GUIDE FOR SUPPORTING

Pediatric Feeding Disorders in Arkansas Schools

Division of Elementary and Secondary Education | Office of Special Education | Arkansas Collaborative Consultants

DR. JEFF ADAMS

Director of Special Education
Arkansas Department of Education
Division of Elementary
and Secondary Education

The Arkansas Division of Elementary and Secondary Education, Office of Special Education is pleased to introduce the Guide for Supporting Pediatric Feeding Disorders in Schools. This guidebook provides current information related to Pediatric Feeding Disorder and how to support students with feeding and swallowing needs using evidence-based practice in the school setting. It is meant to serve as a guidance for administrators, related service providers, educators, child nutrition professionals, school health providers, and other stakeholders.

In order to receive a free and appropriate public education and fully participate in the educational program, children must be adequately hydrated and nourished. Children with Pediatric Feeding Disorder are at risk of their safety and development being compromised. Historically, there has been a lack of understanding as to how children with Pediatric Feeding Disorder should be supported in the school setting, leading to a question of educational relevance . However, IDEA makes clear that students with disabilities have a protected right to receive health-related services that will enable full participation in the educational curriculum. Nutrition certainly falls within that purview. Collaboration among educational professionals and related services providers, along with a district wide procedure, are the key components to ensuring this safety. The Office of Special Education is grateful for the work of the Arkansas Collaborative Consultants and various stakeholders for the creation of this document that will help to achieve that goal.

We want to acknowledge the expertise and efforts of the administrative staff, reviewers, and contributors who meticulously reviewed and refined the content of this guidance document. Their attention to detail and commitment to excellence have played a crucial role in ensuring the document's accuracy and usefulness.

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 Pediatric Feeding Disorders. 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.

Acknowledgements

PEDIATRIC FEEDING DISORDERS WORKGROUP COORDINATORS:

- Jeff Adams, Director of Special Education with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Charity Avery, Related Services Coordinator with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Amy Goddard, Related Services Coordinator with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Amy Orman, Speech-Language Pathology Consultant with Easterseals Outreach Program and Technology Services of Arkansas

With much gratitude, we would like to recognize the following members of the Pediatric Feeding Disorders Workgroup who provided critical input and feedback on the document. Their commitment to attend meetings, provide valuable insight and expertise, and offer both relevant and evidence-based information has been invaluable to the goal of ensuring students in Arkansas remain safe and successful while at school.

- Suzie Baker, Vice President of Education and Outpatient Services, Easterseals Arkansas
- Dana Bennett, RN, Assistant Director, MITS School Health Services with the Arkansas Department of Education, Division of Elementary and Secondary Education
- Sheila Chastain, Registered Dietitian, School Nutrition Specialist, Associate Director Finance and Training, Arkansas Department of Education, Child Nutrition Unit
- Nancy Dill, Registered Dietitian, School Nutrition Specialist, Public School Program Coordinator, Arkansas Department of Education, Division of Elementary and Secondary Education, Child Nutrition Unit
- Nancy Dunn, Director of Easterseals Outreach Program and Technology Services of Arkansas
- Yvonne Greene, Administrator for Monitoring and Program Effectiveness with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Haley Hatch, Director of Special Services and Speech-Language Pathologist, Lake Hamilton School District
- Cheria McDonald, RN-State School Nurse Consultant, Division of Elementary and Secondary Education
- Brie Norton, Speech-Language Pathologist, Bentonville School District
- Danita Pitts, Early Childhood Coordinator with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Rick Porter, Administrator of Dispute Resolution and Special Projects with the Arkansas Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Tabitha Riendeau, Program Advisor with the Department of Education, Division of Elementary and Secondary Education, Office of Special Education
- Micah Roberts, LEA Supervisor, Emerson-Taylor-Bradley School District
- Lauren Rogers, Speech-Language Pathologist, Conway School District
- Allison Thornton, Speech-Language Pathologist, Arkansas Children's Hospital

PEER REVIEWERS

- Jessica Barnett, Occupational Therapy Consultant, Easterseals Outreach Program and Technology Services of Arkansas
- Vanessa Boomer, Speech-language Pathologist, Kids Unlimited Learning Academy
- Jerri Clark, Director of School Health Services, Arkansas Department of Education, Division of Elementary and Secondary Education
- Bethany Compton, Speech Language Pathology Consultant, Easterseals Outreach Program and Technology Services of Arkansas

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 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.

Table of Contents

Table of Contents

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, and eats a regular lunch tray cut up into bite sized pieces. 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 the school year. 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 (PFD)

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.

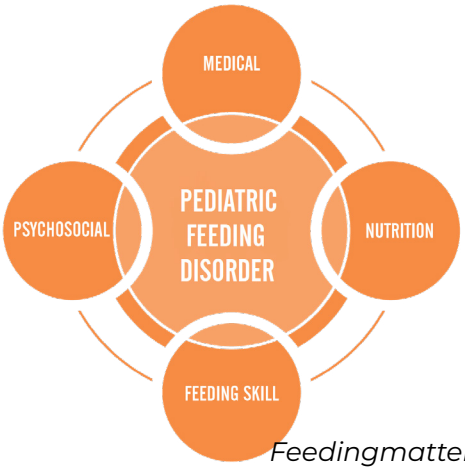
The term Pediatric Feeding Disorders & International Classification of Diseases (ICD) Code for PFD is supported by:

- 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 two weeks and associated with one or more of the following:



Feedingmatters.org

Medical Dysfunction

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

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

SYMPTOMS ARE CLASSIFIED AS

ACUTE PFD

duration LESS than 3 months

< 3 MONTHS

CHRONIC PFD

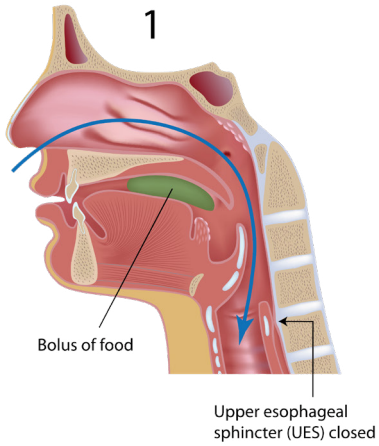
duration GREATER than 3 months

> 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

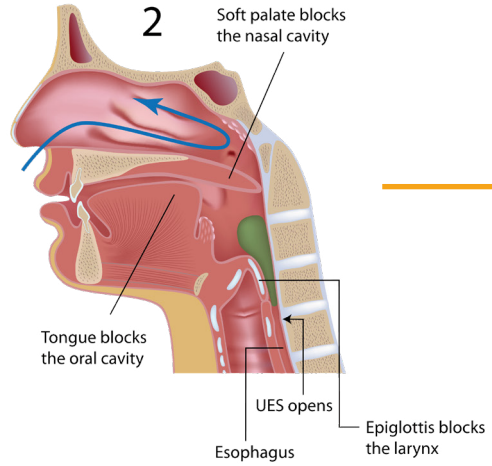


Oral preparatory

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.

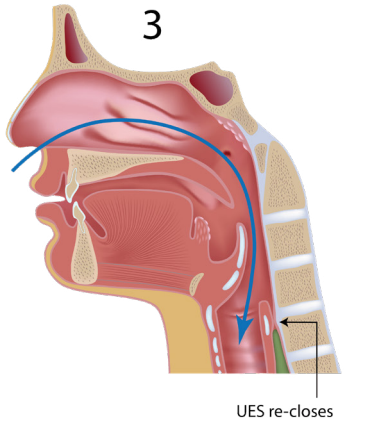
Oral transit

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.

Goday et al. 2019

In schools, some children with PFD may have a disturbance in oral intake that results in a significant educational impact.

This may include 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.
- has significant food limitations that result in undernutrition, dehydration, and/or impacts social interactions.
- need assistance with eating at school (directives as to food choices, amount on spoon, food to drink ratio, pacing, etc.).

THE IEP TEAM SHOULD COLLABORATE TO CREATE A PLAN THAT REDUCES THE IMPACT OF THE CHILD'S FEEDING AND SWALLOWING NEEDS ON INSTRUCTIONAL TIME, WHILE ENHANCING THE CHILD'S FEEDING ABILITIES TO ENCOURAGE PARTICIPATION IN THE LEAST RESTRICTIVE ENVIRONMENT.

