

Department of Health Developmental Disabilities Supports Division Procedure	Procedure Number:
	Supersedes: Supporting People on the DD Waiver with Dysphagia/Risk for Aspiration Procedure 11-1-04
Procedure Title: Supporting People on the DD Waiver with Dysphagia/Risk for Aspiration Procedure	
Effective Date: February 12, 2010	
Approved:	Date:

I. POLICY REFERENCE

Supporting People on the DD Waiver with Dysphagia/Risk for Aspiration Procedure

II. PURPOSE OF PROCEDURE

This procedure clarifies the roles of therapists/eating specialists, case managers, agency nurses, dietitians/nutritionists, direct care staff and family and/or guardians statewide who support individuals on the DD Waiver at risk for dysphagia/aspiration and the steps involved in supporting these individuals. These procedures supplement the current DD Waiver Standards.

III. APPLICABILITY

This procedure applies to all therapists/eating specialists, case managers, agency nurses, dietitians/nutritionists, direct care staff, individuals with a developmental disability, family and/or guardians who support individuals on the DD Waiver at risk for aspiration/dysphagia.

IV. DEFINITIONS

Aspiration Review Coordinator (ARC): Means the Developmental Disabilities Supports Division staff person responsible for monitoring individuals on the DD Waiver identified as being at risk for dysphagia/aspiration.

Aspiration: Means the act of food, saliva, liquids, phlegm or any other solid matter getting below the true vocal cords into the trachea. Aspiration is directly linked to dysphagia.

Continuum of Care (COC) Regional Medical Champions: Means the group of medical professionals who provide local support to interdisciplinary teams and health professionals serving individuals with developmental disabilities across New Mexico.

Division of Health Improvement (DHI) Medical Director: Means the full-time medical expert available to IDT's, Regional Offices, physicians, etc., for consultation and technical assistance regarding the medical issues of individuals on the DD Waiver at risk for dysphagia/aspiration.

Dysphagia: Means difficulty swallowing and may involve one or more of the oral, pharyngeal or esophageal phases of swallowing.

Eating Specialist: Means an IDT member or professional who is knowledgeable and clinically competent in the area of evaluation and treatment of swallowing and feeding disorders and is able to take a leading role in supporting all team members through these processes with educational information, training, individualized written plans and referral sources. Most often an eating specialist is a speech-language pathologist, but an occupational therapist, physical therapist or nurse may also assume the role. There is no certification for this title, however the evaluation and management of individuals with swallowing and feeding disorders is within the role of and scope of practice for speech-language pathologists as identified by the American Speech-Language-Hearing Association (ASHA).

Health Decisions Resources (HDR): Means a group of volunteers from various professions who have experience in the field of developmental disabilities. HDR volunteers offer information and guidance about healthcare decision-making for individuals who have developmental disabilities.

Individual Advocacy and Assistance (IAA) Unit: Means a group of trained mediators with the Developmental Disabilities Supports Division who are committed to supporting and helping other individuals, teams and guardians resolve issues through consensus. The IAA specifically offers mediation, training, advocacy and technical assistance for those individuals who request help with dispute resolution.

Internal Review Committee (IRC): Means the committee comprised of the DDSD and DHI management staff who review, assign follow-up tasks and assure follow-up on incident reports, mortality reviews and site visits.

Mealtime Procedure Packet: Means instructions regarding how an individual at risk for dysphagia/aspiration is to be supported for eating as safely as possible. The packet will include a rationale clarifying why the procedures are important, as well as clear instructions regarding adaptive equipment, proper positioning, assisted eating techniques and nutritional content. Several different disciplines may be responsible for developing each element of the MPP.

