Mealtime Support Resources
Intended Audience: The information in these resources was prepared as a guide for families and staff supporting people with a disability. For anyone experiencing a swallowing difficulty specialist advice should be sought for appropriate assessment of the person’s swallow and development of the correct strategy. However the resources also provide information on good mealtime support, relevant to everybody.
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Acknowledgements: The contributions to these resources by many people from Disability Services are greatly appreciated. In addition, the support and feedback received during the development of this resource from Dr Julie Cichero (The University of Queensland), and Dr Bronwyn Hemsley (The University of Newcastle) is greatly appreciated.

Mealtimes provide a pattern to our day. They provide enjoyment and an opportunity for socializing. We develop skills and develop our family roles through mealtimes. Mealtimes provide a sense of belonging to a group: a family group, a friendship group, a work group or a community group. Our cultures have social meanings in relation to food. We use food as a way of welcoming visitors, relaxing with friends and celebrating special occasions.

Overview – Mealtime Support

Introduction

Mealtimes are an important time of the day for everyone, as they are linked to our physical health, and are also often a time of social interactions, fun and emotional support.

**Mealtimes should be safe and enjoyable for everyone.**

Throughout these resources the terms meals or mealtimes includes snacks.

People with disabilities can experience a range of mealtime issues. Swallowing difficulties and choking are two key areas of concern. Mealtime difficulties increase with age for everyone. However, the average age that a group of people with disabilities living in a large residential facility started to experience swallowing changes was 33 years\(^1\). Difficulties with swallowing can be associated with food and drink entering the lungs (aspiration), choking, malnutrition and dehydration\(^2\).

These resources are for people with disabilities, their families, and people who provide services to people with disabilities.

The information in these *Mealtime Support Resources* is general in nature. If you have concerns about mealtimes for a Person with a disability talk with the Person’s GP or other specialists who she/he consults. If you are working for a disability service, be sure to follow organisational requirements\(^3\).

Safe and enjoyable mealtimes are best supported by a collaborative team. The team always includes the Person and the people directly providing mealtime support such as their family and/or support team. In situations where the Person has a problem with swallowing a Speech Language Pathologist will be involved. It is important that collaboration occurs, such as sharing of information and observations, discussion of issues and consistent implementation of strategies.

Mealtime support may involve a range of people in finding solutions. The Person’s family and support team are crucial in providing mealtime support each day. Speech Language Pathologists are able to identify swallowing difficulties and recommend particular food and drink textures for the Person. Occupational Therapists and Physiotherapists can contribute to mealtime support in relation to maintaining independence and appropriate positioning. Dietitians can assist with maintaining nutrition through healthy eating and drinking. Having healthy teeth and gums is important for mealtime support. Dentists assist with maintaining oral health. Some medications effect appetite, saliva and other aspects of mealtimes. Pharmacists and GPs can provide advice about medication effects and safe swallowing of medication.

**About these resources**

These Mealtime Support Resources:

- include information about:
  - signs of swallowing difficulties
  - meal preparation
  - strategies which can be used to support safe and enjoyable mealtimes
  - health and other information relevant to mealtime support
- are designed so that each section addresses different aspects of mealtime support and can stand alone and can be used as an information sheet for particular situations if required.

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3 In these resources the use of a capital P for Person indicates a Person with a disability.
Swallowing Difficulties and Meal Preparation

Swallowing involves the coordination of many sensory messages and muscle movements. It is important for all of us to safely swallow our food and fluid.

**Four phases of swallowing** are:

- preparing food on the plate and in the mouth in readiness for swallowing (oral preparatory phase)
- moving food to the back of the mouth (oral phase)
- moving food through the throat or pharynx (which is a tube in the neck) past the airway opening which goes to the lungs (pharyngeal phase)
- moving food down the oesophagus - a soft tube that connects the pharynx and the stomach (oesophageal phase).

Swallowing difficulties or “dysphagia” occur when one or more of these four phases of swallowing is disrupted - see *How do we swallow?*, page 34 of this Resource. Many people develop difficulties with swallowing as they age. For a range of reasons, these difficulties may occur at an earlier age for people with disabilities.

**Signs of swallowing difficulties**

It is important to be aware when a Person is experiencing signs of swallowing difficulties and to seek appropriate help. The information sheets *Signs of Swallowing Difficulties* (page 3), and *Choking* (pages 4-5), provide details about observable signs of swallowing difficulties and what to do in these situations.

**Meal preparation for people with swallowing difficulties**

Two key strategies for people with swallowing difficulties are:

- modifying the texture of the food that they eat
- thickening their drinks.

Details of food and drink preparation for people with swallowing difficulties are provided in this section of the *Mealtime Support Resources*.

For a Person who is not chewing effectively, **modifying food texture** breaks up the food for them in another way, and helps them to have more control when moving the food in their mouth and when swallowing.

For a Person who is not swallowing effectively, **thickening drinks** holds the drink together in the mouth, and the drink moves more slowly through the mouth and throat (pharynx). This enables the Person to have more time to control the closing of their airway during swallowing.
Signs of swallowing difficulties

- Choking – partial or complete blockage of the airways

**WHAT TO DO: If someone experiences an episode of choking:**
- Follow current first aid procedures for choking.
- Dial 000 (or 112 if using a mobile phone) – the person who answers will be able to step you through current first aid procedures for choking.
- After the immediate response is over, seek advice from a GP and ask for referral to a Speech Language Pathologist to review the Person’s mealtime support.

- Coughing before, during or after meals/snacks
- Difficulty swallowing specific types of foods or drinks
- Difficulty swallowing medication
- The Person still has food in their mouth after eating (e.g., between their cheek and gums)
- Food or drink comes out of the nose
- Voice changes (e.g. wet or gurgly voice)
- Face changes (e.g. watery eyes or flushed cheeks)
- Fatigue – the Person becomes tired while eating (e.g., slowing down pace of eating, or coughing more often towards the end of the meal)
- Lengthy mealtimes (longer than 30 minutes)
- Gagging
- Vomiting and/or reflux
- Multiple swallows for a single mouthful of food or drink
- Difficulty keeping food, drink or saliva in the mouth
- Difficulty chewing food
- The Person’s breathing pattern changes during mealtimes – e.g. rapid breathing
- Frequent throat clearing
- Closing eyes during mealtimes (perhaps swallowing is painful)
- Rapid rate of eating and overfilling the mouth
- Refusal to eat or drink (e.g. the Person shakes their head during meals; doesn’t finish meals; refuses to come to the meal table; removes food from their mouth)
- Unexplained/recurring chest infections
- The Person is underweight or loses significant weight
- Dehydration – having insufficient drinks/fluids for the body’s needs (e.g., reduced output of urine, dark urine, constipation)

**WHAT TO DO: Some signs outlined above would happen for most people occasionally. However, if you and your team notice any of these signs occurring for a Person on several occasions:**
- If possible make notes about your observations
- Request a Speech Language Pathologist checks the Person for swallowing difficulties.

Factors which can increase risk of having swallowing difficulties

- Difficulty maintaining an upright head and body position during mealtimes
- Difficulty remaining alert during mealtimes
- Taking a medication which reduces swallowing effectiveness
- Experiencing loss of teeth, chronic gum infections and/or tooth decay
- Requiring support from others to eat and drink

**WHAT TO DO: There are many strategies that can be used to assist people who have swallowing difficulties to be safe and to continue to enjoy their meals. It is important to seek advice and collaborate as a team to support people who are experiencing any mealtime issues.**
### Choking

**Choking** occurs when an object (which can include food items) lodges into the airway and partially or completely prevents breathing.

- **When the airway is partly blocked**, the Person continues to breath and usually coughs in attempt to expel the object/s from their airway.
- **When the airway is completely blocked**, the Person is unable to breath. Complete airway blockage can result in death.
- **Aspiration** occurs when food or drink enters a Person’s airway and moves down into their lung. This may cause coughing and may result in pneumonia and sometimes death from the pneumonia infection.

#### What are the signs of choking? – A comparison

<p>| Someone with a <strong>partly blocked airway</strong> can still breathe, speak and cough. | Someone with a <strong>completely blocked airway</strong> cannot breathe, speak or cough. |</p>
<table>
<thead>
<tr>
<th>Signs of a partly blocked airway include the person:</th>
<th>Signs of a completely blocked airway include the person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- may grip own throat</td>
<td>- may grip own throat</td>
</tr>
<tr>
<td>- appears agitated and distressed</td>
<td>- appears agitated and distressed</td>
</tr>
<tr>
<td>- has watery eyes</td>
<td>- has watery eyes</td>
</tr>
<tr>
<td>- unusual or increased saliva loss</td>
<td>- unusual or increased saliva loss</td>
</tr>
<tr>
<td>- is having difficulty breathing (different to what is usual for the person)</td>
<td>- may be making efforts to breathe</td>
</tr>
<tr>
<td>- is making unusual breathing sounds such as wheezing, whistling or snoring sounds</td>
<td>- is not making any sounds of breathing</td>
</tr>
<tr>
<td>- some escape of air can be felt from the nose and/or mouth</td>
<td>- no escape of air can be felt from the nose and/or mouth</td>
</tr>
<tr>
<td>- is coughing and does not stop</td>
<td>- is unable to cough</td>
</tr>
<tr>
<td>- is unable to talk in complete sentences or at full volume</td>
<td>- is unable to speak</td>
</tr>
<tr>
<td>- has a red face</td>
<td>- has a red face at first, turning pale and then blue due to lack of oxygen</td>
</tr>
<tr>
<td>- may develop pale and then bluish skin colour if situation continues and airway blockage is significant</td>
<td></td>
</tr>
</tbody>
</table>
What INCREASES risk of choking?

The support person not following recommendations about food and drink textures and mealtime positioning for a Person with a disability.

The Person:
- being distractible during meals (for example, talking, laughing, fast head and neck movements to see what is happening, while having food in the mouth)
- having swallowing difficulties (dysphagia)
- being on medications which affect swallowing (for example, medications for epilepsy or mental health issues can cause decreased swallowing effectiveness)
- eating quickly (as initiated by the Person or by the care provider)
- cramming food (that is, a single large amount of food or too many small amounts of food being taken into the mouth)
- having either high or low muscle tone in the tongue, cheek, jaw and throat muscles effects coordination of chewing and swallowing (e.g., people with cerebral palsy may have high muscle tone and people with Down Syndrome may have low muscle tone)
- having missing teeth, no teeth or poor gum health
- not being alert during meals
- not being in an upright position during meals
- requiring assistance to drink (increases the risk of choking by four times).