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, brain injury, 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 deficits
- 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

Feeding Skills

- Need for special preparation or texture of food
- 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
- 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

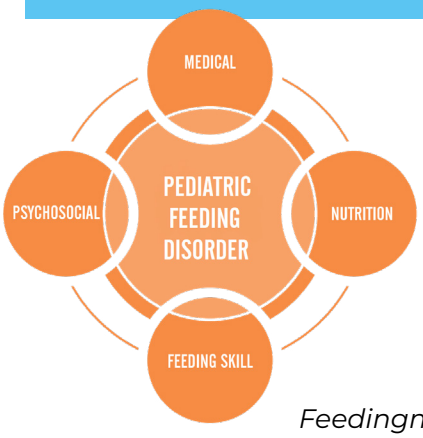
- Chronic respiratory concerns or acute illnesses such as pneumonia
- Coughing/choking during or after swallowing
- Drooling
- Poor oral motor functioning
- Nasal regurgitation
- Wet/gurgly airway sounds following eating or drinking
- Difficulty initiating swallowing

> 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



Feedingmatters.org

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 - 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 regular solids and drinks thin 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 PFD that provide the basis for establishing safe eating at school.

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 FAPE.

3 Case law implications: Several Supreme Court and 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 obtain 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 districtwide PFD procedure requires administrative support and collaboration with team members.

One of the primary roles of administrators is to assist in developing and obtaining approval for a PFD procedure. While this process will vary from school to school, important stakeholders to consider include the:

- Superintendent
- Supervisor/Director of Special Education
- Supervisor/Director of Child Nutrition Programs
- Supervisor/Director of Health Services
- Supervisor/Coordinator of Therapy Services
- Principals

ADMINISTRATIVE SUPPORT IS ESSENTIAL FOR OTHER PFD ACTIVITIES SUCH AS

- Ensuring time for PFD team meetings to plan and discuss school needs
- Providing funds for instrumental swallow studies and equipment such as blenders, slow flow cups, Nuk brushes, etc.
- Addressing concerns by organizing team meetings
- Coordinating professional development for staff

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

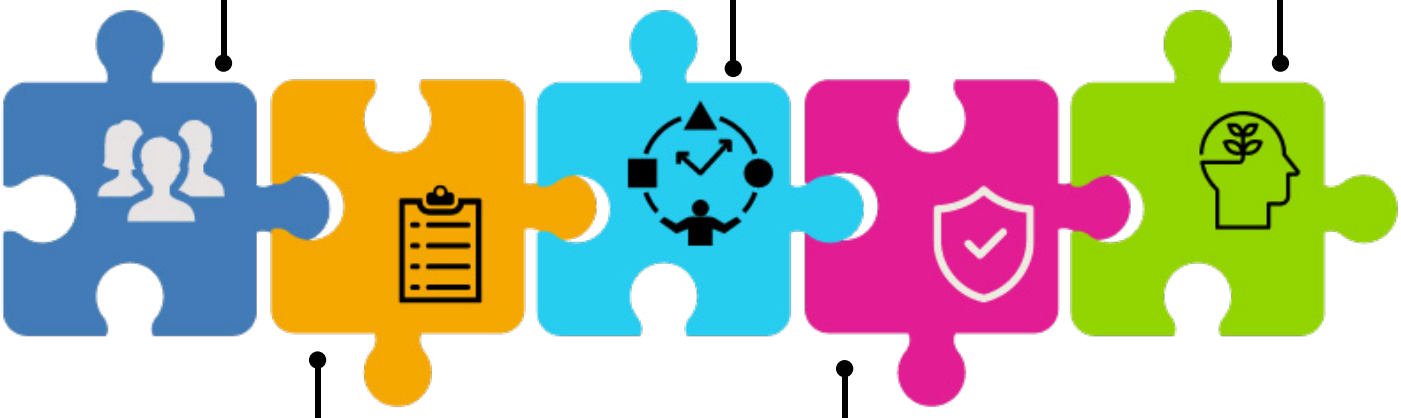
- Creates consistency throughout the school district
- Accountability of staff through clarification of roles and responsibilities
- Documentation ensures that the process is provided consistently
- Establishes a safe mealtime environment for students with PFD

ESSENTIALS OF A STEP-BY-STEP PROCESS

Clarify roles and responsibilities through an interdisciplinary approach

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

Provide ongoing professional learning to school personel



Documentation of the process
(See attached examples)

Develop a Safe Eating Plan (SEP)

Essential Steps to a PFD Procedure in the Schools

1. *Observation Request Form* is submitted to team leaders. After obtaining consent, an informal observation of the student eating is typically performed by the SLP and other s as necessary

2. *Caregiver Interview Form* is sent home in preparation for the interview that is typically conducted by the SLP and/or school nurse.

3. *Interdisciplinary Assessment* is conducted to determine the student's safety when eating and is often performed by the SLP, OT, PT, and school nurse.

4. *Safe Eating Plan* is established and all relevant school personnel are trained by the PFD team. If necessary, an Individualized Health/Emergency Plan is developed or modified by the school nurse and appropriate personnel.

5. *Cafeteria Procedure* is initiated and implemented by appropriate personnel.

6. *IEP meeting* is held and physician release/ communication form is signed signed by appropriate team members.

7. If indicated, the student is referred for an *Instrumental Evaluation*, typically by the SLP and/or OT.

8. *Safe Eating Plan* is revised by the appropriate team members, when indicated by results of the swallow study or whenever there is a change in the student's eating skills.

9. Services and supports to address student needs including safety and functional skills are scheduled and implemented and are often provided by the SLP and OT.

School Setting vs. Medical Setting

Team members who address PFD 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 adult 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.
Patients are served in hospitals, skilled nursing facilities, and outpatient hospital services. Patients are typically seen for a limited amount of time and then discharged.	***Setting and length of care***	Students with disabilities could be educated from 3 years or age until 21 years in the school setting. A student with PFD could receive services as long as required to meet the students needs.
On-site medical support includes nurses, physicians (ENTs, neurologists, pulmonologists, gastrointestinal doctors), dieticians and others.	***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 and efficient 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 PFD services in schools.

A team approach is most effective when all 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 PFD team are responsible for:

- referring students who are at risk.
- monitoring the student's PFD.
- ensuring the saftey of students at school.
- educating school personel and families.

TEAM LEADER

The team leader is the person designated to oversee the PFD process. Various professionals could serve as the team leader based on the their level of training and experience. When dysphagia is the primary concern, the role is filled by the SLP. When concerns are primarily self-feeding or sensory related, the OT is the team leader. For students who are medically fragile, the school nurse may function in this role.

The team leader:

- receives input from all team members on a regular basis.
- ensures that the procedure is followed for each student.
- informs team members.
- confirms the process is documented.

CORE TEAM MEMBER
Potential Roles and Responsibilities

Speech-Language Pathologist

- May serve as team leader, receives and completes the observation request, contacts other core team members, and begins the PFD procedure
- Completes initial identification of students at risk
- Coordinates assessment/treatment including the *Interdisciplinary Observation*
- Attends Videofluoroscopic Swallow Studies (VFSS)
- Writes Safe Eating Plan
- Trains teachers, paraprofessionals and other designated feeders on the student's Safe Eating Plan
- Collaborates to develop and implement, when necessary, strategies to ensure a student's safe eating in the educational environment.
- Maintains or obtains the appropriate training to address PFD in the educational environment.
- 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 when indicated
- Ensures the IHP and SEP are easily accessible

Occupational Therapist

- May serve as team leader
- Initial identification of students at risk
- Conducts the Interdisciplinary Observation 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 PFD
- Brings knowledge of neuromuscular, positioning, sensory awareness, adaptive equipment, and environmental modifications
- Refers the student and parents to other professionals as needed to rule out other conditions
- Attends the IEP meeting when indicated

Physical Therapist

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

CORE TEAM MEMBER
Potential 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 needs
- Trains educational 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
- Might consider rewording "Trains educational staff and other team members on the signs of undernutrition and dehydration and to take appropriate actions.

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 PFD 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 PFD team members on how to address feeding behaviors

SCHOOL STAFF
Potential Roles and Responsibilities

Educational Staff

- Provides information on the student's progress during mealtimes
- 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 PFD team leader as soon as there's a concern
- Implements supports and services to meet student's PFD needs, as outlined in the Safe Eating Plan by the educational team (postural support, assistive technology, feeding strategies, etc.)
- Feeds student(s) according to their Safe Eating Plan
- If indicated, records specific data as outlined in the Safe Eating Plan, which may include amount of food eaten, safety throughout the meal, and use of assistive technology.

