment, observation and discussion with the team around the child. If there are further concerns following the child's presentation following recommendations set, these can be discussed with the class SLT/DSLT/OT in order to inform whether further assessment is indicated.

## OTHER

### Training

Training can be offered to both staff and parents/carers as required. The DSLT, OT or educational psychologist, will lead or teach others. This can be with the support from the class-based therapist and would depend upon the training needs and knowledge of those involved.

### Food Committee

There is a food committee that meets at school; this consists of members of Care, Teaching, Therapy, Medical and Catering staff. Within this forum discussion takes place regarding any dietary considerations related to the pupils eating/ drinking or swallowing needs.

### Special dietary requirements

It is not always possible to provide for individual specialist diets. If this is the case, parents/carers are asked to provide appropriate foods, e.g. dairy free alternatives etc. It is not always possible to provide a wide range of textures or culturally based food e.g. Halal or Kosher meals. However, there should always be a vegetarian option for those children. Parents should identify these needs to school.

### Eating Procedure

Many children arrive at Meath School with their own individual eating preferences. Class and Care teams encourage a greater breadth of diet through slowly staged exposure to different foods.

Any eating programme is implemented after consultation with the DSLT and/or the OT team. Progress should be monitored by the class team and changes should be reported to the relevant therapist mentioned above.

An appropriately prepared packed lunch should be provided by parents when the school are unable to provide alternative textures for a child, for example, on a school trip.

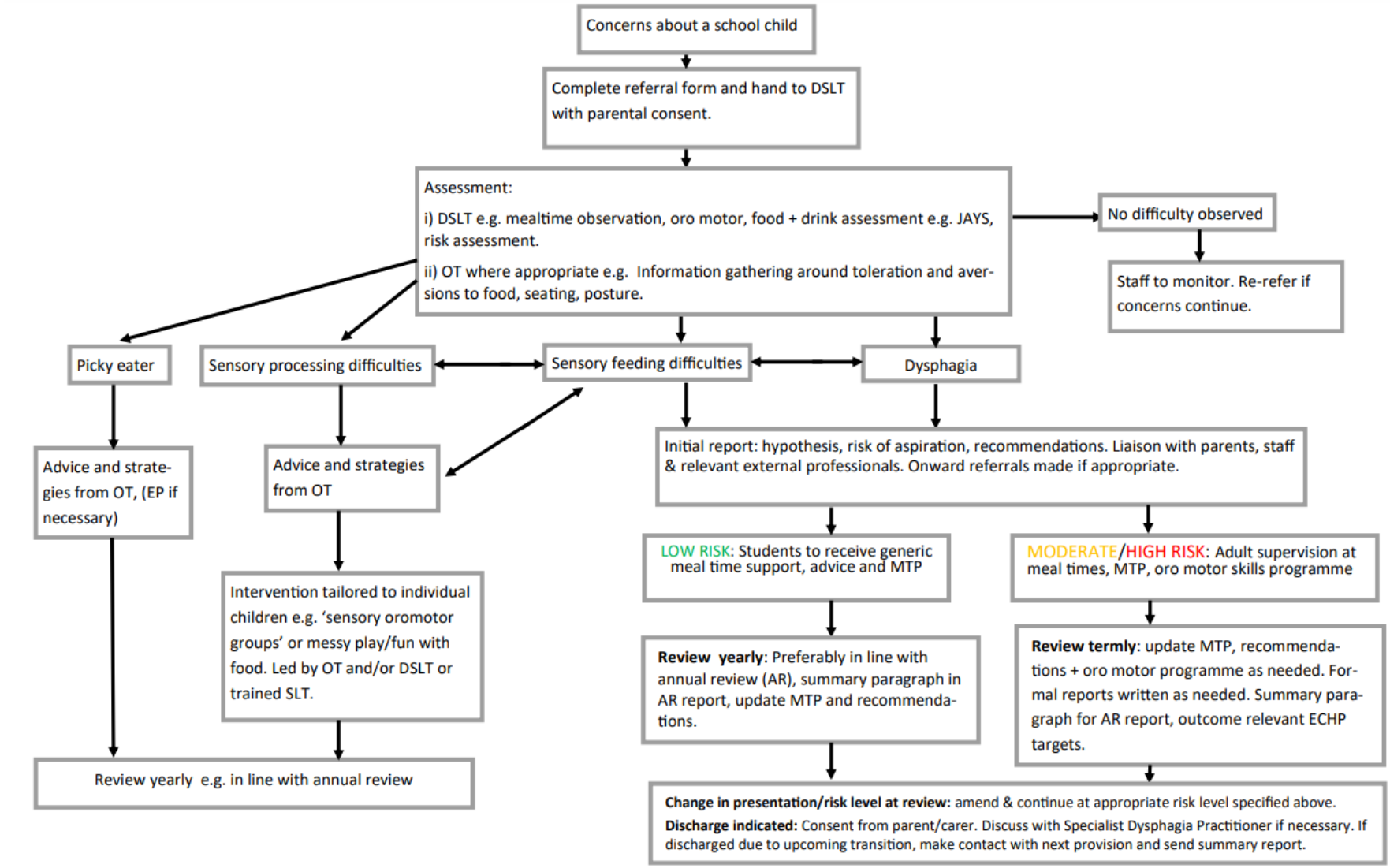
Meath menus are scrutinised and planned to comply with the standards suggested by the DfE. The menus give a balanced meal and although there is a choice of fruit and yoghurt for dessert, there is no choice of main course unless the child has specific dietary requirements e.g. vegetarian option.