What REDUCES the risk of choking?

To reduce the risk of a Person choking:
- ensure the food and drink are the correct texture and temperature for the Person especially if a mealtime plan has been prescribed by a specialist such as a Speech and Language Pathologist e.g. as outlined in a Mealtime Support Plan
- follow all other strategies recommended by specialists in the Person’s mealtime support (such as, positioning, cutlery, speed of meal)
- ensure the Person is alert before eating or drinking
- reduce environmental distractions which may cause the Person to, move suddenly, laugh, talk or be distracted, while eating
- ensure the environment is calm and relaxed and the Person is not rushed
- ensure the Person sits as upright as possible when eating and drinking
- if supporting the Person to eat, explain what you are doing at all times, especially when placing food in their mouth
- if the Person is eating independently, encourage them to place only small amounts of food or drink in their mouth (e.g. ask the Person to use a small spoon to avoid overfilling their mouth)
- if the Person is eating independently, encourage them to eat slowly (e.g. ask the Person to put down their utensils between mouthfuls to help slow the pace of eating)
- stay at the table during mealtimes so that you can provide consistent monitoring and appropriate prompts (that is, bring everything needed for the meal to the table before commencing the meal).

Based on Residential Services Practice Manual Department of Human Services, Victoria, (2009).

The greater the degree of understanding of the specific needs, likes, dislikes and capabilities of the individual, the lower the choking risk. (Thacker, et al., 2008)
Changing food texture: Soft, Minced and Moist, or Pureed

If a Person is experiencing difficulty chewing and swallowing, changing the texture of food is a strategy to support their health and safety.

Swallowing ability is enhanced by variations in texture, shape, volume and the feel of food in the mouth (within safe limits) as these characteristics stimulate the senses. The visual presentation, taste, smell and the temperature all contribute to making the meal more appetising.

A Speech Language Pathologist can identify which textures and specific foods can be eaten safely while maintaining the Person’s enjoyment of meals.

There are three food textures for people with swallowing difficulties:
- Soft - Texture A
- Minced and Moist - Texture B
- Smooth Pureed - Texture C.

These three food textures are outlined on the following pages. These food textures use labels and descriptions from the Australian Standards.

If a Person is assessed as needing a change to their food or drink texture it is important to ensure this is followed for all meals and snacks and reviewed regularly as changes may occur in the Person’s swallow overtime.

RESOURCE “Good Looking Easy Swallowing” by Janet Martin and Jane Backhouse (Published by JFC Foundation, South Australia) includes a range of recipes of different textures which may be useful. Please note: This book doesn’t use the Australian Standards labels to refer to food textures and drink thickeners so care must be taken if someone has been prescribed a particular food or drink texture as above.
Soft - Texture A

- Food in the Soft (Texture A) category may be naturally soft (e.g. ripe banana) or cooked
- Soft food may need to be cut to achieve the recommended particle size
- Soft foods can be chewed but not necessarily bitten
- Soft foods require minimal cutting – easily broken up with a fork
- Soft food should be moist or served with a sauce or gravy to increase moisture content (NB: Sauces and gravies should be served at the required fluid thickness level)
- See Special Notes about Food Textures (foods that require special consideration), on page 13.

**Recommended Soft food particle size for children over 5 years and adults = 1.5 × 1.5cm**

The following table provides some examples of Soft (Texture A) foods.

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Recommended Soft (Texture A) foods (examples only)</th>
<th>Foods to avoid (examples only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>bread cereals</td>
<td>• Soft sandwiches(^{(a)}) with very moist fillings, for example egg and mayonnaise, hummus (remove crusts and avoid breads with seeds and grains)</td>
<td>• Dry or crusty breads, breads with hard seeds or grains, hard pastry, pizza</td>
</tr>
<tr>
<td>rice pasta</td>
<td>• Breakfast cereals well moistened with milk(^{(b)})</td>
<td>• Sandwiches that are not thoroughly moist</td>
</tr>
<tr>
<td>noodles</td>
<td>• Soft pasta(a) and noodles</td>
<td>• Coarse or hard breakfast cereals that do not moisten easily, for example toasted muesli, bran cereals</td>
</tr>
<tr>
<td></td>
<td>• Rice (well cooked)</td>
<td>• Cereals with nuts, seeds and dried fruit</td>
</tr>
<tr>
<td></td>
<td>• Soft pastry, for example quiche with a pastry base</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Other, soft, cooked grains</td>
<td></td>
</tr>
<tr>
<td>vegetables</td>
<td>• Well cooked vegetables(^{(a)}) served in small pieces or soft enough to be mashed or broken up with a fork</td>
<td>• All raw vegetables (including chopped and shredded)</td>
</tr>
<tr>
<td>legumes</td>
<td>• Soft canned vegetables, for example peas</td>
<td>• Hard, fibrous or stringy vegetables and legumes, for example sweet corn, broccoli stalks</td>
</tr>
<tr>
<td></td>
<td>• Well cooked legumes (the outer skin must be soft), for example baked beans</td>
<td></td>
</tr>
<tr>
<td>fruit</td>
<td>• Fresh fruit pieces that are naturally soft, for example banana, well-ripened pawpaw</td>
<td>• Large/round fruit pieces that pose a choking risk, for example whole grapes, cherries</td>
</tr>
<tr>
<td></td>
<td>• Stewed and canned fruits in small pieces</td>
<td>• Dried fruit, seeds and fruit peel</td>
</tr>
<tr>
<td></td>
<td>• Pureed fruit</td>
<td>• Fibrous fruits, for example pineapple</td>
</tr>
<tr>
<td></td>
<td>• Fruit juice (^{(b)})</td>
<td></td>
</tr>
<tr>
<td>milk yoghurt</td>
<td>• Milk, milkshakes, smoothies(^{(b)})</td>
<td>• Yoghurt with seeds, nuts, muesli or hard pieces of fruit</td>
</tr>
<tr>
<td>cheese</td>
<td>• Yoghurt (may contain soft fruit)(^{(b)})</td>
<td>• Hard cheeses, for example cheddar and hardened/crispy cooked cheese</td>
</tr>
<tr>
<td></td>
<td>• Soft cheeses(^{(a)}) for example Camembert, ricotta</td>
<td></td>
</tr>
<tr>
<td>meat fish</td>
<td>• Casseroles with small pieces of tender meat(^{(b)})</td>
<td>• Dry, tough, chewy, or crispy meats</td>
</tr>
<tr>
<td>poultry eggs,</td>
<td>• Moist fish (easily broken up with the edge of a fork)</td>
<td>• Meat with gristle</td>
</tr>
<tr>
<td>nuts, legumes</td>
<td>• Eggs(^{(a)}) (all types except fried)</td>
<td>• Fried eggs</td>
</tr>
<tr>
<td></td>
<td>• Well cooked legumes (the outer skin must be soft), for example baked beans</td>
<td>• Hard or fibrous legumes</td>
</tr>
<tr>
<td></td>
<td>• Soft tofu, for example small pieces, crumbled</td>
<td>• Pizza</td>
</tr>
<tr>
<td>desserts</td>
<td>• Puddings, dairy desserts,(^{(b)}) custards,(^{(b)}) yoghurt(^{(b)}) and ice-cream(^{(b)}) (may have pieces of soft fruit)</td>
<td>• Dry cakes, pastry, nuts, seeds, coconut, dried fruit, pineapple</td>
</tr>
</tbody>
</table>

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| Moist cakes (extra moisture, e.g. custard may be required) |
| Soft fruit-based desserts without hard bases, crumbly or flaky pastry or coconut, for example apple crumble |
| Creamed rice, moist bread and butter pudding |
| **miscellaneous** |
| Soup (may contain small soft lumps, e.g. pasta) |
| Soft fruit jellies or non-chewy lollies (a) |
| Soft, smooth, chocolate |
| Jams and condiments without seeds or dried fruit |
| Soups with large pieces of meats or vegetables, corn, or rice |
| Sticky or chewy foods, for example toffee |
| Popcorn, chips, biscuits, crackers, nuts, edible seeds |

(a) These foods require individualised consideration.
(b) These foods may need modification for individuals requiring thickened fluids.

**Source:** Dietitians Association of Australia and The Speech Pathology Association of Australia, 2007. ‘Texture-modified foods and thickened fluids as used for individuals with dysphagia: Australia standardized labels and definitions.’, *Nutrition and Dietetics*, 64 (Suppl. 2), pp. S53 – S76.

This reference provides information about the evidence base for these standardised labels and definitions.
Minced and Moist – Texture B

- Minced and moist food is soft and moist and should easily form into a ball
- With minced and moist food, a Person uses their tongue rather than teeth to break up the small lumps
- Minced and moist food should be easily mashed with a fork
- Minced and moist food may be presented as a thick puree with obvious lumps in it
- Lumps are soft and rounded (no hard or sharp lumps)
- See Special Notes about Food Textures (foods that require special consideration), on page 13.

**Recommended Minced and Moist food particle size for children over 5 years and adults = 0.5cm x 0.5 cm**

The following table provides some examples of Mince and Moist (Texture B) foods.