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 for all students with PFD
- Serves as mediator with team members and parents
- Understands pediatric feeding disorders and the district procedure

>Click to review the roles of administration

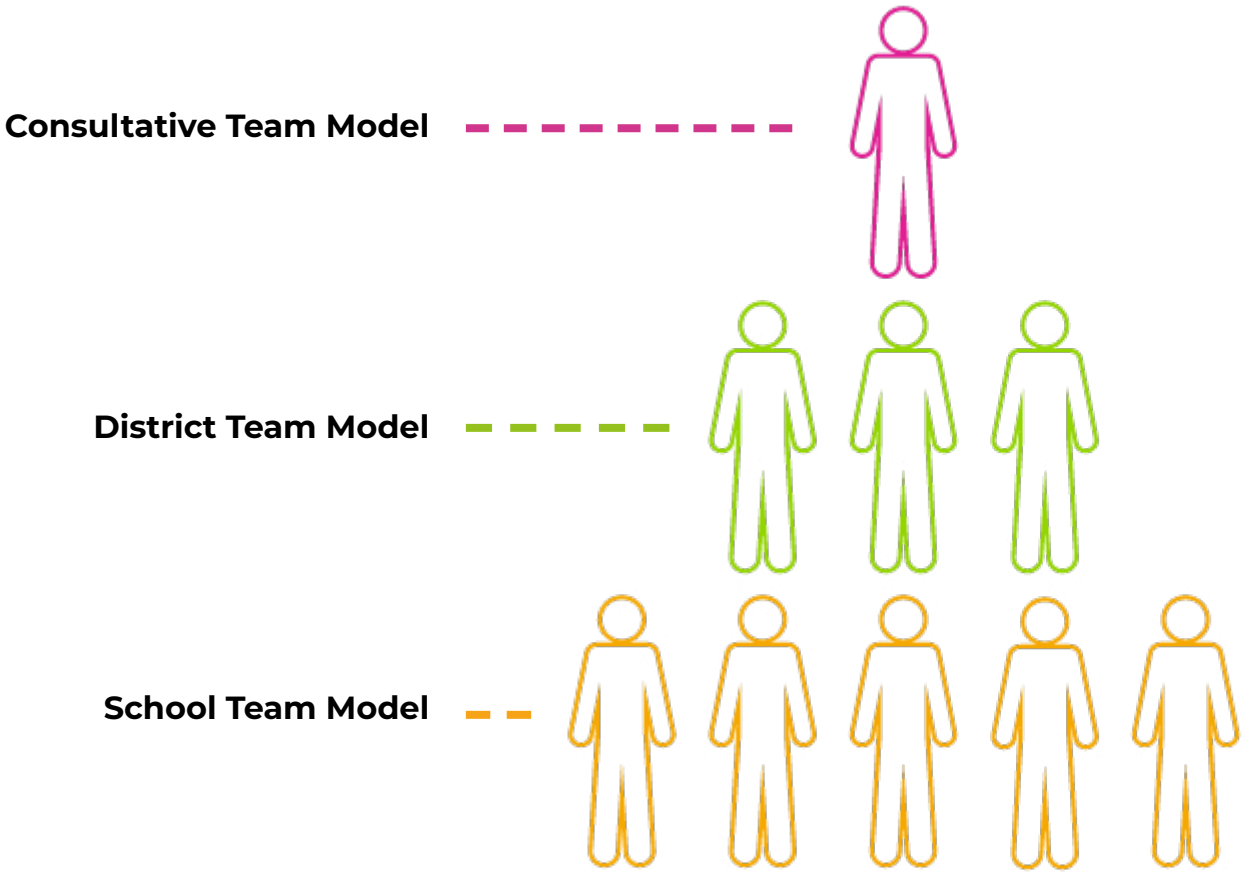
Potential Role of the PARENTS/CAREGIVERS

Parents are a required member of the IEP team and essential members when supporting PFD needs in schools. Their potential roles on the team are to:

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

TEAM MODELS

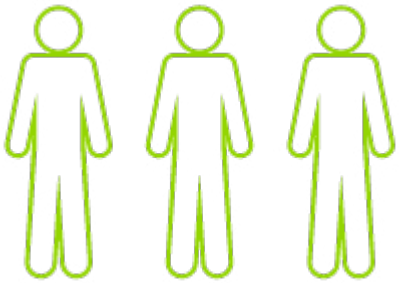
There are various team models that can be used in a school district to address PFD. The team model will depend on the make-up of the district and experience of school staff. The following team models are described in the context from the least to most SLPs or OTs trained in PFD.



TEAM MODELS **BREAKDOWN**

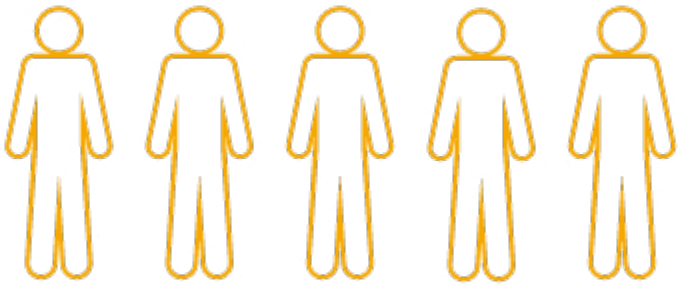
Consultative Team Model

The consultant is assigned to work with the school based SLP, OT, PT, nurse, and educational and cafeteria staff to create Safe Eating Plans for all students in the district with PFD concerns. 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.



District Team Model

Ideally, a district team is composed of an SLP, OT, and school nurse that are experienced in PFD and travels to various school sites to support students with PFD and work collaboratively with the school based personnel.



School Team Model

The school team model is used when the school has trained SLPs, OTs, and nurses to support all students with PFD.

IF AN ARKANSAS DISTRICT DETERMINES THE NEED FOR OUTSIDE CONSULTATIVE SERVICES, A REFERRAL CAN BE PLACED THROUGH DESE/OSE TECHNICAL ASSISTANCE PROVIDERS

>click here to place your referral

SECTION 3

STUDENTS EAT SAFELY: FOLLOW THE FORMS

There are 9 steps for addressing PFD that provide the basis for safe eating at school. The steps described in this section are listed in the Team Procedure Checklist.

>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 caregiver. 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: CAREGIVER INTERVIEW FORM

> *Click for Caregiver Interview Form*

A member of the PFD team 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.
- gather information about the student's current feeding practices at home.
- identify the caregiver's concerns about their child's mealtimes.
- inform the caregiver of the district's procedure and goal of safe and efficient mealtimes at school for their child.
- inform the caregiver of the school team's concerns about their child's mealtimes at school.
- include the caregiver as part of the problem-solving team.

The PFD team member should recognize that feeding a child can be an emotional subject for caregivers. Their experiences and opinions should be considered throughout the process, as the caregiver is the expert on their child.

STEP 3: INTERDISCIPLINARY ASSESSMENT

> *Click for Interdisciplinary Assessment Form*

PREPARING FOR THE INTERDISCIPLINARY ASSESSMENT

Step 3

Review

Review the Caregiver Interview Form as a team.

Contact

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

Explain

Explain to the student's designated feeder 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.

Oral Motor Observations

During the Mealtime Assessment

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?

Lip closure
Can the student achieve lip closure when eating?

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.

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

LIQUIDS

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:

Step 3

- 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

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.

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 the student's ability to eat safely and efficiently. This includes, but is not limited to, solid food modifications, positioning, pacing, cueing, utensils, and feeding equipment.
- When a concern is observed (such as inadequate chewing, coughing, etc.), modify the meal by trialing the suggested modification, adaptations, and strategies to determine the safest way for the student to eat.
- It should also include observations and notations of the student's activity and participation ability and their body structure and function.
- The PFD team should meet with the IEP team to discuss the mealtime assessment results and determine next steps.

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*

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 efficiently.

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 monitor

> *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. Staff training should be documented on the *Trained Feeders Form*. Periodic monitoring by the PFD team is to ensure the Safe Eating Plan continues to be implemented correctly.

POSSIBLE TEAM MEMBER TRAINING RESPONSIBILITIES

SLP
Food and liquid modification, special precautions, and considerations

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. 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 prescription for thickener each year.