Supports and Assessment for Feeding and Eating (SAFE) Clinic: Means a group of clinical professionals who have established a clinic that evaluates and recommends assistance for individuals with developmental disabilities, their families and care providers in improving safety for eating, health and nutrition. The clinic also provides the following:

- technical assistance
- support and continuing education for professionals involved in supporting eating for individuals with developmental disabilities throughout the life span
- pre-service education for graduate and undergraduate students in feeding/eating approaches for children and adults with developmental disabilities
- assistance and care to families and care providers in locating appropriate community resources for direct treatment, adaptive equipment and follow-up services

Video Fluoroscopy Swallowing Assessment (also known as VFSS, VSA or VSS): Means an assessment by video fluoroscopy in a medical radiology facility. The video fluoroscopy evaluates the person’s swallowing mechanism by having the person swallow liquids, solids and/or medications mixed with barium. This allows for the dynamic evaluation of the oral, pharyngeal and upper esophageal mechanisms and identifies aspiration if it occurs. If abnormal swallowing is identified, the clinician determines the physiological area of abnormality and whether management strategies will help to minimize aspiration. This evaluation is most useful when performed collaboratively by a radiologist and an eating specialist.

V. PROCEDURE

Note: This procedure begins with a diagnostic-oriented set of protocols (A – F) followed by a set of treatment-oriented protocols (G – N).

	Responsible Person / Agency	Actions
A	IDT/Provider Agency Nurse	<ol style="list-style-type: none"> 1. Identifies individuals with a developmental disability as potentially at risk for dysphagia/aspiration through observation or through a score of over 50 on the aspiration screening tool administered by the agency nurse or other appropriate person as designated. 2. IDT develops an interim emergency plan if there is an immediate health risk.
B	Individual/Guardian	<ol style="list-style-type: none"> 1. Expresses the wishes/desires of the individual regarding eating. 2. Becomes informed/educated on dysphagia/aspiration issues and alternatives for safe eating. 3. Participates in medical appointments. 4. Advocates for the individual’s needs, wishes and civil rights.

		5. Makes healthcare decisions.
C	Case Manager (CM)	<ol style="list-style-type: none"> 1. Assists the individual/guardian with choosing a therapist/eating specialist and completing the Freedom of Choice (FOC) form as soon as possible. If no therapist/eating specialist is available, CM contacts Aspiration Review Coordinator (ARC) and/or the designated DDS staff. 2. Advises the individual/guardian of their rights and responsibilities and provides an informational brochure on dysphagia/aspiration. 3. If the individual/guardian agrees, the CM will: <ol style="list-style-type: none"> a. Complete a budget within one week of receiving the signed FOC form. b. Schedule the evaluation to be completed within one month of budget approval. 4. If the individual/guardian does not agree, the CM will: <ol style="list-style-type: none"> a. Explore with the individual/guardian the reasons for disagreeing with the recommendations of the therapist/Eating Specialist. b. Call an IDT meeting to discuss options such as: a referral to Health Decisions Resources (HDR) or Individual Advocacy and Assistance Unit (IAA), referral to SAFE (Supports and Assessment for Feeding and Eating) Clinic, referral to Primary Care Physician (PCP), and/or evaluation and provides additional written information on resources available through the DOH and Contractors including “Aspiration Prevention Considerations for Teams”. c. Guide IDT in developing a plan of action to support safe eating as much as possible.
D	Therapist/Eating Specialist	<ol style="list-style-type: none"> 1. If recommended, arranges for video-fluoroscopy and/or other diagnostic tests in collaboration with the nurse. 2. Completes an evaluation within one month of budget approval. 3. Develops assigned components of the Mealtime Procedures Packet. 4. Sends evaluation report and MPP components to the CM.
E	Agency Nurse/Therapist	<ol style="list-style-type: none"> 1. Collaborates in arranging recommended diagnostic tests. 2. If PCP does not share the concerns of the team, calls Continuum of Care (COC) Regional Medical Champions or refer to SAFE Clinic or call the DHI Medical Director.