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Recommended Mince and Moist (Texture B) foods (examples only)</th>
<th>Foods to avoid - in addition to the foods to avoid listed for Soft – Texture A (examples only)</th>
</tr>
</thead>
</table>
| bread cereals rice Pasta noodles | • Breakfast cereal with small moist lumps, for example porridge or wheat flake biscuits soaked in milk  
• Gelled bread (bread soaked in thickened fluid)  
• Small, moist pieces of soft pasta, for example moist macaroni cheese (some pasta dishes may require blending or mashing) | • All breads, sandwiches, pastries, crackers, and dry biscuits  
• Gelled breads that are not soaked through the entire food portion  
• Rice that does not hold together, e.g. parboiled, long-grain or basmati rice  
• Crispy or dry pasta, for example edges of a pasta bake or lasagne |
| vegetables legumes | • Tender cooked vegetables that are easily mashed with a fork  
• Well cooked legumes (partially mashed or blended) | • Vegetable pieces larger than 0.5 cm or too hard to be mashed with a fork  
• Fibrous vegetables that require chewing, for example peas |
| fruit | • Mashed soft fresh fruits, for example banana, mango  
• Finely diced soft pieces of canned or stewed fruit  
• Pureed fruit  
• Fruit juice \(^a\) | • Fruit pieces larger than 0.5cm  
• Fruit that is too hard to be mashed with a fork |
| milk yoghurt cheese | • Milk, milkshakes, smoothies \(^a\)  
• Yoghurt \(^a\) (may have small soft fruit pieces)  
• Very soft cheeses with small lumps, for example cottage cheese | • Soft cheese that is sticky or chewy, for example Camembert |
| meat fish poultry eggs, nuts, legumes | • Coarsely minced, tender, meats with a sauce. Casserole dishes may be blended to reduce the particle size  
• Coarsely blended or mashed fish with a sauce  
• Very soft and moist egg dishes, for example scrambled eggs, soft quiches  
• Well cooked legumes (partially mashed or blended)  
• Soft tofu, for example small soft pieces or crumbled | • Casserole or mince dishes with hard or fibrous particles, for example peas, onion  
• Dry, tough, chewy, or crispy egg dishes or those that cannot be easily mashed |
### desserts
- Smooth puddings, dairy desserts,\(^{(a)}\) custards,\(^{(a)}\) yoghurt,\(^{(a)}\) and ice-cream\(^{(a)}\) (may have small pieces of soft fruit)
- Soft moist sponge cake desserts with lots of custard, cream or ice-cream, for example trifle, tiramisu
- Soft fruit-based desserts *without* hard bases, crumbly or flaky pastry or coconut, for example apple crumble with custard
- Creamed rice

### miscellaneous
- Soup\(^{(a)}\) — (may contain small soft lumps, e.g. pasta)
- Plain biscuits dunked in hot tea or coffee and completely saturated
- Salsas, sauces and dips with small soft lumps
- Very soft, smooth, chocolate
- Jams and condiments without seeds or dried fruit

### Desserts with large, hard or fibrous fruit particles (e.g. sultanas), seeds or coconut
- Pastry and hard crumble
- Bread-based puddings

\(^{(a)}\) These foods may need modification for individuals requiring thickened fluids.

**Source:** Dietitians Association of Australia and The Speech Pathology Association of Australia, 2007. ‘Texture-modified foods and thickened fluids as used for individuals with dysphagia: Australia standardized labels and definitions’, *Nutrition and Dietetics*, 64 (Suppl. 2), pp. S53 – S76.
Smooth Pureed – Texture C

- Smooth pureed food is smooth and lump free.
- Smooth pureed food is similar to the texture of commercial pudding.
- At times, smooth pureed food may have a grainy quality, but should not contain lumps.
- Smooth pureed food is moist and cohesive enough to hold its shape on a spoon (i.e. when placed side by side on a plate these consistencies would maintain their position without ‘bleeding’ into one another).
- Smooth pureed food can be moulded, layered or piped.

See Special Notes about Food Textures (foods that require special consideration), on page 16.

For duty of care reasons ALL recommendations in a Person’s mealt ime support plan must be followed. The following table provides some examples of Smooth Pureed (Texture C) foods.

Note Some individuals may benefit from the use of a runny pureed texture. (Runny pureed foods do not hold their shape; they bleed into one another when placed side by side on a plate).

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Recommended Smooth Pureed (Texture C) foods (examples only)</th>
<th>Foods to avoid - in addition to the foods to avoid listed for Soft (Texture A) and Minced &amp; Moist (Texture B) (examples only)</th>
</tr>
</thead>
</table>
| bread cereals rice Pasta noodles | • Smooth lump-free breakfast cereals, for example semolina, pureed porridge  
• Gelled bread (bread soaked in thickened fluid)  
• Pureed pasta or noodles  
• Pureed rice | • Cereals with coarse lumps or fibrous particles, for example all dry cereals, porridge  
• Gelled breads that are not soaked through the entire food portion |
| vegetables legumes | • Pureed vegetables  
• Mashed potato  
• Pureed legumes, for example baked beans (ensuring no husks in final puree)  
• Vegetable soups that have been blended or strained to remove lumps(a) | • Coarsely mashed vegetables  
• Particles of vegetable fibre or hard skin |
| fruit | • Pureed fruits, for example commercial pureed fruits, vitamised fresh fruits  
• Well mashed banana  
• Fruit Juice(a) without pulp | • Pureed fruit with visible lumps |
| milk yoghurt cheese | • Milk, milkshakes, smoothies (a)  
• Yoghurt(a) (lump-free), for example plain or vanilla  
• Smooth cheese pastes, for example smooth ricotta  
• Cheese and milk-based sauces(a) | • All solid and semi-solid cheese including cottage cheese |
| meat fish poultry eggs, nuts, legumes | • Pureed meat/fish (pureed with sauce/gravy to achieve a thick moist texture)  
• Soufflés and mousses, for example salmon mousse  
• Pureed legumes, hummus  
• Soft silken tofu  
• Pureed scrambled eggs | • Minced or partially pureed meats  
• Scrambled eggs that have not been pureed  
• Sticky or very cohesive foods, for example peanut butter |
| desserts | • Smooth puddings, dairy desserts(a)  
• custards(a) yoghurt(a) and ice-cream(a)  
• Gelled cakes or cake slurry, for example fine sponge cake saturated with jelly  
• Soft meringue | • Desserts with fruit pieces, seeds, nuts, crumble, pastry or non-pureed garnishes  
• Gelled cakes or cake slurries that are not soaked through the entire |

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Food Groups | Recommended Smooth Pureed (Texture C) foods (examples only) | Foods to avoid - in addition to the foods to avoid listed for Soft (Texture A) and Minced & Moist (Texture B) (examples only)
---|---|---
miscellaneous | • Cream\(^a\), syrup dessert toppings\(^a\) | • Soup with lumps
 | • Soup\(^a\) — pureed or strained to remove lumps | • Jams and condiments with seeds, pulps or lumps
 | • Smooth jams, condiments and sauces | food portion

\(^a\) These foods may need modification for individuals requiring thickened fluids.

**Source:** Dietitians Association of Australia and The Speech Pathology Association of Australia, 2007. ‘Texture-modified foods and thickened fluids as used for individuals with dysphagia: Australia standardized labels and definitions’, *Nutrition and Dietetics*, 64 (Suppl. 2), pp. S53 – S76.
### Special notes about food textures

Some foods and other items require special consideration for people with swallowing difficulties.

<table>
<thead>
<tr>
<th>The following foods were identified as requiring emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bread</strong></td>
</tr>
<tr>
<td>• Bread requires an ability to both bite and chew. The muscle activity required for each chew of bread is similar to that required to chew peanuts or raw apple. For this reason, individuals who fatigue easily may find bread difficult to chew</td>
</tr>
<tr>
<td>• Bread requires moistening with saliva for effective chewing. Bread does not dissolve when wet; it clumps. It poses a choking risk if it adheres to the roof of the mouth, pockets in the cheeks or if swallowed in a large clump. This is similar to the noted choking effect of ‘chunks’ of peanut butter.</td>
</tr>
<tr>
<td><strong>Ice-cream Ice</strong></td>
</tr>
<tr>
<td>• Ice-cream and ice are often excluded for people who require thickened fluids, because ice-cream and ice melt and becomes a thin liquid at room temperature or in the mouth.</td>
</tr>
<tr>
<td><strong>Jelly</strong></td>
</tr>
<tr>
<td>• Jelly may be excluded for individuals who require thickened fluids. This is because jelly melts in the mouth if not swallowed promptly.</td>
</tr>
<tr>
<td><strong>Soup</strong></td>
</tr>
<tr>
<td>• Individuals who require thickened fluids will require their soups thickened to the same consistency as their fluids unless otherwise advised by a Speech Language Pathologist</td>
</tr>
<tr>
<td><strong>‘Mixed’ or ‘dual’ food consistencies</strong></td>
</tr>
<tr>
<td>• These textures are difficult for people with poor muscle coordination to safely contain and manipulate within the mouth</td>
</tr>
<tr>
<td>• These are food textures or consistencies where there is a solid as well as a liquid present in the same mouthful</td>
</tr>
<tr>
<td>• Examples include individual cereal pieces in milk (e.g. cornflakes in milk), fruit punch, minestrone soup, commercial diced fruit in juice, watermelon</td>
</tr>
<tr>
<td><strong>Special occasion foods or fluids</strong></td>
</tr>
<tr>
<td>• Special occasion foods (e.g. chocolates, birthday cake) should be well planned to ensure that they are appropriate for individuals requiring texture-modified foods and/or thickened fluids</td>
</tr>
<tr>
<td><strong>Nutritional supplements</strong></td>
</tr>
<tr>
<td>• For a person who also required thickened fluids, nutritional supplements may require thickening to the same level of thickness</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
</tr>
<tr>
<td>• Individuals having Smooth Pureed food - Texture C, being given whole tablets or capsules is unsuitable. Consult with medical and pharmaceutical staff</td>
</tr>
<tr>
<td>• Individuals requiring any form of texture-modified food or fluids may have difficulty swallowing medications. Seek advice if in doubt.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics of foods that pose a choking risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stringy</strong></td>
</tr>
<tr>
<td>For example: rhubarb, beans</td>
</tr>
<tr>
<td>Celery is considered a choking risk until three years of age</td>
</tr>
<tr>
<td><strong>Crunchy</strong></td>
</tr>
<tr>
<td>For example: popcorn, toast, dry biscuits, chips/crisps</td>
</tr>
<tr>
<td><strong>Crumbly</strong></td>
</tr>
<tr>
<td>For example: dry cakes or biscuits</td>
</tr>
<tr>
<td><strong>Hard or dry foods</strong></td>
</tr>
<tr>
<td>For example: nuts, raw broccoli, raw cauliflower, apple, crackling, hard crusted rolls/breads, seeds</td>
</tr>
<tr>
<td>Raw carrots are considered a choking risk until three years of age</td>
</tr>
<tr>
<td><strong>Floppy textures</strong></td>
</tr>
<tr>
<td>For example: lettuce, cucumber, uncooked baby spinach leaves</td>
</tr>
<tr>
<td><strong>Fibrous or tough food</strong></td>
</tr>
<tr>
<td>For example: steak, pineapple</td>
</tr>
<tr>
<td><strong>Skins and outer shells</strong></td>
</tr>
<tr>
<td>For example: corn, peas, apple with peel, grapes</td>
</tr>
<tr>
<td><strong>Round or long shaped</strong></td>
</tr>
<tr>
<td>For example: whole grapes, whole cherries, raisins, hot dogs, sausages</td>
</tr>
<tr>
<td><strong>Chewy or sticky</strong></td>
</tr>
<tr>
<td>For example: lollies, cheese chunks, fruit roll-ups, gummy lollies, marshmallows, chewing gum, sticky mashed potato, dried fruits</td>
</tr>
<tr>
<td><strong>Husks</strong></td>
</tr>
<tr>
<td>For example: corn, bread with grains, shredded wheat, bran</td>
</tr>
<tr>
<td><strong>‘Mixed’ or ‘dual’ consistencies</strong></td>
</tr>
<tr>
<td>For example: foods that retain solids within a liquid base (e.g. minestrone soup, breakfast cereal, e.g. cornflakes with milk); watermelon</td>
</tr>
</tbody>
</table>

Thickening drinks/fluids

Thickened drinks assist a Person with swallowing difficulties by moving slowly in the mouth and into the throat. Thickened drinks hold together, have more bulk and are more easily sensed in the mouth than regular thin fluids. The Person is more able to control the fluid as it passes through their mouth, and throat (pharynx), which gives them more time for closing the airway during swallowing.