Step 5

STEP 5:
SCHOOL MEAL MODIFICATION FORM

> *Click for Prescription for School Meal Modification Form*

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 IDDSI to meet the recommended modifications and any student specific needs as outlined on the Safe Eating Plan. It is the responsibility of the Child Nutrition Program staff to ensure all meal modifications are carried out during school meals.

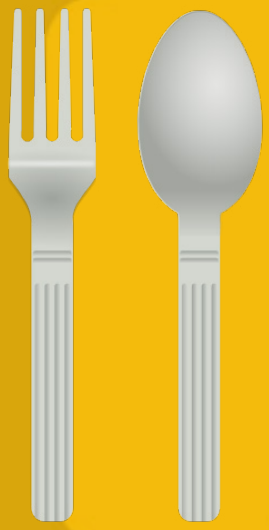
Training Resources

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, 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 INDIVIDULAIZED EDUCATION PROGRAM (IEP) CONFERENCE

>> Click for School District IEP Form

Once the team has established a Safe Eating Plan, an IEP meeting should 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 IHP 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, as related to educational impact and to determine the need for establishing goals in the IEP.

It should include:

- Description of the evaluative data regarding swallowing concerns, including: oral and pharyngeal phase dysphagia, oral sensory motor disorders, etc.
- Review of the medical history regarding swallowing and feeding.
- Actions that have been taken to ensure safety, including diet modifications or other strategies.

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

STEP 7:
INSTRUMENTAL EVALUATION REFERRAL (VFSS)

> Click for 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.
>>ACH - Authorization to Release Health Information to Schools
>>ACH - En Espanol Authorization to Release Health Information to Schools
>>Le Bonheur - Authorization to Release Medical Records
>>Le Bonheur - Autorización para la divulgación de expedientes médicos

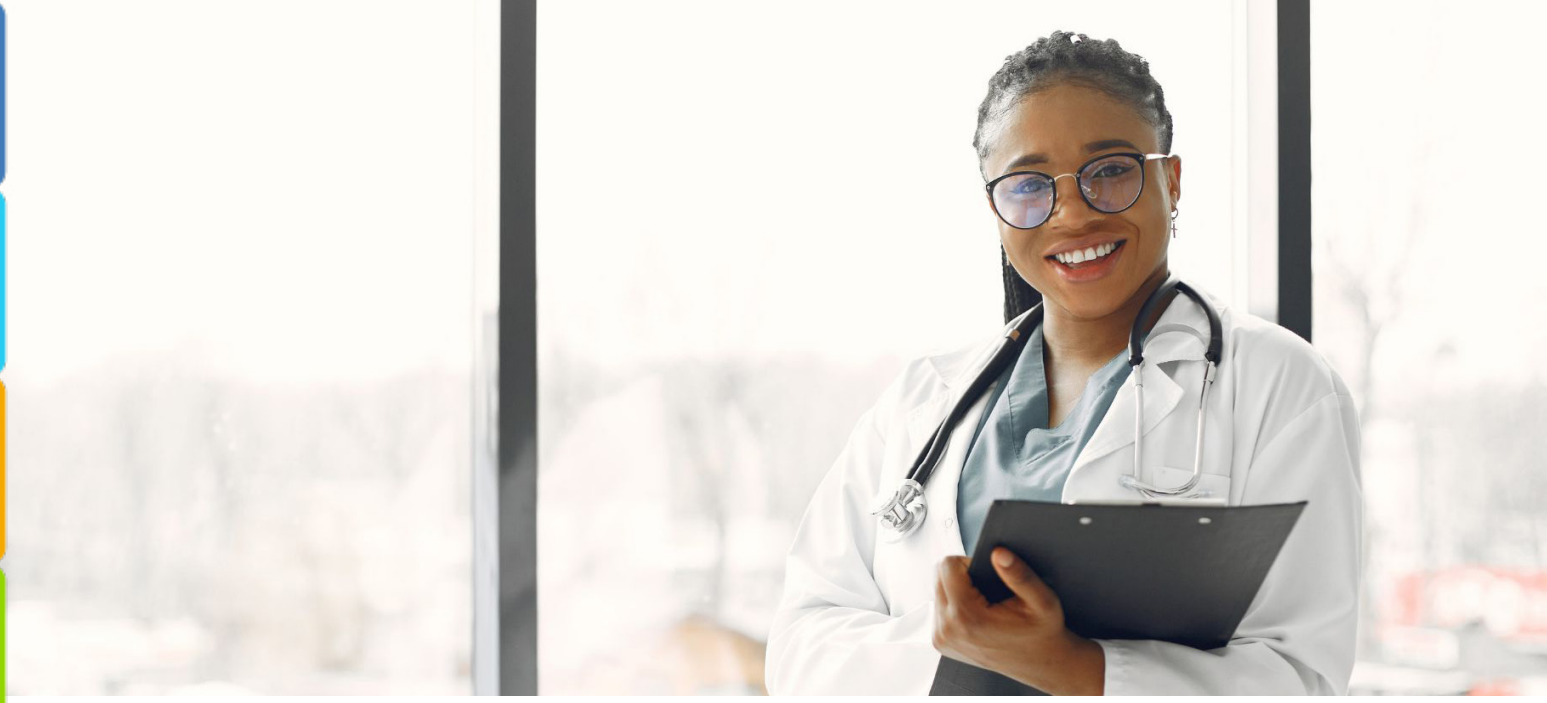
Step 7

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.

Once the appointment has been scheduled and a release of information has been signed, the team leader should 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 dietitians. The school nurse often assists in working with the physicians and parents to obtain necessary information to facilitate safe feeding at school.

Step 7

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 consistently coughing during mealtime, 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 <u>not</u> necessary to conduct the Interdisciplinary Swallowing and Feeding Observation or to write and implement a Safe Eating Plan.

STEP 8:
REVISION OF SAFE EATING PLAN FORM

> Click for Safe Eating Plan Form

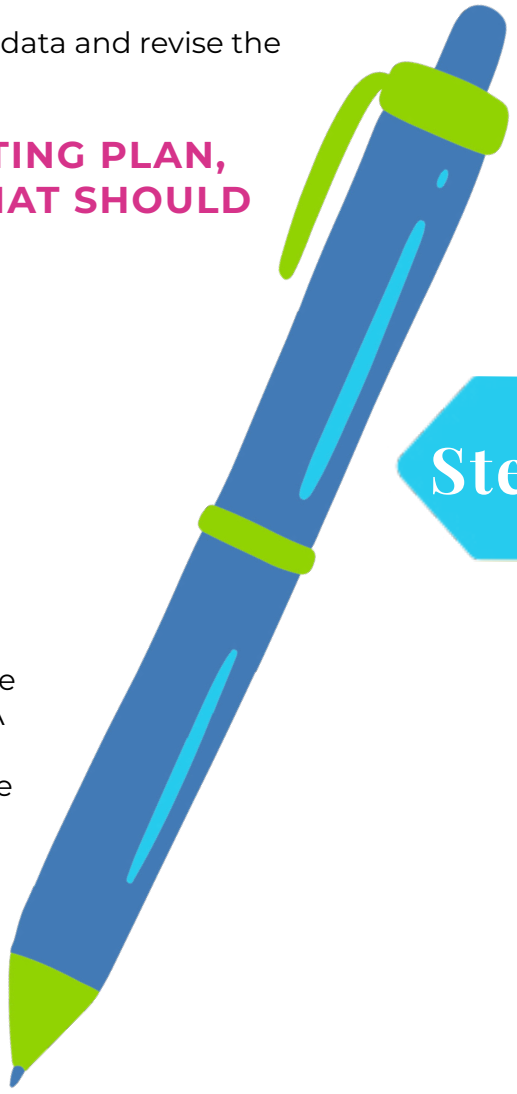
REVISIONS TO THE SAFE EATING PLAN ARE INDICATED WHEN:

- 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.



Step 8

THE SCHOOL NURSE should train staff on revisions to the Individualized Health Plan and Emergency Plan. The LEA should have the appropriate team members, including caregivers, sign the Emergency Plan. This, along with the Safe Eating Plan, should be kept in a known, accessible location.