		3. If positive for risk of aspiration, writes a Healthcare Plan and Crisis Prevention Plan.
F	Case Manager (CM)/IDT	<ol style="list-style-type: none"> 1. If the evaluation is positive for a risk for dysphagia/aspiration, the CM will: <ol style="list-style-type: none"> a. Convene an IDT meeting including a nutritionist, nurse, eating specialist and other therapists as needed (OT, PT, etc.) no later than two weeks after the completion of the evaluation and/or diagnostics. b. IDT Agenda should include: results of the evaluation/diagnostic findings, distributing information on dysphagia/aspiration risk, distributing and reviewing the MPP, creating a dental care plan, weight monitoring plan and a training schedule for staff to be trained by the therapist and/or nurse. c. If oral eating is not safe: the team will discuss options, pros and cons of tube feeding, quality of life issues and health care decision processes. The decision concerning the use of the feeding tube is made by the individual/guardian. d. Notify ARC and/or designated DDSD staff person to add person to the aspiration monitoring list. 2. If the evaluation indicates there is not a risk for dysphagia/aspiration, the CM will: <ol style="list-style-type: none"> a. File documentation in the Primary Record. b. Screen the individual annually through the Health Assessment Tool (HAT) evaluation.
G	Agency Nurse/IDT	<ol style="list-style-type: none"> 1. If feeding tube is necessary, the agency nurse/IDT will arrange a referral to the appropriate specialist and monitor individual through the procedures and discharge back to the program. 2. Develop a tube feeding protocol. 3. Train direct support staff on the tube feeding protocol and keep an updated training log.
H	Case Manger (CM)/IDT	<ol style="list-style-type: none"> 1. Calls an IDT meeting whenever necessary to assure ongoing safe eating practices are being addressed and implemented. 2. Observes a minimum of one meal/snack every six months during the CM's site visit; notifies the agency nurse, therapist/eating specialist and house manager if any unusual signs/behaviors are noticed related to the consumer's eating or if there are any concerns about the consumer's eating (see "Identifying individuals at Risk

		<p>for Aspiration & What To Do About It”, page 2).</p> <p>3. Completes “Quarterly Review for Persons With Dysphasia/Risk for Aspiration” residential form and day program form (including information received from the therapist/eating specialist every six months) and sends to the designated staff at the RO.</p>
I	IDT Members	<ol style="list-style-type: none"> 1. Notify the Eating Specialist, agency nurse, house manager and case manager if any unusual signs/behaviors related to the individual’s eating are noticed (see “Identifying individuals at Risk for Aspiration & What To Do About It”, page 2) or if there are any concerns about the individual’s eating. 2. Contact RO or ARC for assistance if needed. 3. If any of the following conditions exist, an IDT meeting should be called immediately (the agency nurse is required to attend this meeting): <ol style="list-style-type: none"> a. Hospitalization due to aspiration or choking incident. b. Unexplained weight loss or weight loss of greater than 10% in 6 months. c. Initiation of a feeding tube. d. Illness or physical change that affects eating. 4. If issues of possible neglect are observed, file an Incident Report (IR) with the Division of Health Improvement (DHI).
J	House Lead/Manager, Day Program Supervisor	<ol style="list-style-type: none"> 1. Notifies the therapist/eating specialist (or nurse if the consumer is tube fed) immediately when new staff begin working with the individual are hired and need to be trained. 2. Ensures that no staff assists an individual with eating until they are properly trained. 3. Attends IDT meetings and offers input.
K	Residential Agency/Day Program Agency	<ol style="list-style-type: none"> 1. Distributes MPP to agency nurse, home manager/supervisor and service coordinator. 2. Ensures that the complete MPP or feeding tube protocol is available at the residence or day program site. 3. Ensures that the Health Care Plan and the Crisis Prevention Plan are available at the residence or day program site.
L	Eating Specialist	<ol style="list-style-type: none"> 1. Contacts the SAFE clinic for technical assistance on writing MPP, if needed. 2. Trains in person all staff who assist the individual with eating, including house managers and day program