Types of thickened fluids are:
- Mildly thick - Level 150
- Moderately thick - Level 400
- Extremely thick - Level 900.

Each level number is based on the Australian fluid viscosity (thickness) scale. Each of these fluid thickness levels are outlined below.

Drink/fluid thickeners
It is very important to make sure the Person has enough drinks/fluids each day so that they don’t become dehydrated. This includes having access to drinks between meals. If there are any concerns about maintaining adequate fluid intake for a Person, it is important to involve a dietitian.

**There should be a recipe in the home of a Person who is having thickened drinks.**
This recipe is specifically for the brand of thickener they are using.

Always follow the recipe for amount of thickener, amount and temperature of fluid, preparation and storage processes, specified in the Person’s mealtime support plan.

Preparing thickened drinks
- the Speech Language Pathologist or other specialist will work with the Person and the support team to identify the most appropriate thickener and recipe
- spoonfuls’ should be a level spoon and not a heaped spoon
- avoid lumps – if thickened drink is lumpy seek help from a team member or for example a Speech Pathologist
- some thickened drinks will need to be left standing for a specified period of time to reach the required thickness (follow recipe instructions)
- some fluids continue to thicken if left standing for a prolonged time, and are no longer suitable for the Person. The consistency of the drink should always be checked each time it is served
- all drinks the Person receives should be thickened
- to ensure adequate intake of fluids daily, thickened drinks should be offered more regularly throughout the day rather than just at mealtimes. If the Person does not drink enough, adding extra taste to drinks may encourage the Person to drink more.
- caution should be taken in relation to foods which are also fluids – for example, ice-cream, jelly thick-shakes/smoothies and ice-chips are foods which melt in the mouth and change to a thinner consistency - these foods should not be given to people who need to have thickened fluids.

See Special Notes about Food Textures on page 13.

When following a thickener recipe but the drink is not the right thickness, seek help from a team member experienced in preparing these drinks, or Speech Language Pathologist.

Tips for thickening fluids
- discard any leftover thickened drinks after 24 hours
- use flavoured drinks – they taste nicer and help give extra sensory information.
- If people are reluctant to drink try offering a variety of different flavours.

Pre-packaged thickened fluids:
- do not require any preparation
- not many people will use these exclusively as it is very expensive for the Person (e.g., these could be useful for when the Person is away from home).
Levels of thickened drinks/fluids

Mildly Thick Fluid - Level 150
- runs fast through the prongs of a fork, but leaves a mild coating on the prongs
- is thicker than naturally thick fluids such as fruit nectars, but for example, not as thick as a thickshake
- pours quickly from a cup but slower than regular, unmodified fluids
- may leave a coating film of residue in the cup after being poured
- usually drunk from a cup
- effort is required to drink this thickness via a standard bore straw – a wide straw is preferable.

Moderately Thick Fluid - Level 400
- slowly drips in dollops through the prongs of a fork
- is similar to the thickness of room temperature honey or a thickshake
- is cohesive and pours slowly
- may be drunk directly from a cup although fluid flows very slowly
- is difficult to drink using a straw, even if using a wide bore straw
- spooning this fluid into the mouth may be the best way of taking this fluid.

Extremely Thick Fluid - Level 900
- sits on and does not flow through the prongs of a fork
- is similar to the thickness of pudding or mousse
- is cohesive and holds its shape on a spoon
- it is not possible to pour this type of fluid from a cup into the mouth
- it is not possible to drink this thickness using a straw.
- spoon is the optimal method for taking this type of fluid.
- this fluid is too thick if the spoon is able to stand upright in it unsupported.

Source  Dietitians Association of Australia and The Speech Pathology Association of Australia, 2007. ‘Texture-modified foods and thickened fluids as used for individuals with dysphagia: Australia standardized labels and definitions’, Nutrition and Dietetics, 64 (Suppl. 2), pp. S53 – S76.

Further details about fluids for infants and young children are provided within this document.
Medication and mealtimes

Swallowing medication

Taking medication becomes an important issue for a Person with swallowing difficulties, especially if they have difficulty with thin liquids or foods that are hard or lumpy.

A Person may refuse their medication if they experience fear, stress or anxiety due to difficulty swallowing medication. If this is occurring someone like a Speech Language Pathologist can identify when a Person is having difficulty swallowing medication and can assess why this is occurring. This information should then be provided to a medical practitioner or pharmacist, who can then identify solutions for the Person.

Medication should be provided orally (i.e., by swallowing) only if it is safe to do so. If there are concerns about the Person’s ability to swallow medications, seek medical advice. (e.g. medical practitioner, pharmacist).

Options for medication textures include:
- some tablet medications may be provided in a liquid form
- some medications in tablet form can be crushed and dissolved in warm water (consult a Pharmacist before cutting or crushing any medications; some medications should not be crushed but swallowed whole, for example sustained release tablets)
- it may be easier for the Person to swallow tablets individually rather than several at one time.

Never modify medications without medical advice.

Medication side effects and mealtimes

Medications have side effects that can impact on mealtimes. Approaches to limiting these side effects include:
- dry mouth – consider how moist a meal needs to be for the Person to be able to swallow safely; pay attention to the Person’s oral health (seek advice from someone like a Speech Language Pathologist and/or Occupational Therapist)
- varying alertness levels – consider timing of meals to match the Person’s times of high alertness; check the timing of medications in relation to meals
- feelings of nausea – seek medical advice for reducing the nausea for the Person.

Medications can also affect the taste of food, a Person’s appetite, and nutritional absorption of food.

Record any observations you make which may be due to side effects of a Person’s medications and seek medical advice.

Therefore for any Person with swallowing difficulties or medication side effects that affect mealtimes, the type and texture of their medication should be considered. If you are uncertain, raise this immediately with your manager to check what action is required. A Speech Language Pathologist may be able to provide relevant information about the Person’s swallowing for the medical practitioner or pharmacist. The pharmacist has access to resources which detail how medication can be safely altered or substitutes (titled “Don’t Rush to Crush”).

Remember to remind the Person’s doctor about swallowing difficulties whenever a change of medication is prescribed.

NOTE: Some fibre based laxatives are a choking risk and should be avoided.
Additional Strategies for Safe and Enjoyable Meals

Food and drink preparation for people with swallowing difficulties is discussed in the previous section.

In this section, additional strategies for safe and enjoyable meals are outlined. These include:

- mealtime support strategies used by the support person (including before, during and after meals)
- paying attention to the Person's mealtime environment
- mealtime positioning (sometimes involves specialised seating)
- using specialised cutlery, plates, cups and other equipment
- supporting a Person to slow down their speed of eating and drinking
- supporting a Person to learn or re-learn mealtime skills
- enabling people to enjoy mealtimes
- chopping food.
Mealtime support strategies used by the support person

Below are some strategies for supporting a Person to eat and drink more safely. Specific strategies relevant for each Person will be outlined in their mealtime management plan.

The mealtime support plan

- Be familiar with the Person’s mealtime support plan and contact the Speech Language Pathologist who prepared the plan, if there is any strategy you do not understand.
- Prepare food and drink according to the mealtime support plan
- Be aware of what specific strategies are included in the Person’s mealtime support plan.

Before the meal

- Where possible involve the Person in the preparation of the meal or the dinner table. Involving the Person will help prepare them for the meal they are about to eat as this helps their brain prepare for swallowing.
- Ensure the Person is fully alert before eating. If they appear drowsy, try assisting them to wipe their face with a cool cloth, or some upbeat music. If these strategies don’t help the Person to become alert, delay the meal until they are not drowsy.
- When you serve the meal and drinks check that the texture and consistency is correct and matches what is stated in the Person’s mealtime support plan.
- Pay attention to how the food looks – keep each food type separate on the plate, even if pureed.
- Bring everything needed for the meal to the table, so that you can sit with the Person or group and stay with them

During the meal

- Always sit at the table (rather than stand) with the Person you are physically assisting to eat and drink. This will enable you to provide the physical support required and will prevent strain on your body while you are providing this support (see also, *Mealtime positioning* page 25).
- Be prepared for emergency responses for choking. Ask a First Aid Trainer for specific information about what to do if someone is choking (see *Choking* page 4-5).
- When physically assisting a Person to eat their meal it is important to clearly communicate what you are doing, and watch and wait for the Person to communicate with you.
- It is also important for you to use the Person’s preferred communication system.
- Allow time for a meal. Do not rush a Person while they are eating.
- If a Person eats slowly, perhaps keep half of their meal warm and serve it once the first half is eaten.
- If you are assisting someone to eat, wait for the Person to tell you they are ready for the next mouthful. If they cannot talk they may tell you by looking at you or by opening their mouth. Do not force someone to eat before they are ready, as this is dangerous.
- Remember to communicate during the meal – let the Person know what you are doing, what they are eating and drinking, and include some social chat.
- Some people may need encouragement not to talk while they are chewing and swallowing.

After the meal

- Encourage the Person to clear their mouth of food before they leave the table. They may need an extra drink to help them swallow the remaining food in their mouth.
- Everyone should remain upright (sitting or standing) for at least 30 minutes after the meal to minimise the possible effects of reflux.
- Where possible involve the Person in cleaning up after the meal to help them understand the full routine of mealtimes.
Paying attention to the mealtime environment

The mealtime environment is important in supporting safe and enjoyable meals for everyone.

Physical and social considerations
- A calm, warm and inviting atmosphere can help to maintain enjoyment and interest in mealtimes, and encourages eating and drinking.
- The aroma of food being prepared makes the room more inviting and increases the Person’s appetite which prepares them for the meal.
- Curtains, wall-coverings, tablecloths, place mats and plants contribute to a warm, homely atmosphere.
- Ensure there is adequate lighting and no glare or shadow.
- Ensure the people you are supporting have enough space to eat their meal. Larger tables or separate smaller tables can be used if someone needs more space or to avoid interruption from others. Also allow room for a support person so they can provide support in a position that minimises the risk of physical strain on their body.