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 9:
STUDENT SUPPORT

>> Click for Student Support Form

For students receiving special education and related services through IDEA, the IEP team must consider if the child requires 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

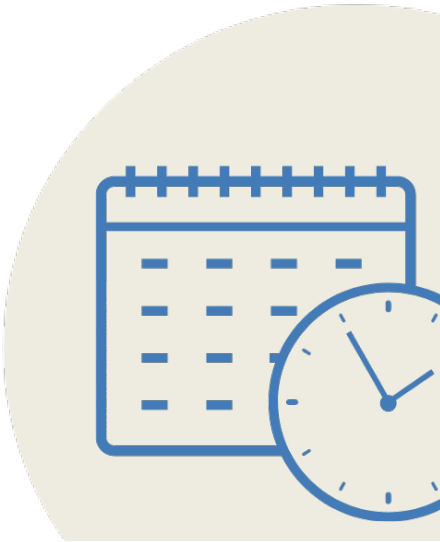
In addition to consultative services to monitor the Safe Eating Plan, students with PFD may also receive direct services for therapeutic intervention.

DIRECT SERVICES MAY INCLUDE:

- interventions to target oral motor and swallowing needs.
- interventions to support self-feeding needs.

Step 9

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. All services, including consultation, should be documented.



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 is in need of 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.

SCENARIO 3: EXAMPLE

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

Caregivers are notified:

The Caregiver Interview Form is completed during the child's eligibility evaluation. The designated SLP meets with the caregivers to discuss the information on the completed form and shares the district's process and goal for safe and efficient mealtimes.

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 and other team members if indicated. Information is gathered on the need for special seating, utensils, food 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 educational 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 PFD information is added:

An IEP meeting is held to discuss the feeding and swallowing concerns 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 educational staff.

Implementation of the Safe Eating Plan is monitored by the PFD team:

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 PFD 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 are eligible for IDEA services, including PFD, and must have an IEP in place by 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 may 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 important information about their child's mealtimes with the school team.

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. In pre-k programs, students may eat in their classrooms at tables.
Caregivers and family members assist the student with meals.	⟷	Student's mealtimes are typically monitored by school or program staff. Students may not always be fed or monitored by the same person every day.

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

SECTION 5

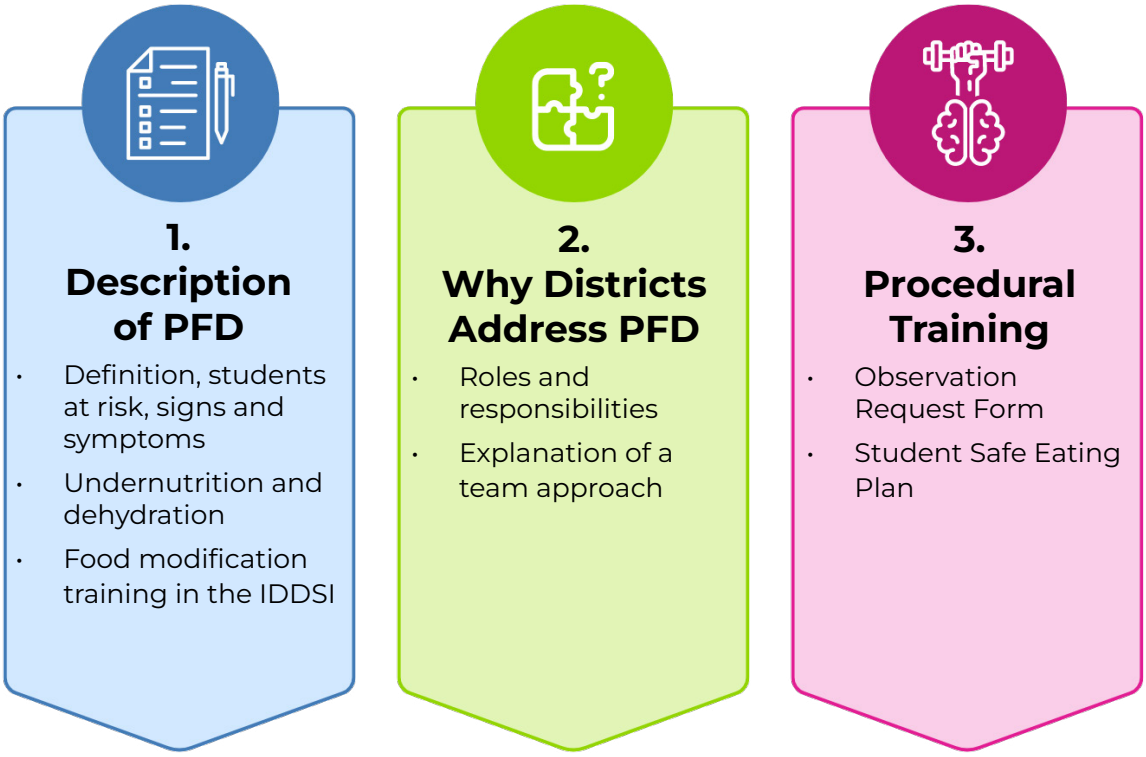
Training Considerations

The PFD team should consider the training needs of their system. These trainings may range from a district wide overview of PFD to student specific training on Safe Eating Plans.

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 a resource for training staff.

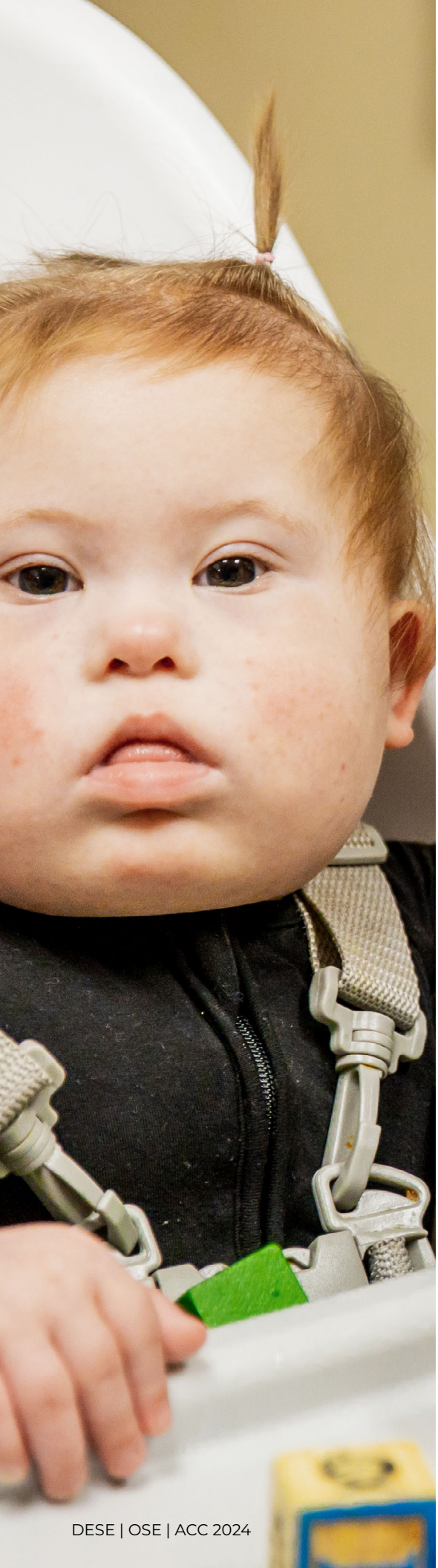
Training considerations include:



**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 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 several avenues by which related service providers may improve their knowledge, skills, and comfort level with PFD.

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. Using tools such as:

- *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*

Therapists should highlight the skills they are comfortable with and work on the areas that need further knowledge by seeking professional development, mentors, or articles to learn more.

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 PFD 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 PFD 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 Disorder.

See ASHA Learning Pass.

4: ACCESS EXPERIENCED STAFF

Some SLPs and OTs in the district have the knowledge and experience to address PFD. Consider using them as mentors to coach and support other staff members. The school district often needs to adjust the mentor's workload to allow time to work with PFD team members. By utilizing mentors who already have the knowledge, skills, and experience to address dysphagia and guide those needing their skills updated, the district is building capacity and expanding the staff that can work independently.

5: LEARN ABOUT EACH STUDENT WITH A PFD ON YOUR CASELOAD

Learn as much as you can about the type of PFD of the students who are assigned to your case-load. Consider specializing your research to include the student's specific type of feeding and swallowing concerns. This could include specific swallowing and feeding signs that are typical of the population you are serving and how to address each sign.

SECTION 6

School Services for PFD

The educational team determines all services necessary to meet a students PFD needs. While students with a Safe Eating Plan should receive ongoing monitoring and consultation or services on behalf of the student. 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 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).