L	Eating Specialist	<p>supervisors, and keeps an updated training log.</p> <ol style="list-style-type: none"> 3. Observes staff implementation of MPP at least once a month, periodically alternating observations between the residential and/or day program staff with no less than a quarterly visit for each site. 4. Gives refresher training to all staff as necessary indicated by the monthly mealtime observation, or at a minimum of semi-annually. 5. Participates in IDT meetings related to aspiration or eating issues. 6. Reviews/updates MPP at least annually. 7. Assures that the MPP is available at the residence/day program site and is current. 8. After the initial documentation submission, the following information will be sent to the case manager every six months in addition to the required annual and six-month progress report, or more frequently if determined necessary by the IDT: <ul style="list-style-type: none"> • dated training rosters • brief dated summary of significant monthly observation findings regarding implementation of the MPP • current dated MPP
M	Agency Nurse	<ol style="list-style-type: none"> 1. Develops and implements a Health Care Plan to address the individual's dysphagia/aspiration that will include: <ul style="list-style-type: none"> • administering safe medication procedures (in collaboration with the therapist/eating specialist) • consistent weight monitoring as deemed necessary by the physician and the IDT • monitoring of pulmonary status 2. Develops and implements an individualized Crisis Intervention Plan related to the individual's dysphagia/aspiration. 3. If there is more than one nurse involved (e.g., a residential and a day program nurse), the residential nurse will take the lead in developing the plans with input from the other nurse(s). 4. Develops a tube feeding protocol if the individual is tube fed (see page 4 of "Identifying Individuals at Risk of Aspiration and What To Do About It"), and sends a copy of the protocol to the case manager in addition to having it available for use in the home/day program. 5. Trains residential and day staff on the use of all appropriate plans including the tube feeding protocol and/or positioning. Document on a dated training roster. 6. Submit items in # 1-5 to the case manager when changes

		occur, at least semiannually.
N	Registered Dietician/Nutritionist	<ol style="list-style-type: none"> 1. Completes and sends a copy of the Nutritional Content Section of the MPP to the case manager within 30 days of the assessment (see page 4 of “Identifying Individuals at Risk of Aspiration and What To Do About It”), and updates the assessment at least annually. 2. Trains residential/day program staff and family on the nutritional component of the MPP as often as needed, at least semiannually and documents on a dated training roster. 3. Monitors the nutrition portion of the MPP a minimum of four times a year, revises as necessary, documents and submits to the case manager. 4. Submits item # 1 to the case manager annually, item # 2 semiannually and item # 3 when changes occur, at least semiannually.

VI. LIST OF ATTACHMENTS

Identifying Individuals at Risk for Aspiration & What To Do About It

Identifying Individuals at Risk for Aspiration & What To Do About It

What is Aspiration and why is it important?

Aspiration refers to fluid or food entering the airway and moving down into the lungs.

Aspiration can be caused by food and/or oral secretions entering the lungs while eating or it can be caused by stomach contents moving back up the esophagus and spilling into the person's airway. Either can cause aspiration pneumonia. Usually when someone aspirates they cough in an attempt to clear the food or fluid out of their lungs. Some people with neurological damage resulting in a weakened cough reflex do not cough – this is called “silent aspiration”.

Swallowing problems resulting in aspiration are more common in individuals with developmental disabilities (especially those with cerebral palsy), in individuals who have had a stroke, and in individuals who are elderly. Frequent aspiration can cause pneumonia and/or permanent damage to the lungs and if left untreated may even cause death.

Step One: Identify Risk Factors

Review the individual's medical record for any of the following:

- Recurrent pneumonia or other respiratory infections
- Diagnosis of Dysphagia and/or GERD
- Repeated unexplained low grade fevers
- Tube feeding
- Greater than 10% weight loss within 6 months
- Rumination (during or after meals)
- Tracheitis (inflammation of the windpipe)
- Rales or Rhonchi (rattling or bubbling sounds in the chest when breathing – heard through a stethoscope by nurse or physician)

Or any of the following conditions in conjunction with observable risk factors listed in the next section:

- Scoliosis
- Spasticity
- Seizure Disorder
- Tardive Dyskinesia
- Periodontal (dental) disease
- Xerostomia (dry mouth)
- Congestive Heart Failure
- Chronic obstructive pulmonary disease (COPD)
- Cancer
- Diabetes

AND, observe the individual during a meal. If you see any of the following symptoms, whether or not in conjunction with a condition listed above, an assessment is needed.