Minimising distractions
Minimising distractions in a mealtime environment can help people to focus their attention on eating. For example turning down the volume, or turning off the TV and radio; avoiding other loud noises or conversations; and reducing the number of people walking around the dining room.

A Person who has difficulties concentrating may benefit from facing away from distractions, such as where people are moving around. If the Person has good concentration skills, the presence of a group of people at a dining table makes mealtimes a social occasion and more enjoyable.

Think about mealtimes as a possible learning environment by:
- setting up the environment to involve the Person in meal preparation
- setting up the environment to maximise independence at mealtimes
- encouraging the Person to use their preferred communication system to participate in choices and social interactions.

Other team members or professionals such as Occupational Therapists may be able to assist you to consider how you can involve people more in food preparation, making the environment more conducive to better mealtime outcomes and how to assist people become more independent at mealtimes.

See also Enabling people to enjoy mealtimes, (page 26) and Supporting a Person to learn or re-learn mealtime skills (page 25).

PRACTICAL SUGGESTION: Preparing the mealtime environment

- the aroma of a frying onion before mealtimes can, help people relax and prepare for the meal (both emotionally and physically).

Source: An experienced direct support worker
Mealtime positioning

Everyone needs to sit in a position that provides the best postural support and a safe position for swallowing.

For people with disabilities, position during mealtimes will vary depending on their movement skills and physical requirements (such as strength of trunk muscles).

It is important that each Person feels secure and is comfortable when sitting so they can focus their attention on what they are eating and drinking.

Appropriate positioning of the Person’s head, neck and body can be the difference between eating safely and risking aspiration or choking on food or drink. For example, it isn’t safe to eat with the head tilted back or too far forward.

If the Person is unable to maintain a safe sitting position during mealtimes, a Speech Language Pathologist will work with an Occupational Therapist or Physiotherapist to identify the best seating arrangement for the Person. This should be recorded in a mealtime support plan for the Person.

In situations where there are no specified positioning recommendations, the following information is relevant to everyone.

Position during the meal

- Use an appropriate chair. The height of the chair should enable the Person to have both feet comfortably on the floor and their knees at right angles to the floor.
  - Where a Person’s feet do not reach the floor, a footrest may be useful.
  - The Person should sit with their hips as far back in the chair as possible and still have a small space between the back of their knees and the front of the seat. Cushioning and other supports may be used to achieve this.
  - The chair should have a back that supports the Person’s trunk upright and maintains their head in a midline position. Cushions or footstools may help to achieve an appropriate position.
  - At times a Person to may need assistance to reposition to maintain an appropriate position during the meal.

Position after the meal

After a meal we should remain in an upright position for at least 30 minutes to avoid problems associated with reflux (partly digested food coming back up the food pipe causing pain and burning).

Position of the support person when physically assisting someone with eating and drinking

- The support person should always be seated so they are at head level with the Person they are assisting.
- The support person’s chair should be directly in front of the Person or face them across the corner of the table.

The position of the support person is important to:

- aid communication and social interaction between the Person being assisted and the support person
- enable the support person to monitor whether the Person is eating well or experiencing difficulty
- enable support strategies to be implemented
- ensure the Person being assisted maintains a safe swallowing position (tilting the head up to someone who is standing up is not safe)
- ensure the support person is in the best position to minimise the risk of physical strain on their body.
Specialised cutlery, plates, cups and other equipment

Specialised equipment can assist people to:
• develop and maintain their independence (or partial independence) at mealtimes
• improve their position when eating and drinking.

It is important for each Person to be as independent as possible when eating and drinking. A Person’s ability to eat and drink independently, or to be partly independent (e.g. hand over hand support to bring the food to the mouth), can help to initiate swallowing and can increase their self esteem.

The appropriate specialised equipment is usually assessed by an Occupational Therapist who will also make recommendations for how to use them.

Equipment may have multiple uses. The components, or the materials themselves, are designed for a specific purpose.

It is important that the item of specialized equipment is available at every meal or snack (even away from home), and that any information about how to support its use is followed (e.g., position of the plate, physical prompts).

Use of this equipment, combined with support strategies, will help the Person to develop their independence.

Examples

Plates with built up edges that increase independence in scooping food onto fork or spoon

Cutlery with built-up handles, angled necks or made of soft plastic

Cups – with handles, shaped cups to give room for the nose or to direct flow of the drink, and weighted cups to assist with minimising hand tremor

Non-slips mats to prevent plate movement
Assisting a Person to eat and drink

Being reliant on another person when eating and drinking places a Person at higher risk of choking than being independent in eating and drinking.

Therefore it is important to take time and care when assisting someone to eat and drink and follow all strategies in their mealtime support plan.

Eating
- avoid providing food from behind
- if possible, place the plate of food in front of the Person who is eating, rather than if front of the person who is providing assistance
- consider the angle you are bringing the spoon or fork to the Person’s mouth as this can influence their head position
- consider how/where you place the food in the Person’s mouth
- perhaps encourage the Person to hold the spoon or fork with you (this may assist with cues about food reaching their mouth and may assist with self-esteem)
- observe when the Person has swallowed (e.g., you may be able to see their “Adams Apple” in their throat move up and down, you may be able to hear them swallowing)
- chat with the Person to help them feel relaxed and to enjoy their meal
- If the Person is receiving nutrition through a tube (e.g. PEG), if possible, do this when the rest of the household has their meal so that the Person can enjoy the social interaction of mealtimes – and include their oral tasters if these are included in their mealtime support. Talk with a Dietitian or Speech Language Pathologist if you have any questions or concerns.

**EXAMPLES**

**Eating strategies from individual mealtime support plans include:**
- *Let me know verbally when it is time to eat and let me smell my meal.* *This will help me get ready to eat*
- *Sit beside (or in front) of me. Please don’t stand as this increases the likelihood of me tipping my head back to look up at you.*
- *Let me know when you are ready and what food/drink you are going to give me (e.g. “Ok X, I have some pumpkin here”) (For someone with a visual/hearing impairment – is there any other touch cues that are needed e.g. a light touch on my shoulder will let me know when you are offering me food/drink).*
- *Present the spoon just in front of my mouth at the level of my lower lip. Wait for me to open my mouth and bring my head down before moving the spoon into my mouth. Please do not put food into my mouth if my head is tipped back.*
- *I will let you know when I am ready for the next mouthful by nodding my head a little.*
- *Do not force me to accept a mouthful if I am turning my head away.*

**Drinking**

Some people have difficulty breathing with a cup to their mouth. Therefore remove the cup every 3-4 sips to enable the Person to take some breaths.

Some people may find removing the cup disorganises their movement coordination, so by simply tipping the cup down while it is still in contact with their lips, may assist them to take a breath.

**Learning**

Some people may be able to learn or relearn greater independence at mealtimes, (e.g., through the use of adapted cups, plates and cutlery).

If you have any questions or concerns about assisting a Person to eat and drink, a Speech Language Pathologist is able to help you.
Supporting a Person to slow down at mealtimes

Eating and drinking quickly places any person at risk of choking and pneumonia. Therefore it is important to support people who eat and drink quickly, to slow down. If possible, identify why the Person is eating quickly, for example:

- Is she/he concerned that someone else might eat their food?
- Is she/he having difficulty coordinating and slowing down their arm movements?
- Is she/he taking large mouthfuls?
- Is she/he generally stressed, tense or anxious?

It may require support over multiple meals for a Person to learn to reduce the speed at which she/he eats and drinks, and to maintain this slower pace. Professor Justine Joan Sheppard reported that people with a disability reduced their speed of eating after an average of 20 meals with a consistent support person using consistent strategies (personal communication, May 2012)

Strategies for supporting a Person to slow down their speed of eating or drinking need to be individualised for each Person according to the reason/s why they are eating quickly, their learning style, communication skills and sensory preferences.

Identifying effective support for each Person will often involve exploring and trialing a number of strategies. A range of people will need to collaborate in relation to this, for example: the Person, their support network, a Speech Language Pathologist and an Occupational Therapist.

**Strategies to support a Person to slow down their speed of eating and drinking**

*Explaining to the Person the benefits* of eating and drinking more slowly (benefits for health and for enjoyment).

**Gestural prompts** – for example:

- sitting beside the Person and placing your hand midway between the Person’s chin and their plate in between mouthfuls (this is a prompt and should not be used to prevent a Person from seeing their food or getting food to their mouth)
- gesturing to the Person to place the eating utensil on the plate between mouthfuls.

**Use of rhythm** – for example:

- slow rhythmical music during mealtimes
- slow rhythmical tapping on the table
- a slow metronome (music rhythm device).

Creating a *relaxed environment at mealtimes* – for example:

- quiet background music rather than the television,
- quiet “chatting” about the day with the Person and their housemates,
- check lighting (avoid flickering or glare),
- sometimes eating alone (if that is the Person’s choice)
- checking if the Person needs to use the toilet before meals (see example below).

**Everyone seated during mealtimes**, including support workers (this adds to a relaxed environment and enables monitoring)

Sitting at the table with the Person and *modelling* slower eating and drinking.

Using a *smaller fork or spoon* (some people have found a long handled parfait spoon useful)

Using *lightly weighted cutlery or wrist weights* (provides sensory information to assist muscle coordination)

Presenting a meal as *several smaller dishes/portions*

**Having two plates** – a serving plate and an eating plate (having a serving plate and an eating plate for everyone at the table, naturally slows down the meal and creates opportunities for social interaction.

**Filling cup to ¼ full** (and having a small jug for repeated amounts)
Using a straw for drinking (if trying this strategy, make sure you talk with a Speech Language Pathologist as drinking with a straw can be difficult to coordinate with swallowing for some people).

**Light touch or pressure prompts,** for example, gentle pressure down on the Person’s arm between mouthfuls, may provide sensory information to assist with muscle coordination (this should not be sufficient pressure to prevent the Person from moving their arm).

Preparing and sharing a Social Story or Information Story about slowing down eating and drinking.

**Verbal prompts**, for example:
- “Put your cup/fork/spoon on the table”
- “Take your time”
- “Don’t forget to chew”
- “Well done; now take a break”
- “Have a break between mouthfuls”.

Use the Person’s preferred communication strategy (e.g., signs or symbols to indicate these messages).

Note: Be cautious with using verbal prompts as some people may become reliant on these and it can be difficult to reduce or fade verbal prompts.