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?
- Does the child 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?

EXAMPLES OF MONITORING AND CONSULTATION MAY 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 feeding practices.
5. Resolving conflicts when they occur, 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, growth, and functioning in the school setting. Initially, it may be necessary for the mealtime environment to be quiet and free of distraction. 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 work to ensure safety at the beginning of school. Each district will have a different organizational structure, resources, and system that will influence which team members complete these steps. When possible, the PFD Team Leader 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 appropriate 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 educational staff retrained if necessary.
- Copies of the Safe Eating Plan are shared with appropriate school personnel.

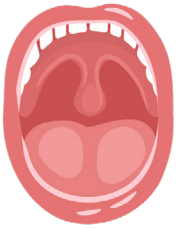
Transfer Procedure During the School Year
During the school year, when a student transfers to a new location, a process should be followed to ensure that the student's swallowing and feeding concerns are immediately addressed. The school team should ensure the student's Safe Eating Plan is included in 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 implemented by the SLP or OT for the purpose of strengthening oral motor skills and desensitizing sensory issues. Interventions may also be implemented by trained staff and caregivers and monitored by the SLP or OT. Exercises to improve oral motor and sensory motor deficits may be implemented by trained staff and caregivers under the training and monitoring of the SLP and/or OT.

To be effective:

- interventions should be specific to the child's needs
- interventions should be done frequently and repeatedly with fidelity.
- caregivers and appropriate staff are trained to assist the student with the interventions throughout the day.
- data should be taken regularly to drive interventions and monitor progress.

Points to remember when supporting a plan for oral phase dysphagia and sensory motor disorders:

→ Therapy should be based on clinically observed deficits in the child and should focus 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).

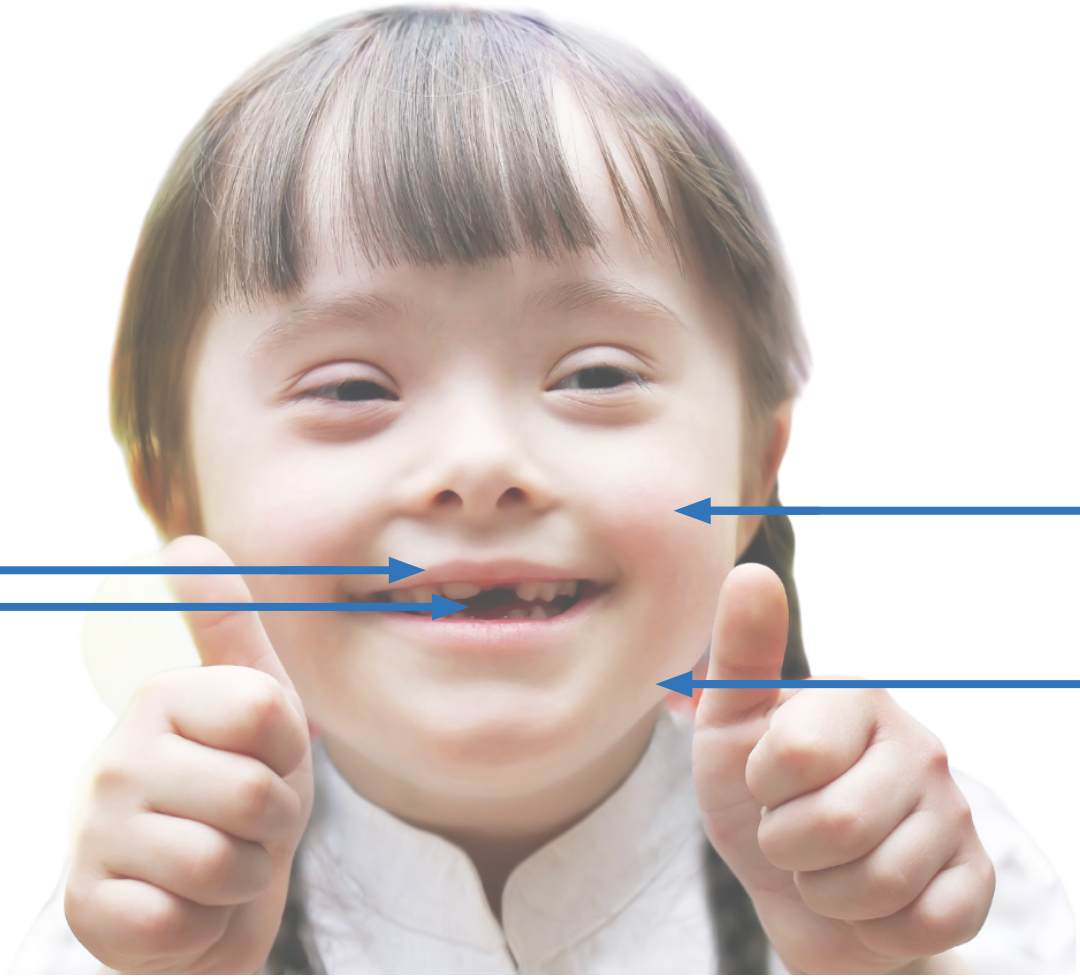
→ Oral motor program should be intensive and systematic with the goal being to progress to a more normalized diet.

According to ASHA, primary eating milestones are:

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

>> Click for ASHA's Feeding and Swallowing Milestones

Oral Phase
S T R U C T U R E S
and Their Roles



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

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

3. JAW
Movements (horizontal, vertical, and rotary) are necessary for effective biting and chewing.

4. CHEEKS
Have normal tone, they remain tight against the gums and keep the bolus from falling into the lateral sulci

INTERVENTIONS TO CONSIDER

School-based teams must closely evaluate the skills a child needs to manage an age-appropriate diet and consume enough volume safely, while providing meaningful practice opportunities (West, 2024).

Spoon feeding

Biting

Lip closure

Chewing

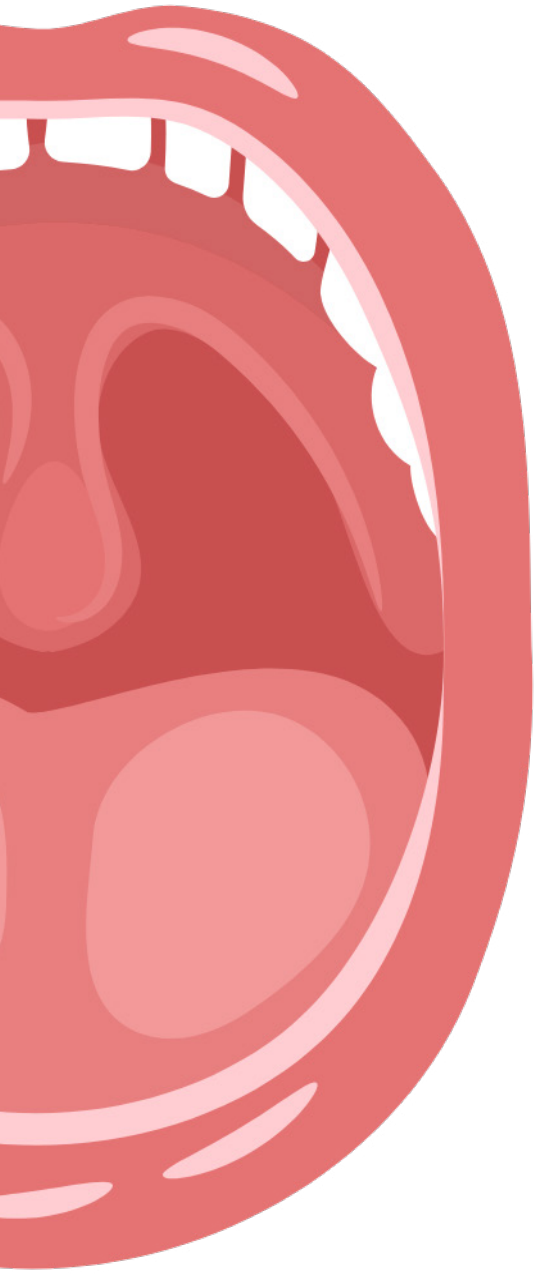
Drink to bite ratio

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 from 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 an essential 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?

In these instances, the student's PFD team should meet to problem solve medical instability issues.

TRANSITIONING TO OR FROM TUBE FEEDING

General information

When a child requires some or all of their nutrition from a feeding tube, the most common ways are the nasogastric tubes (NG), jejunostomy tubes (JEJ, PEJ or RIJ tubes), and the percutaneous endoscopic gastrostomy tubes (PEG tube).