- Unable to feed themselves
- Coughing, gagging or excessive throat clearing during or after meals
- Gurgling sounds in the throat while breathing
- Pocketing food inside the cheek
- Weak or absent cough
- Choking on food or liquid
- Wet sounding speech
- Poor head control and/or not able to remain alert during the meal
- Increased mucous, especially clear mucous with bubbles, excessive drooling
- Wheezing without asthma
- Fear of eating or refusal to eat or drink
- Very slow eating – more than 30 minutes to eat a meal
- Getting very fatigued during meals
- Bluish lips or fingernails
- Watery eyes during eating or drinking
- Nose running or sneezing during eating (when allergies or cold not present)
- Tendency to swallow food whole without chewing
- Coughing when lying flat or upon sitting up quickly from a reclined position

Step Two: Arrange for Further Assessment

If any of the above are noted, the individual should be assessed to determine if they need intervention to reduce their risk. The individual's primary care physician should be made aware of the above risk factors you have noted for the individual. Sometimes the medication the individual takes may contribute to problems swallowing if they cause the person to be sedated or have a dry mouth. This possibility can be explored with the physician. If the risk factor is rumination, you will want the physician to first rule out physical causes such as GERD, esophageal stricture, hiatal hernias, etc. before assuming that it is a behavioral concern. The physician may also wish to refer the individual for a video fluoroscopy. To assure that this procedure provides the team with the most useful information possible, see the separate handout "Swallowing Studies (MBS/VSA) For Individuals with Developmental Disabilities" for considerations in arranging an effective video fluoroscopy.

If you have a speech therapist on the team with expertise in swallowing disorders you should also alert them to your observations, and if they confirm high risk, involve an OT or PT to look at positioning issues and a dietician to look at nutrition.

If the IDT lacks expertise with swallowing disorders, a good resource for assessment in New Mexico is the Supports and Assessment for Feeding and Eating clinic (SAFE) at the Center for Development and Disability. This clinic has an interdisciplinary team of eating specialists who can evaluate the individual, provide a recommended meal time procedures packet and a video tape demonstrating proper feeding/eating techniques. To arrange a SAFE clinic appointment, call Elizabeth Ceysens RD at 505-272-0285.

If the only risk factor is rumination, and physical causes have been ruled out by the physician, then a behavioral support plan would be needed rather than a meal time procedures packet. If rumination occurs in conjunction with other risk factors, both types of plans may be needed.

If assessment determines that the individual is indeed at risk for aspiration and eating orally, a team of professionals with expertise in swallowing disorders should **collaborate** to prepare a meal time procedures packet for care givers to follow while supporting the individual during meals. If the individual has a feeding tube, a feeding tube protocol is needed, because aspiration can still occur if the individual is not positioned and fed through the tube properly. Some individuals may have both a meal time procedures packet and a feeding tube protocol if they use both avenues. For instance, some individuals receive most of their nutrition through a feeding tube, but eat orally for social and pleasurable reasons; other may receive most of their nutrition orally, but may supplement with feeding tubes if intake of sufficient calories has been a problem.

Step Three: Review of the Meal Time Procedures Packet and or Feeding Tube Protocol

The purpose of the meal time procedures packet and/or Feeding Tube Protocol is to provide easy to understand instructions for the individual and their family and/or support staff to minimize the risk of aspiration. It is not a fancy medical report for the therapists. Therefore the packet and/or protocol should be reviewed by the case manager/service coordinator to assure that it is complete and easy to understand.