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**EXAMPLES**

**Supporting a Person to slow down their pace of eating and drinking**

**Example 1**

Ms M has intellectual disability, uses a wheelchair, previously had a PEG and was transitioned to solid food several years ago. She has Down Syndrome and very prominent tongue thrust, and was eating all her meals extremely quickly. Her vision is also severely impaired, so hand signs were used to communicate with her, but we were unsure how much she could see. If given a bowl of food she would continue to place food very quickly into her mouth until she aspirated (food entered her windpipe and she began coughing). We implemented body signing with her, where Ms M would take several spoonfuls of food, then the Support Worker would sign ‘more’ on her chest or ‘finished’ with hand over hand with her thumb. Ms M would sign ‘more’, and then would keep eating. While this was tedious at first, it gave Ms M time to finish chewing what was in her mouth, and to know that she could choose to eat more and that the food wasn’t going anywhere. This enabled Ms M to have some control over what was happening during meals. Over time she stopped needing as many body sign prompts to stop and sign ‘more’, and was able to start pacing herself independently.

**Example 2**

Ms F was often thumping on the table and making loud noises during lunch and eating her food very quickly, with the result that she was constantly aspirating it. She was non verbal, so for a while we couldn’t work out what the issue was. We realised that when this was occurring Ms F was needing to go to the toilet, but couldn’t communicate this. So she was eating her food as fast as she could, and when asked to slow down, she would thump the table and make loud noises. So we noted in her mealtime support plan to assist her to go to the toilet before each meal, and magically the challenging behaviours and fast eating stopped and she started to enjoy her mealtimes.

*These examples are real and were provided by a Disability Services Speech Language Pathologist.*
Supporting a Person to learn or re-learn mealtime skills

Some people with disabilities have had limited opportunities to learn independence in mealtime skills. In addition, some people with disabilities have significant physical impairments (e.g., limited movements due to cerebral palsy). Others have more subtle movement differences (e.g., difficulty starting, sequencing, switching and stopping movements). Physical impairments and movement differences can lead to a Person having difficulty managing cutlery and cups to eat and drink independently.

Relying on assistance from another person to place food and drink in the mouth increases risks of choking and pneumonia. Preparedness to take food into our mouths and swallow it safely is easier when we have control over the process than when we are reliant on others. Therefore it is important to support each Person to learn or re-learn mealtime skills to be as independent as possible during mealtimes.

A number of the strategies already discussed in this resource can increase a Person’s independence at mealtimes. These include:

- paying attention to the mealtime environment – for example, minimising distractors while learning is occurring
- paying attention to the position of the Person in their chair, the position of the Person in relation to the table, and the position of plates and other mealtime items
- using mealtime equipment to support hand grip, stability of plates, scooping food from plates and drinking that avoids spillage.

Additional strategies for supporting mealtime skill development include:

- identifying appropriate prompts which assist the Person to learn the sequence of cutting and scooping foods
- selection of food for ease of cutting and use of cutlery
- being aware of whether the Person is left or right handed when using cutlery
- identifying how a Person can be partly independent in mealtime
- slowing mealtimes down so it doesn’t matter if it takes time for the Person to eat at least some of their meal more independently
- building a Person’s arm and hand strength and coordination in other activities during the day.

Supporting people with mealtime skills is consistent with the principles of active support. However, it may take time, and a focus on finding solutions, to support each Person to be actively involved in mealtimes. If you have any questions about supporting a Person to learn or re-learn mealtime skills, an Occupational Therapist or someone skilled in sensory and movement difficulties and teaching people new skills.

**PRACTICAL SUGGESTIONS: Learning skills during mealtimes**

Mealtimes can offer wonderful opportunities for learning new skills and for socialising. Choice making during mealtimes (e.g., between food options) can increase overall choice making skills and self determination for people with disabilities.

As mealtimes often bring people together and food is often highly motivating, it can be the perfect setting to encourage increased interaction and communication.

A lot of our conversations with others happen at mealtimes. They may range from comments about what is happening (e.g., “this tastes good”), to conversations about things that have happened outside of the mealtime (e.g., “I had a good day today because …”), to asking others questions. A Person with a disability could be encouraged to take turns in these conversations.

Depending on the Person’s communication preferences, they could answer questions, make comments, ask others questions, offer others different plates of food. This could involve interpreting their facial expressions or non-verbal actions (e.g., “You look like you are enjoying that”) or directing your conversation to them “We bought this at the shops today / I had a great time shopping with you today.”

*Based on information in the Spot on DD Newsletter December 2012 [www.spotondd.org.au](http://www.spotondd.org.au)*
Enabling people to enjoy mealtimes

Mealtimes are often the social focus for households and are the basis of many social activities at home. Dining out for picnics, barbecues, at cafes or restaurants and at cultural events are also important in most people’s lives. All people should be supported to enjoy mealtimes, in particular people with swallowing difficulties, as they may find mealtimes stressful.

**Questions for Self Reflection and Discussion** Supporting Choices at Mealtimes

- What are this Person’s favourite foods/drinks? How do they indicate this?
- What does this Person’s family like to eat?
- What family events would this Person like to be part of, & contribute food to?
- What is this Person’s culture? What cultural events or foods does she/he enjoy?
- Does this Person have a preferred mealtime and snack routine (for example a quiet cup of tea on the deck each morning, a glass of wine with the evening meal)?
- How does this Person prefer to have meals – for example: In a quiet environment? In a social environment? Does this vary?
- How do this Person’s mealtime preferences fit with those of other household members?
- Can mealtime seating arrangements be flexible, or do household members like to sit at a particular place at the table?
- Is the household group encouraged to relax and have meals at a leisurely pace?
- Does the television being on in the background support enjoyable mealtimes?
- What do you do during meals? Are you able to sit at the table with the household?
- How can this Person be involved in planning meals, food shopping and preparing meals?
- How can this Person make day to day choices about food and drink?
- Does this Person like to prepare snacks (e.g., muffins or smoothies) for the household?
- Can the dining table have a cloth, flowers or other pleasant decoration?
- Does this Person like to eat out – What opportunities does she/he have to do this?
- How can we plan ahead for special occasions such as Christmas and parties, to make sure there are plenty of options for the Person so that others won’t be tempted to provide them with unsuitable foods as “treats”?

This information is important to note/record for anyone who is not familiar with the Person and who may be supporting them (e.g., respite, school or work staff, relief staff).

Enabling people to enjoy meals is consistent with supporting people to have safe and nutritious mealtimes. If you are having difficulty resolving mealtime safety and nutrition with mealtime enjoyment, seek input from others such as family members, teachers, a Speech and Language Pathologist or Occupational Therapist.

Mealtimes are an opportunity for **communication and conversation**. It is important, therefore, that effective communication strategies are in place. Using the Person’s preferred communication strategies (e.g., Key Concepts signs or picture communication board):

- discuss the meal with the Person to increase their interest and appetite.
- let the Person choose their meal and drinks and, where possible, involve them in the meal preparation (e.g., using visual recipes, weekly menu planning). Enabling them to make decisions about their meals will help to improve their appetite, interest in their meal and quality of life.
- we all like to spend time chatting during meals, so it is important not to rush through meals.

**Special considerations for people who have visual and/or hearing impairment** include:

- letting the Person know what you are doing when supporting them to eat or drink.
- supporting the Person to maintain independence by placing objects and furniture in the same locations on the table and in the kitchen.
- sitting where the Person with hearing impairment can easily see you using signs, symbols, gestures, object or other communication strategies.

Chopping food

Chopped food is for people who:
- are unable to use a knife and fork to effectively prepare pieces of food
AND/OR
- have some missing teeth
AND
- have a consistently effective ability to chew
AND
- do not eat food quickly (low choking risk).

People who have swallowing difficulties (dysphagia) or a history/risk of aspiration of food or choking should have one of the three food textures which are for people with swallowing difficulties (unless medical specialists have identified that the Person needs an alternative to oral intake - e.g., PEG, see Attachment 3 page 36).

Regular foods should be chopped to a maximum of 1.5 x 1.5 cm pieces.
Based on current knowledge of average airway sizes, pieces of food larger than this could place any person at risk of choking.

People of small size and height may require smaller pieces of food to be safe.

These pieces are about the size of the top of the thumb to the base of the thumbnail. These pieces are smaller than a 10 cent piece.

All of us tend to moisten our food (e.g., with gravy, sauces, spreads, dips or custards. As well as adding flavour, these assist us to swallow naturally dry foods). Therefore a Person whose food is being chopped may have some food recommendations similar to those in the table below.

See also Special Notes about Food Textures (foods that require special consideration) on page 13.

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Recommended foods for chopping (examples only)</th>
<th>Foods to avoid (examples only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>bread</td>
<td>Cut bread into 1.5 x 1.5 cm pieces.</td>
<td>Avoid thick bread crusts</td>
</tr>
<tr>
<td>cereals</td>
<td>Some people may prefer toasted bread.</td>
<td>Be aware of different breads having different densities such as heavy multigrain (see also, Special Notes about Food Textures, page 13 in relation to bread)</td>
</tr>
<tr>
<td>rice</td>
<td>Spreads and moist fillings help moisten the bread.</td>
<td></td>
</tr>
<tr>
<td>pasta</td>
<td>Cereals, rice, pasta, noodles prepared to be no larger than 1.5 x 1.5 cm pieces</td>
<td></td>
</tr>
<tr>
<td>noodles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vegetables</td>
<td>Cooked vegetables cut into 1.5 x 1.5 cm pieces</td>
<td>Avoid vegetables with tough skins such as capsicum and corn.</td>
</tr>
<tr>
<td>legumes</td>
<td>Vegetables can be cooked in any way (remove skins)</td>
<td>Avoid whole raw carrots or celery</td>
</tr>
<tr>
<td></td>
<td>Raw vegetables can be shredded, thinly sliced or grated (such as lettuce, carrot and celery, tomato)</td>
<td></td>
</tr>
<tr>
<td>fruit</td>
<td>Fruit cut into 1.5 x 1.5 cm pieces</td>
<td>Avoid stringy or fibrous fruit such as pineapple,</td>
</tr>
<tr>
<td></td>
<td>Fruit can be fresh canned or frozen.</td>
<td>Avoid whole apples</td>
</tr>
<tr>
<td></td>
<td>Fruit can be juiced, grated, thinly sliced, or stewed.</td>
<td>Avoid whole hard fruit</td>
</tr>
</tbody>
</table>
| **milk yoghurt cheese** | Yoghurt, cream cheese, cottage cheese  
Any cheese cut into 1.5 x 1.5 cm pieces  
Check pre-grated cheese for long strips, and reduce length if necessary |  |  |
|---|---|---|---|
| **meat fish poultry eggs, nuts, legumes** | Well-cooked tender meat, fish  
chicken or sausages cut into 1.5 x 1.5 cm pieces.  
Gravy or sauce can be added to moisten meats.  
Thinly cut or shaved deli meat,  
tinned tuna, tinned chicken – this may need further cutting to achieve appropriate size of pieces  
Eggs cooked in any way | Avoid stringy or fibrous foods such as,  
chewy meat, fat or gristle, and chicken skin.  
Ensure no bones are left in fish. |  |
| **desserts** | Cakes, pies, jelly, sweet biscuits, cut into 1.5 x 1.5 cm pieces.  
Custard, ice-cream, dipping biscuits in hot drink are ways that moisture can be added.  
Small spoonfuls of ice cream and mousse. |  |  |
| **miscellaneous** | Potato chips, corn chips and savoury biscuits broken into 1.5 x 1.5 cm pieces.  
Dips, salsa, and sour cream are ways that moisture can be added.  
Flaked almonds and crushed peanuts, walnut pieces. | Avoid hard foods such as nuts and boiled lollies. |  |

The differences between Chopping food and Soft-Texture A include:

- a wider range of textures are suitable for Chopped food
- Soft-Texture A is for people with an assessed swallowing difficulty.
Health and Mealtime Support

All body processes are interlinked. Mealtimes are linked to a range of other health and well-being factors. Three of these are:

- oral health
- nutrition
- reflux.