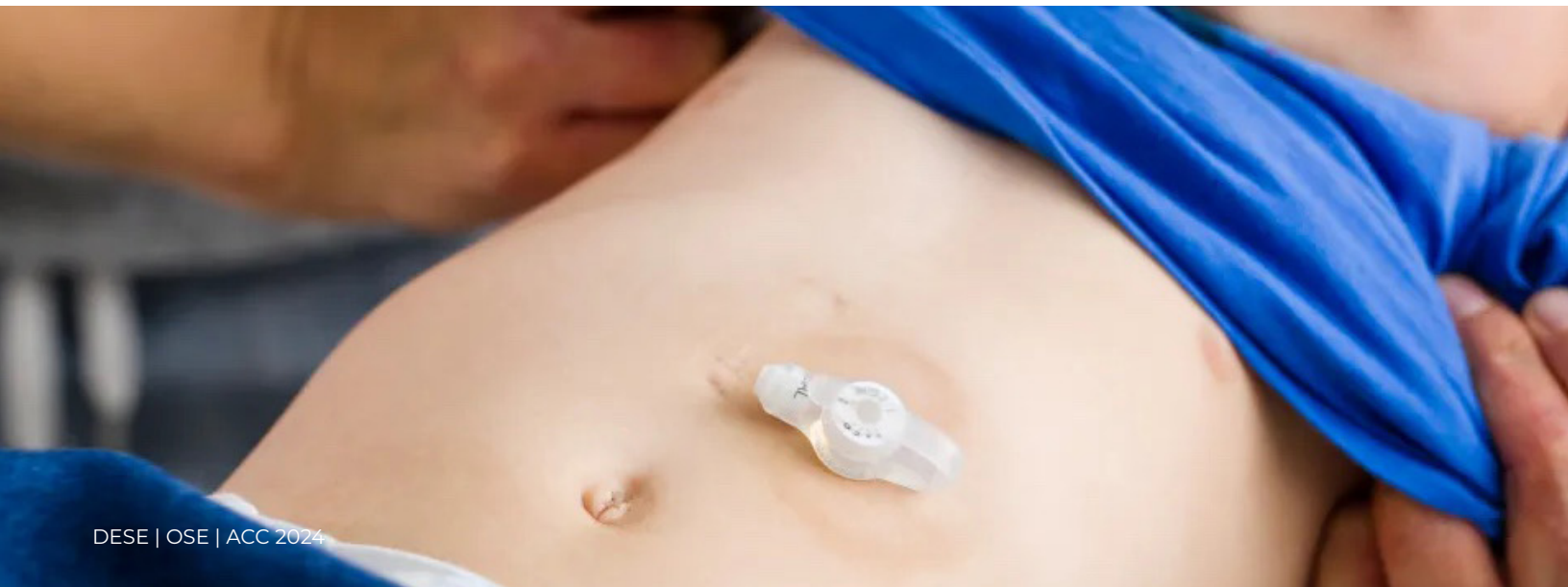
When does a child need tube feeding?

- The child is unable to sustain nutrition orally due to oral motor deficits or aversion but has a safe 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 caregiver'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 tube feeding 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 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:

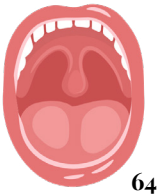
- Oral defensiveness
- Oral hypersensitivity
- Picky eating
- Feeding aversion
- Feeding jags (eats only one thing)
- Limited eating (only eats a certain amount)
- Food refusal
- Vomiting and gagging

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 supported by the PFD team, 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 PFD team should work with caregivers and physicians to identify 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.





DIVISION OF ELEMENTARY
& SECONDARY EDUCATION

ALL IN

INCLUSIVE LEARNING. FULL ACCESS. BETTER OUTCOMES.

Division of Elementary and Secondary Education
Office of Special Education
Arkansas Collaborative Consultants

In partnership with Emily M. Homer, CCC-SLP, ASHA Fellow

Design services privded by 9+C Designs
www.9CDesigns.shop

References

References

American Speech and Hearing Association. (n.d.). What are person-centered functional goals? https://www.asha.org/siteassets/uploadedfiles/icf-swallowing.pdf

Arvedson, J. (2017), Evaluating feeding and swallowing disorders in infants and children. ASHAwebinar.

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

Arvedson, J., & Lefton-Greif, M. (2017). Instrumental Assessment of Pediatric Dysphagia. Seminars in Speech and Language, 38(02), 135–146. https://doi.org/10.1055/s-0037-1599111

CEC Policy Manual, 1997 Section Three, Professional Policies, Part 1 Chapter 3, Special Education in theSchools.

Council for Exceptional Children. (2022). Homepage. Council for Exceptional Children. https://exceptionalchildren.org/

Daggett, L.M., (2013). Reasonable Supervision in the City: Enhancing the Safety of Students with Disabilities in Urban (and Other) Schools, Fordham Urban Law Journal, 41, 501-556.

Davis-McFarland, E. (2008). Family and Cultural Issues in a School Swallowing and Feeding Program. Language, Speech, and Hearing Services in Schools, 39(2), 199–213. https://doi.org/10.1044/0161-1461(2008/020)

Fischer, E., Arvedson, J., Silverman, A., Davies, WH., Satter, E., Berlin, K., Sato, A., & Rudolph,C. (2005). Reconceptualizing feeding and feeding disorders in interpersonal context: the case fora relational disorder. Journal of Family Psychology. Vol. 20, No. 3, 409-417. DOI: 10.1037/0893-3200.20.3.409.

Gellert-Jones, M., Nov. 16, 2018. Training Caregivers to Feed Children with Complex Medical Needs [paperpresentation], ASHA Convention, Boston, MA.

IDEA Subchapter 3 Infants and Toddlers with Disabilities. 2023. Section 1435. https://sites.ed.gov/idea/statute-chapter-33/subchapter-iii

Family Guide Pediatric Feeding Disorder . (2020). https://www.feedingmatters.org/wp-content/uploads/2020/09/FeedingMattersFamilyGuide.pdf

Feeding Matters - Serving Kids with Pediatric Feeding Disorder. (n.d.). Feeding Matters. https://www.feedingmatters.org/

Food jags: MedlinePlus Medical Encyclopedia. (n.d.). Medlineplus.gov. https://medlineplus.gov/ency/article/002425.htm#:~:text=A%20food%20jag%20is%20when

Goday, P. S., Huh, S. Y., Silverman, A., Lukens, C. T., Dodrill, P., Cohen, S. S., Delaney, A. L., Feuling, M. B., Noel, R. J., Gisel, E., Kenzer, A., Kessler, D. B., Kraus de Camargo, O., Browne, J., & Phalen, J. A. (2019). Pediatric Feeding Disorder. Journal of Pediatric Gastroenterology and Nutrition, 68(1), 124–129. https://doi.org/10.1097/MPG.0000000000002188

Homer, E. M. (2008). Establishing a Public School Dysphagia Program: A Model for Administration and Service Provision.
Language, Speech, and Hearing Services in Schools, 39(2), 177–191. https://doi.org/10.1044/0161-1461(2008/018)

References

Homer, E. M. (2016). Management of swallowing and feeding disorders in schools. San Diego Plural Publ.

Homer, E. M., Bickerton, C., Hill, S., Parham, L., & Taylor, D. (2000). Development of an Interdisciplinary Dysphagia Team in the Public Schools. Language, Speech, and Hearing Services in Schools, 31(1), 62–75. https://doi.org/10.1044/0161-1461.3101.62

Individuals with Disabilities Education Act, 20 U.S.C. ß 1400 et seq. (2004)

International Dysphagia Diet Standardization Initiative. (2019). IDDSI - IDDSI Framework. Iddsi.org. https://iddsi.org/Framework

Kingsnorth, S., Wincentak, J., Provvidenza, C., Townley, A., Hoffman, A., Perlin, R., Raffaele, C., Li, C., & Beal, D. (2017). Optimizing feeding and swallowing in children with physical and developmental disabilities: A practical guide for clinicians.

Marzano, R. J., Warrick, P. B., Rains, C. L., Dufour, R., & C, J. (2018). Leading a high reliability school. Solution Tree Press.