A complete meal time procedures packet should include individualized instructions in five sections. Different professionals will likely write each section; the most likely discipline to prepare each section is listed in the checklist below. Copies of therapists' reports will not be accepted instead of individualized instructions for this packet, because direct care staff should not have to hunt through a report for this information. It is often helpful to include diagrams, pictures and/or equipment ordering information.

- Rationale – Why procedures in the plan are important for the individual
 - Speech Language Pathologist or Occupational Therapist
- Appropriate Eating Equipment
 - Spoons/utensils, and/or
 - Dishes, and/or
 - Cups/straws
 - Information regarding equipment vendors/resources
 - Speech Language Pathologist or Occupational Therapist
- Proper Positioning (during and after meals and medications)
 - Person eating, **and**
 - Person assisting with the meal
 - Positioning equipment
 - Physical Therapist or Occupational Therapist
- Assisted Eating Techniques
 - Food texture, and/or
 - Liquid consistency, and/or
 - Presentation of the food
 - Degree of supervision during meals
 - Problems to watch for
 - Cross reference to Health Care Plan if medication is needed to prevent reflux or other medication is taken with meals
 - Speech Language Pathologist or Occupational Therapist
- Nutritional Content

- Foods to encourage, and/or
- Foods to avoid, and/or
- Fluid intake, and/or
- Calorie requirements
- Number of meals and/or snacks per day
 - Registered Dietician/Nutritionist

A complete Feeding Tube Protocol is usually prepared by the nurse on the team and should include at least the following sections:

- Description of the Type of Tube and whether Bolus or Continuous Pump
- Appropriate Equipment/Supplies
 - 60cc catheter tipped syringe
 - gloves
 - water
 - feeding bag (if pump is used)
 - Pump
- Proper Positioning (during and after meals and medications)
 - Positioning equipment
 - Seating angle (never less than 30 degrees)
 - Post meal positioning (no less than 45 degree angle for 45 minutes after meals, to prevent reflux)
- Techniques
 - Wash hand and put on gloves
 - Flushing the tube with water before and after feeding
 - Step by step instructions for feeding with type of tube the individual uses
 - Pump Rate (if using pump)
 - If Bolus, amount of time to deliver prescribed amount of nutrition
 - Cleaning tube site
 - Problems to watch for – and what to do if they occur (e.g. tube replacement, tube gets plugged, skin irritation, excess gastric residual)
 - Cross reference to Health Care Plan if medication is needed to prevent reflux or other medication is taken with meals*
- Nutritional Content
 - Liquid Nutrient – type and amount
 - Hydration schedule between meals
 - Registered Dietician/Nutritionist should consult on this aspect

**ALERT: all medications delivered via feeding tube must be liquid or crushable and dissolved. Therefore, if an individual is being switched from a time-release pill to a liquid form, dosage and/or schedule will need to be adjusted to account for faster release time of liquid medication into the blood stream. Time release and coated pills are not acceptable because small particles remaining even when crushed plug the feeding tube.*

Although some of the above areas may not be relevant for all individuals – all plans should address all areas. So for example, if an individual doesn't require any special equipment, the plan should simply state that no special equipment is needed; or if the individual doesn't have any special considerations for nutritional content, the plan should state that the individual can eat whatever they choose as long as it is prepared to the texture specified in the plan.

If there are areas that are not addressed, or there are instructions that are not clear – the team should go back to the author(s) and ask for clarification to be written into the plan. Verbal clarification only is often not reliably implemented. So, for example, if the plan calls for all food to be chopped, but it doesn't say how small the pieces should be chopped, ask for a size reference to be added to that section. Or, if the plan states that the individual should have "adequate fluid intake" – ask that number of ounces or cups be specified.

Step Four: Distribution of Meal Time Procedures Packet and/or Feeding Tube Protocol

Authors from the appropriate disciplines should submit their sections of the meal time procedures packet and/or feeding tube protocol to the case manager within 30 days from assessment. The case manager will compile all sections and distribute to the following entities, who will in turn distribute them to appropriate staff within their agencies (at least those indicated in secondary bullets).