Information on each of these topics is provided below.
Supporting oral health

Oral health includes the health of teeth, gums and other parts of the mouth. Pleasant smelling breath and clean teeth are something we pay attention to when meeting others, and contribute to how we are viewed by others. Good oral health contributes to our health and wellbeing in a range of ways, including nutrition, appearance, social relationships and general health. In particular, good oral health contributes to mealtime safety and enjoyment.

The oral health of people with disability needs particular attention, especially if they have eating and drinking difficulties. For example, tooth or gum infections can increase the risk of pneumonia for people with swallowing difficulties.

All oral health recommendations must be followed to promote the Person’s general health and well-being and to minimise the risk of infections.

Every person should thoroughly clean their teeth at least twice each day. This involves brushing teeth for 2-3 minutes. The brush should be replaced every 3 months. Flossing of teeth should be considered for everyone. There are small plastic frames available for assisting other people to floss a Person’s teeth. If people are not comfortable with others assisting with brushing and flossing teeth, they may have sore or sensitive areas. It is important to get assistance with addressing this sensitivity by talking with your team and requesting help from the specialist team. Positioning and feeling comfortable are factors to consider.

If a Person has no teeth it is still important to pay attention to oral health. Twice daily brushing of gums with a soft toothbrush will limit bacteria build up in the mouth.

Regular dental check ups (every 6 months) are also very important. Some people will need support to relax in the chair and be comfortable with the dentist checking inside their mouth.

QUESTIONS FOR SELF REFLECTION AND DISCUSSION Supporting a Person’s oral health

- What is the Person’s understanding of oral health and what are the best ways to share information with her/him? (e.g. consider a social story)
- What is the Person’s current oral health routine?
- Are the Person’s teeth being cleaned effectively at least twice each day?
- Would a different toothbrush (perhaps an electric toothbrush) assist with improved teeth cleaning?
- What type of toothpaste does the Person prefer to use? (e.g., consider texture and taste differences and toothpastes for sensitive teeth)
- How can the Person be supported to become more independent and effective in cleaning their teeth?
- What aspects of teeth cleaning and oral health are working well for this Person and what aspects are not working well?
- How can we find solutions for the aspects which are not working well?
- How does the Person communicate when they have discomfort (e.g., toothache or painful gums)?

It may take time to find out the best ways to support each Person’s oral health.

There are oral care products that may be worth considering such as:
- mouthwash (for increased fluoride exposure, or antibacterial effect)
- specialized toothpastes (e.g., for dry mouth)
- products to assist with strengthening (remineralisation) of tooth enamel (e.g., tooth mousse)
- use of an oral irrigator/dental jet (to assist when a Person is “pocketing” food or when a Person is unable to tolerate a toothbrush, or as an introductory step in improving oral hygiene when a Person has very swollen gums/tender mouth)
• oral swabs to clean a Person’s mouth
• antibacterial solution (e.g., administered in dilute form in a spray bottle) can improve or maintain oral health.

It is important to discuss these strategies with a Person’s dentist as well as including others in decision making and monitoring of these products if used.

Encouraging a tooth-friendly diet and paying attention to the timing of snacks and drinks may also assist in prevention of oral health problems. Collaborative partnerships with a dietitian can support clients who have particular nutritional needs.

Supporting a Person to be comfortable at dental checkups can include
• finding the right dentist/oral health service for each Person (there may be more than one public oral health service to choose from; you may be able to access free dental services from university dental clinics; the Person may choose private dental care)
• helping the Person to understand and get prepared for a dental visit (e.g. a social story)
• arranging for a familiar person to accompany the Person
• being aware of some strategies dentists may use to put a Person at ease (you might be able to request these if they aren’t offered routinely)
• supporting good communication while at the dentist
• stepped processes for desensitising a Person who is uncomfortable when at the dentist
• making sure the dentist has information about medications the Person is using, and any health issues that may be relevant (check with the dentist or the Person’s doctor if you are not sure what these might be).

RESOURCES  Oral Health

Oral health information for people with an intellectual disability (2008) from Dental Health Services Victoria has lots of helpful information to support these activities, and provides support for professionals and carers to support behaviours of concern.


Queensland Health, Queensland Government, Oral Health website
http://www.aechc.org/resources_dental.html
http://www.scopevic.org.au/index.php/site/resources#Health_well_being
Nutrition and health

Good nutrition supports all body functions and long term health. Having inadequate nutrition, being over or being underweight increases the risk of health complications.

The five food groups that provide all the nutrition the body needs are:

- breads, cereals, pasta, rice and noodles (at least five serves per day)
- vegetables and legumes (at least five serves each day)
- fruit (at least two serves each day)
- milk, yoghurt and cheese (two serves each day)
- meat, fish, poultry, eggs, nuts and legumes (at least one serve each day).

Source: Dietary Guidelines for all Australians (includes resources and brochure) [http://www.nhmrc.gov.au/publications/n29-n30-n31-n32-n33-n34]

It is important to include food from all of these groups each day for a balanced diet. Other foods such as cakes, pastries, oils and crisps should be included in small amounts.

In most situations, having food with a variety of colours, tastes, smells and textures is a key to healthy eating. Menu planning is a way of ensuring that this happens for a group of people living together.

Speech Language Pathologists, Occupational Therapists, Health Liaison Officers and Medical Practitioners can assist with general information about nutrition.

A Dietitian should be consulted if the Person:

- has swallowing difficulties and is having difficulty maintaining adequate nutrition
- is significantly underweight or significantly overweight
- is experiencing dehydration (signs include, decreased volume of urine, dark urine, constipation)
- is diagnosed with a condition such as diabetes or PKU
- is identified as having food allergies or intolerances.

Food preferences and requirements vary. For example, someone from a particular cultural background may prefer foods typically prepared by that cultural group. Someone who leads a physically active lifestyle will need more food than someone who does not.

As people grow older, their digestion of food may become less efficient and they may have fewer teeth. Therefore, attention should be given to maintaining good nutrition.
Reflux

Gastro-oesophageal reflux (GOR) is sometimes called heartburn or regurgitation. Reflux occurs when stomach contents are brought back up into the oesophagus (food pipe) and throat. The muscle band (sphincter) in the lower part of the oesophagus relaxes, and partly digested stomach contents (including stomach acid) to move back up to the throat.

People with disabilities who have difficulty communicating may have difficulty explaining experiences of significant discomfort from reflux. Signs of reflux include:

- recurrent vomiting
- pain when swallowing
- having pain behind the chest bone
- refusing to eat
- breath smelling of stomach contents
- being distressed during or after meals,
- self-injury
- night time coughing,
- damaged teeth (from the acid content of the reflux)
- disturbed sleep
- low iron levels
- weight loss.

Reflux can lead to a range of other medical conditions (including cancer of the oesophagus). Therefore if a Person has signs of reflux, she/he should be assisted to consult a doctor. Scans (e.g. endoscopy) and medication may be necessary to identify and address reflux.

Practical approaches to reducing reflux include

- remaining upright after meals
- having smaller more regular meals
- avoiding particular foods and drinks that can make reflux worse.

![Diagram of the digestive system showing the mouth, throat, oesophagus, stomach, and intestines.](Image of diagram)
Attachment 1 How do we swallow?

We prepare the food on our plate and in our mouth in readiness for swallowing (oral preparatory phase):

- When we hear and smell food being cooked and see food on our plate this lets our body know that we have to get ready to eat and drink (e.g. saliva starts to be produced)
- Our lips remove the food or drink from our fingers, the cutlery or cup/straw, or we bite of pieces of food (e.g., from a sandwich)
- Our lips close to stop the food or drink from falling out
- We chew the food to break it down into smaller pieces to help with digestion and so it can pass easily through our food pipe (to avoid choking)
- We use our tongue to gather the food as we chew and mix it with saliva.

We move the food to the back of the mouth (oral phase):

- When we have chewed the food enough we use our tongue to move the ball of food towards the back of our mouth to get ready to swallow.

The food moves through our throat (pharyngeal phase):

- We stop breathing to keep us safe and stop food going down our airways and into our lungs.
- The soft palate at the back of mouth rises to stop food going up into our nose.
- Our voice box moves up and forwards so the epiglottis (a flap of cartilage that acts like a valve) blocks off our airway to stop food and drink going into our lungs.
- The band of muscle at the top of our food pipe opens which allows the ball of food to pass into our food pipe and then closes once the food has passed.

The food moves through the food pipe (oesophageal phase):

- Now that our airway is safe because the food has passed the opening of the airway, we start breathing again.
- Food moves down our food pipe towards our stomach.
- A band of muscle at the top of our stomach opens to let the food go into our stomach and then closes again so it stays there (stops reflux).

People can have difficulty with any stage of the swallowing process. Some people may have difficulties with more than one stage.

People may experience these difficulties from birth and others may develop difficulties later in life (e.g. after a stroke). For all of us, our swallowing abilities change as we get older.

Permission for use of Illustrations – Diane Chen.
Modified Barium Swallow (MBS) (also known as a videofluroscopic swallowing study)

A Modified Barium Swallow (MBS) is an x-ray that is taken when people are eating and drinking. The information is captured as a moving x-ray that allows the Speech Language Pathologist to gather information about what is happening with internal structures in the mouth and throat and to see if food or drink is entering the lungs (aspiration). The procedure is conducted at a hospital in the radiology (x-ray) department or in some private radiology clinics.