Nagele, D. A., Hooper, S. R., Hildebrant, K., McCart, M., Dettmer, J., & Glang, A. (2019). Under-Identification of Students with Long Term Disability from Moderate to Severe TBI: Physical Disabilities: Education and Related Services, 38(1), 10–25. https://doi.org/10.14434/pders.v38i1.26850

Pediatric Feeding and Swallowing. (n.d.). American Speech-Language-Hearing Association. https://www.asha.org/practice-portal/clinical-topics/pediatric-feeding-and-swallowing/

Philadelphia, H. S. for C. with C. P. H. S. for C. with C. P. 4400 B. A. (2020, February 19). Coming to the Table. HMS School. https://hmsschool.org/news/coming-to-the-table/

Students Eat Safely Emily M. Homer | Speech-Language Pathologist Consultant. (n.d.). Emilymhomer.com. Retrieved April 30, 2024, from https://www.emilymhomer.com/

What is Pediatric Feeding Disorder? (2019). Feeding Matters. https://www.feedingmatters.org/what-is-pfd

Power-deFur, L. (2009). Dysphagia services in schools: Applying special education requirements to a health service. Perspectives on Swallowing and Swallowing Disorders, 18, 86-90.

Power-deFur, L. & Alley, N.S.N. (2008). Legal and financial issues associated with providing services in schools to children with swallowing and feeding disorders. Language, Speech, and Hearing Services in Schools, 39, 160-166.

Rogers, L., Magill-Evans, J., & Rempel, GR. (2012). Mothers' challenges in feeding their children with autism spectrum disorder—Managing more than just picky eating. Published online: 18 August 2011# Springer Science+Business Media, LLC 2011.

Sheppard, J. (2005). The role of oral sensorimotor therapy in the treatment of pediatric dysphagia.Perspectives on Swallowing and Swallowing Disorders (Dysphagia) Vol, 14, Issue 2, Article 1, Jun2005, 6 -10. https://doi.org/10.1044/sasd14.2.6

References

Sheppard, J. (2008), Using motor learning approaches for treating swallowing and feeding disorders: a review. Language, Speech, and Hearing Services in Schools, 39 (2), 227-236. DOI: 10.1044/0161-1461(2008/022)

The American Journal of Occupational Therapy, 2007, Vol. 61(6), 686–700.Specialized Knowledge and Skills in Feeding, Eating, and Swallowing for Occupational Therapy Practice,The American Journal of Occupational Therapy, 2007, Vol. 61(6), 686–700.

Urban, M. & Hazelwood, RJ, 2019. Are you ready to manage dysphagia? ASHA Leader, Vol. 24, Issue 7, July 2019.

Viviers, M., Johgh, M., Dickonson, L., Malan, R., & Pike, T. (2020). Parent-reported feeding andswallowing difficulties of children with autism spectrum disorders (aged 3 to 5 years) compared totypically developing peers: a South African study. African Health Sciences. Mar. 2020, 20(1), 524-532. doi: 10.4314/ahs.v20i1.59

West, K. M. (2024). Treating Pediatric Feeding Disorders and Dysphagia: Evidence-Based Interventions for School-Based Clinicians. Language Speech and Hearing Services in Schools, 1–14. https://doi.org/10.1044/2023_lshss-23-00016

World Health Organization . (2013). How to use the ICF A Practical Manual for using the International Classification of Functioning, Disability and Health (ICF) Exposure draft for comment World Health Organization Geneva. https://www.who.int/classifications/drafticfpracticalmanual.pdf

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: ☐ 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 *Persons attending: ☐ Teacher ☐ SLP ☐ OT ☐ PT ☐ Administrator ☐ Nurse ☐ Parents ☐Other: _____ *Issues addressed: ☐ Emergency Plan ☐ Medical History ☐ Referral to Physician ☐ Release of Information ☐ Safe Eating Plan discussed ☐ Referral for VFSS ☐ Information from IEP sent to Food Service for recommended changes ☐ Other: _____
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 *attended by: _____
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 ☐ History of recurrent pneumonia ☐ Weight loss/history of undernutrition	☐ Receives nutrition through tube feeding ☐ 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) ☐ Poor upper body control ☐ Poor oral motor functioning ☐ Maintains open mouth posture ☐ Drooling ☐ Nasal regurgitation ☐ Food remains in mouth after meals (pocketing) ☐ Swallowing solid food without chewing ☐ Overstuffing ☐ Effortful swallowing or difficulty initiating swallow	☐ Food and/or drink escaping from the mouth or trach tube ☐ Slurred speech ☐ Eyes watering/tearing during mealtime ☐ Wet breath sounds and/or gurgly voice quality following meals or drinking ☐ Coughing/choking during meals ☐ Unusual head/neck posturing during eating ☐ Hypersensitive gag reflex ☐ Mealtime takes more than 30 minutes ☐ Needs assistance with mealtimes

ADDITIONAL ADVERSE BEHAVIORS OBSERVED:

☐ Avoids food textures, colors, tastes, etc.
☐ Feeding jags (eats only one thing)
  ☐ Limited eating (only eats a certain amount)
☐ Maintains open mouth posture
  ☐ Spitting up or vomiting associated with eating and drinking
	☐ Gags easily
	☐ Food refusal
	  ☐ Feeding aversion
	  ☐ 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 ☐ Pocketing: ☐ Lateral sulcus ☐ Anterior sulcus ☐ Not clearing the oral cavity before swallow ☐ Anterior loss/poor lip seal	☐ Excessive chewing ☐ Hyper/hypo sensitivity ☐ Difficulty with bolus formation ☐ Other:

Pharyngeal Phase:

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

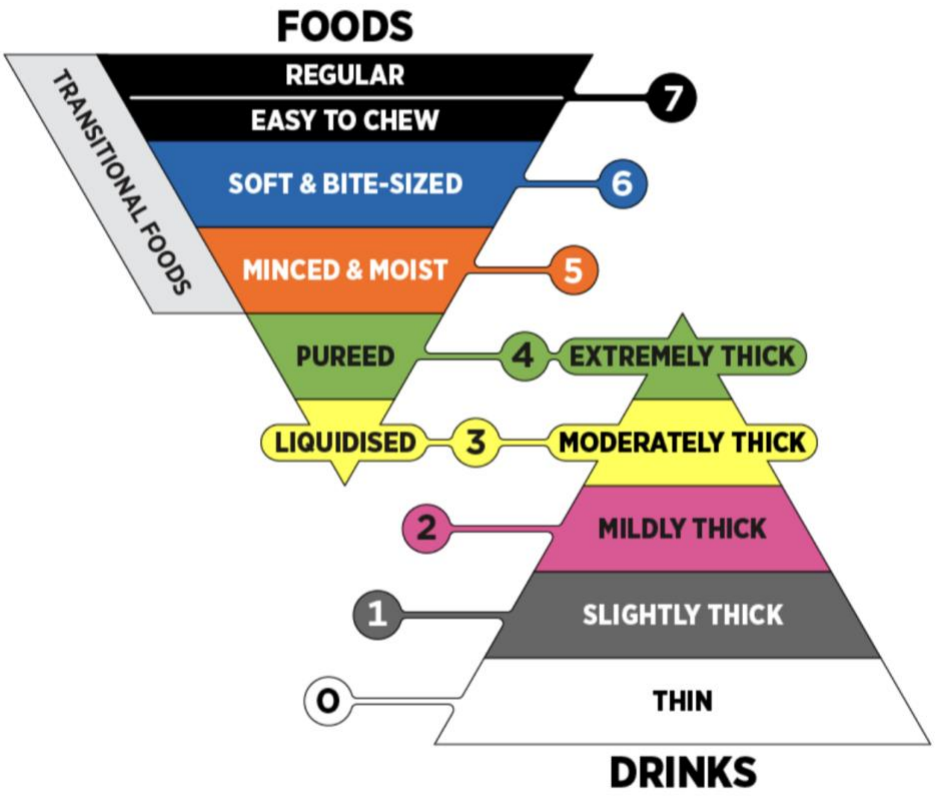
Cups with two handles help

- 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.

The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.



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.

Homer, E. M. (2016). *Management of swallowing and feeding disorders in schools*. San Diego Plural Publ.

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

R., Raffaele, C., Li, C., & Beal, D. (2017). *Optimizing feeding and swallowing in children with physical and developmental disabilities: A practical guide for clinicians*.

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 • Difficulty keeping warm • 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. • 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 regularly and works directly with caregivers and physicians

http://www.emilymhomer.com