### Equipment to be provided for eating and drinking assessment:

- Resource file (including assessment sheets)
- Wet wipes
- Pulse oximeter
- Thickener
- Personal protective equipment (gloves, apron if necessary)
- Hand sanitiser
- Pre-packaged food e.g. powdered desserts, bite and dissolve crisps, biscuits or cakes (if required)
- Range of drinking vessels, e.g. valved straw, Doidy cup, flip top silicone straw style bottle

- Clinical waste facilities (in the medical room)
- Paediatric stethoscope (for cervical auscultation where appropriate).

## Appendix A – CARE PATHWAY: Eating and Drinking Difficulties



## Appendix B – Risk of Aspiration Form

SPEECH & LANGUAGE THERAPY DEPARTMENT

**RISK OF ASPIRATION IN CHILDREN**

Name: _____ Date of birth:_____
NHS number: _____ Date of assessment:_____
Speech & Language Therapist: _____ Time of assessment:_____

| | | |
|---|---|---|
| **1. MEDICAL CONDITION** | Respiratory / asthma | Cardiac |
| Neurological | Syndrome / Trauma | Other |
| **2. CONSIDERATIONS** | Sensory Feeding Disorder | Motor feeding disorder |
| Variable feeding status | Length of meals | Oxygen sats / therapy |
| GOR / LPR | Vision /Hearing | Tone high / low |
| Medication | Oral hygiene | other |

| TRIALS | Swallow | | | Swallow | | | Swallow | | |
|---|---|---|---|---|---|---|---|---|---|
| **3. STATE** | mild | moderate | severe | mild | moderate | severe | mild | moderate | severe |
| Alertness | | | | | | | | | |
| Positioning | | | | | | | | | |
| Fatiguability | | | | | | | | | |
| Control of secretions | | | | | | | | | |
| **4. SWALLOW ASSESSMENT** | | | | | | | | | |
| Anticipatory | | | | | | | | | |
| Lip clearance / seal | | | | | | | | | |
| Bolus manipulation | | | | | | | | | |
| Gagging | | | | | | | | | |
| Tongue Thrust | | | | | | | | | |
| Bite Reflex | | | | | | | | | |
| Initiation of sequence | | | | | | | | | |
| Pocketing | | | | | | | | | |
| Laryngeal elevation | | | | | | | | | |
| Cough | | | | | | | | | |
| How many to clear | | | | | | | | | |
| Colour change | | | | | | | | | |
| Eye tearing | | | | | | | | | |
| Suspension of respiration on CA | | | | | | | | | |
| Audible change | | | | | | | | | |
| Voice post swallow | | | | | | | | | |
| Change in breathing pattern | | | | | | | | | |
| Change on oxygen saturations | | | | | | | | | |
| **RISK ASCRIBED IS** | | | | | | | | | |