Speech Language Pathologists may request a MBS in order to help them determine what are safe consistencies of food or drink for a Person or to help them identify if food and/or drink is entering the airway/lungs. If the Speech Language Pathologist is considering a MBS they will also discuss this with the following people as appropriate: the Person; family members/Statutory Health Attorney; support team; the Person’s doctor or specialist; the speech pathologist involved in the MBS if it occurs at a hospital.

Generally a referral is required from a doctor or medical specialist for the MBS to occur.

Prior to the Modified Barium Swallow (MBS):

It is important to follow any specific instructions or recommendations that are given to you when the appointment for a Modified Barium Swallow is arranged.

You can help prepare the Person for what to expect and ensure a successful appointment by providing them with information containing photographs of a MBS. It may also be useful to see if it is possible to visit the radiology clinic a day/week before the appointment (see Eating and Drinking Safely resource for people with disabilities).

During the Modified Barium Swallow (MBS)

The MBS involves eating and drinking different foods and drinks containing contrast material (barium) under x-ray equipment. The food and drink will look and taste slightly different because of the barium. The barium enables us to “see” the food and drink moving through the throat.

Where possible, a familiar support person and the Speech Language Pathologist who has organised the MBS will be present to provide support. There will also be unfamiliar people present including a Speech Language Pathologist who is trained in conducting an MBS, along with a Radiologist (a doctor trained to read x-rays) and a Radiographer (a person trained to operate the x-ray machine).

The Radiologist and the Speech Language Pathologist view the video during the MBS to assess the Person’s ability to swallow and will provide information and recommendations before you leave.

After the Modified Barium Swallow (MBS)

A formal report will generally be written by the Speech Language Pathologist who led the MBS and sent to the Speech Language Pathologist in the community and the Person’s doctor. Further follow up and discussions will occur based on the recommendations in this report.

Following an MBS or a Barium Swallow (see below), the Person’s stools/faeces may have a white appearance. This is normal and is the barium passing out of the body.

Barium Swallow

A Barium Swallow is different from an MBS and is conducted when more information is needed about how food moves down the Person’s food pipe (oesophagus) and into their stomach. The movement of the drink through the food pipe into the Person’s stomach is recorded on video like a ‘moving x-ray’.

A referral from a doctor or medical specialist would be required and the Barium Swallow is conducted in the radiology department in a hospital or radiology clinic.

If the Person has a known swallowing difficulty and a medical professional is considering a Barium Swallow, it is important to let them know about the Person’s mealtime support plan due to the large quantity of barium that the Person will need to drink.
Attachment 3 Alternatives or supplements for eating and drinking

Some people may find it difficult to safely consume an adequate amount of food and fluids to meet their nutrition and hydration requirements. This may occur due to significant swallowing difficulties or other complex health reasons. For these reasons alternatives to oral intake or consideration of how oral intake could be supplemented may be considered.

“Tube feeding” options which may be alternatives to oral intake or ways to supplement a Person’s eating and drinking including:

- Nasogastric Tube (NG)
  - A tube is passed through a Person’s nose and into their stomach.
  - This is usually suitable as a short term option
- Percutaneous Endoscopic Gastrostomy (PEG)
  - A surgical procedure is undertaken to create a hole (stoma) through the abdominal wall and directly into the stomach.
  - A tube is then inserted through the hole which allows fluids and some medications to be introduced directly into the stomach.
  - Specially designed supplements allow the Person to receive the nutrition that they require
- Jejunostomy
  - This is similar to a PEG but the hole (stoma) goes into the Person’s small intestine.

When people receive one of these alternatives it does not mean that they will not be able to continue to have some oral intake.

Decisions to introduce “tube feeding” will occur after collaboration between: the Person; the Person’s family and/or statutory health attorney; Support workers and carers; Speech Language Pathologist; Medical professionals; Health Liaison officer; Dietitian and Social Worker.

During the consultation information will be gathered and considered in relation to issues which may include:

- degree of swallowing difficulty
- ability to maintain daily requirements for food and fluids
- ability to take medications orally
- the Person’s overall health needs
- the Person’s quality of life.

These discussions will help to generate an outcome that will have the best outcome for that Person given their situation.

Support after the insertion of a tube

If someone has one of these alternatives introduced, support from a range of health professionals will continue to be provided. These will include recommendations about how to provide the Person with nutrition through the tube and how to avoid infections (e.g. using gloves).

For those alternatives that create a hole (stoma) all recommendations for providing nutrition and avoiding infections specified by the GP or nursing staff must be followed.

Ongoing support from a dietitian will also be important to ensure that the Person continues to receive enough supplement to meet their nutrition and hydration needs. For those people who are continuing some oral intake, it may be important to record information to help monitor how much they are eating.

See section on “Assisting a Person to eat and drink” (page 25) for further relevant information.
Attachment 4  Example Mealtime Support Plan template

…………………….’s Mealtime Support Plan

This template provides recommended content in a recommended sequence. Formatting details can be added.
“'I' wording in mealtime support plans increases the adherence to the specified mealtime support strategies by support workers (Professor Justine Joan Sheppard, personal communication, May 2012)

…………………… has a Mealtime Support Plan because [insert reasons - e.g. ……………………… has swallowing difficulties and often eats too quickly]

Therefore ………………. is at risk of ……………………… [e.g. choking and pneumonia] .

For these reasons you must always follow all strategies in this mealtime support plan. Practices not outlined in the plan are not permitted.

I require foods that are [e.g. minced and moist (Texture B)]

Pieces of food must be no larger than [e.g. 0.5 x 0.5] cm

[Insert Australian Standards description for this food texture from this Resource]

[Insert photo of plate of food at this food texture]

See attached tables for details of foods that I can safely eat [attach Australian Standards Table for this food texture from this Resource – attach Special Notes table as well. Be aware if the Person has any food allergies and include this information in this section.]

Example meals that I enjoy and that are safe for me to eat are [insert]

I require drinks that are [e.g. mildly thick - (Level 150)]

[Insert Australian Standards description for this fluid level from this Resource]

[Insert photo of this fluid level on a fork]

[Insert drink preparation recipe and storage instructions]

I need you to support me to eat and drink safely and to enjoy meals, in the following ways:
[e.g. preparation, environment, sensory, positioning – perhaps a photo of the Person sitting in appropriate position, cutlery/plate/cup/mat, verbal or touch prompts, slowing pace of eating, teaching independence, oral health, social/communication, giving choices, relevant cultural considerations, eating out, considerations involving other household members]

Include relevant links to other support plans such as for fluid/food monitoring, dietitian’s advice/menu, communication, mobility, oral health, or positive behaviour support food access.

Signs that I am having difficulties during the meal that could lead to me being unsafe include:
[e.g. looking tired, coughing]

[use list from information sheet to describe signs relevant to this Person]

What to do if you observe any of these signs
[e.g. immediate response followed by, recording, and contacting Team Manager and Speech Language Pathologist]

Recording
Make sure you record any signs of swallowing difficulties or other mealtime issues for ……………………… in the Report Book.
[Specific recording sheets will be used in some situations –usually for short term monitoring]

If you have any questions or concerns about ………………………….’s Mealtime Support Plan contact ………………………… on [insert phone number for team and email contact]

Plan writer/s …………………………

Signature/s …………………………

Date ………………………… Review date for this mealtime …………………………

Mealtimes Support Resources
Department of Communities, Child Safety and Disability Services  2013
In what situations would mealtime recording be appropriate?

- in situations where mealtime support strategies are being introduced or changed, to find out if the strategies are effective
- to obtain specific details about mealtime difficulties (e.g., if a Person is refusing food, then recording time of day, how much food, types of food and who is providing support, may help to identify the issue/s)
- to gather information for a Dietitian or other specialist about what a Person is eating and drinking (e.g., food diary, fluid intake recording).

What needs to be considered when developing a mealtime recording sheet?

- only use recording sheets when the information must be obtained and cannot be obtained in any other way
- be clear about the purpose (why is the information being collected?)
- don’t try to record everything – prioritise the information you need
- a combination of ticking boxes and brief descriptions or comments often give the most useful information and are most practical for recording
- recording should be time limited (1-2 weeks)
- people doing the recording should receive information/training about how to record
- examples of a completed form with the type of information you would like recorded are useful
- give feedback to the team based on the recordings they have made – how the information is being used
- avoid the recording sheet being used as a staff monitoring tool by others
- be clear about the difference between recording sheets and screening or assessment tools
- if recording of fluid intake and urination (in relation to dehydration) is required, Occupational Therapists often have experience in gathering this type of information for continence purposes (e.g., foods with high fluid content, signs of dehydration and how to identify urine output).

What would a useful mealtime recording sheet look like?

- it would be individualised for each Person’s situation
- the recording sheet would clearly state:
  - what information is being collected
  - why the information is being collected
  - how it will be useful for understand the Person’s situation
  - that the recording sheet is not a staff monitoring tool
  - how to record the information that is required
- the recording sheet should be consistent with the Person’s mealtime support plan (but should not replace the plan, for example it should not describe support strategies in detail).
Example Mealtime Support Recording Sheet – Coughing

To be completed for each meal or snack

[Person’s name] has a mealtime support plan due to [provide the reason briefly e.g. because she/he has swallowing difficulties]

[Person’s name]’s MEALTIME SUPPORT PLAN MUST BE FOLLOWED FOR ALL MEALS AND SNACKS (See mealtime support plan for details)

Column A – tick this column if the person did not experience any coughing then go to column E and place initials

Column B – tick this column if the person coughed any time during and/or up to 15 minutes following meal or snack

Column C – briefly describe meal/snack e.g. meat and vegetables prepared according to the mealtime support plan, thickened fruit juice.

Column D – note if there is something you have observed that may indicate the reason for the coughing

Column E – please place your initials as the Speech Language Pathologist may need to explore more detail with you.

<table>
<thead>
<tr>
<th>Date</th>
<th>Meal/snack</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Please tick if the person had no difficulties</td>
<td>Tick if coughing occurred</td>
<td>Indicate type of food and or fluid that caused choking including type of preparation</td>
<td>Any comments such as health of the person, person ate something not appropriately prepared for them, the person very tired etc or any other difficulties noted.</td>
<td>Staff initials</td>
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<tr>
<td></td>
<td>Breakfast</td>
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<td>Morning Tea</td>
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<td>Afternoon Tea</td>
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<td>Dinner</td>
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<td></td>
<td>Snacks (please indicate time of snack)</td>
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