- Family
- Therapists who authored sections of the Meal Time Procedures Packet (so they all have a copy of the whole thing)
- Residential Provider
 - Nurse
 - Home Manager/Supervisor
 - Service Coordinator
- Day Program Provider
 - Nurse
 - Site Supervisor
- PCP

Step Five: Training

Training should be provided by the author(s) of the meal time procedures packet and/or feeding tube protocol – or a qualified individual who has been trained on the specific procedures previously (e.g. nurse, competent staff) – to the individual and all those who assist them with meals. Such training should provide an opportunity for the individual assisting to practice the technique with immediate feedback from the trainer. Periodic review sessions are advised.

Step Six: Assure Proper Implementation

Both case managers, supervisors and packet/protocol authors should observe the individual during a meal at least quarterly, to determine if the plan is being followed consistently, including all five areas of the plan. If equipment is lost or broken it should be replaced promptly. As new staff is hired they should be trained before assisting the individual to eat. The other reason periodic observation is a good idea is that the individual's condition may change over time alerting the team to the need for re-assessment and revision of the meal time procedures packet and/or feeding tube protocol.

Sometimes individuals and/or their families object to certain recommended strategies for reasons of personal preference or cultural beliefs. For example the individual may feel that pureed food stigmatizes them as eating "baby food", or perhaps one of the foods considered unsafe, is an important part of a cultural celebration. Teams should work together to see if strategies can be creatively identified to address the concern and still maximize safety. For example, can the

pureed food be layered to appear like a “casserole”? Or is it possible to compromise on chopping it finely? Can the culturally important food be prepared in a safer manner – or given in small portions to minimize the risk? In the end, self-determination and family preferences must be respected – assuming the risk has been fully explained. However, the issue should be revisited at least every six months if the individual’s health continues to suffer as a result of not implementing recommended prevention measures – they may change their mind later.

Follow Up Checklist

In summary, if a risk factor is identified by you or any other team member, then:

- Arrange for the individual to be assessed by appropriately trained professionals, such as
 - Primary care physician
 - SAFE clinic
 - Video fluoroscopy
 - Assessment by therapists on the IDT, or initiate therapy services
- Review results of assessment with the team and determine needed intervention, such as
 - Meal time procedures packet
 - Medication changes
 - Placement of feeding tube
 - Feeding tube protocol
 - Behavioral plan (e.g. to address rumination)
- Review meal time procedures plan and/or feeding tube protocol for completeness and clarity
 - Rationale
 - Appropriate Eating Equipment
 - Proper Positioning
 - Assisted Eating Techniques
 - Nutritional Content
- Assure that meal time plan is available to staff in all settings where the individual eats
 - Home
 - Day program
 - Other
- Assure that staff are trained to properly implement the meal time procedures packet and/or feeding tube protocol
- Quarterly, observe a meal to monitor
 - Is meal time procedures packet and/or feeding tube protocol available on site?
 - Is proper equipment available and used?
 - Is positioning correct?
 - Are assistive eating techniques being implemented?
 - Has the staff person assisting with the meal been trained?
- Assure that a Crisis Prevention Plan is developed so that staff know what to do if the individuals’ aspiration develops into a crisis, such as
 - Turning blue, can’t talk or make sounds
 - Isn’t breathing or having great difficulty breathing
 - Looks very ill
 - Running a fever
- Assure that the Health Care Plan addresses positioning and procedures for delivery of medication in a manner that reduces risk of aspiration.
- Assure support is being provided for proper dental hygiene.

- At least every six months, discuss with the team how meals are going;
 - Do the meal time procedures packet and/or feeding tube protocol seem effective in reducing observable symptoms? (If no, consider reassessment or revision)
 - Do additional team members need training?
 - Is implementation difficult in certain aspects? (If yes, ask plan author(s) if adjustments are possible)
 - Are symptoms worsening? (If yes, arrange reassessment)