MANAGING DYSPHAGIA IN THE SCHOOLS

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Disclosure Statement

- Emily Homer, Coordinator of Speech Therapy Programs, St. Tammany Parish Schools
- Financial- I am a paid employee of St. Tammany Parish School Board. I am not a paid employee of ASHA
- Non-financial- I am an ASHA member. As an ASHA member I support ASHA’s policy agenda which includes most advocacy initiatives supported by the organization. Additionally, I support financial and non-financial initiatives for school based speech language pathologists and ASHA members.
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Kim Priola, Assistant Coordinator of Speech Therapy Program, St. Tammany Parish Schools

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Background information

- Dysphagia team for 15 years
  - Children eat safely at school reducing the risk of choking and aspiration
  - Children receive adequate nutrition because they are fed correctly
Prevents or delays tube feeding because children don’t get sick

Teachers are knowledgeable and are less fearful of a child choking at school or of them harming a child by feeding them incorrectly
According to IDEA all children are entitled to FAPE. In order for a child to have FAPE he/she MUST be healthy, well nourished and hydrated so that they can:

- Attend school
- Benefit fully from academic instruction and the curriculum
- Socialize with peers
- Efficiently complete their meals in times similar to their peers
System supported procedure

- Important because:
  - School personnel are trained to recognize the signs and symptoms of dysphagia
  - School personnel know what to do and who to contact when they have a concern about feeding
System supported procedure

- With the procedure comes documentation of efforts that ensure that the steps in the procedure are followed.
- Recent court cases support the educational relevance of treating dysphagia and the responsibility of school districts to do so.
- Refer to references for the process we used to get a system supported procedure.
Team members who are assigned to the school make up that team's dysphagia team. SLP, OT, PT, nurse, teacher, etc.

- Need a large number of dysphagia trained SLPs
- Facilitates regular monitoring of students
- Allows for more involved dysphagia therapy
- Team members available to interact frequently with other school staff as well as with parents/guardians
- Most knowledgeable dysphagia professional is on campus for emergencies
A separate team comprised of an SLP, an OT and school nurse who specialized in dysphagia, travels to various school sites to serve the students with dysphagia.

- Works well for small districts or districts with few dysphagia trained SLPs.
- Core team members have a larger dysphagia caseload and as a result develop more experience and knowledge.
- Few core team members means that ongoing training and staff development are easier.
Dysphagia Team Models: Combination Team

District has some schools with dysphagia trained SLPs & some schools without dysphagia trained SLPs

- Most teams are school-based, which allows the person most knowledgeable to be on campus
- For schools where this is not possible, a system core team serves the students with dysphagia working closely with school personnel
- SLPs with coursework and training in dysphagia are able to use their skills
Other Scenarios

- Contract services with a private consultant when the district has no dysphagia trained SLPs on staff.
- Referral source: An SLP in a school system receives no support on a building or district level but continues to work with parents to obtain an outside referral and provides the safest feeding procedures to the staff and documents this process.
School level team: an SLP in a specific school may have knowledge and experience in pediatric dysphagia and works with building administration to develop procedures to work with dysphagia cases. The District at large may not have a formal process/procedure in place but the school base model may lead to the development of district policies etc.
Procedure

- Used successfully for 15 years
- Has been successfully adapted throughout the country in other districts including MISD where they put together a very nice manual.
- Each district tweaks the procedure to adhere to the policies of their state and district.
- Email Kim or myself for copies of our procedure, forms, other info. We will gladly share what we have.
Dysphagia Team Procedure: follow the forms!

- Complete Referral Form
- Contact Parents/Caregivers
- Conduct Interdisciplinary Consultation
- Hold IEP Meeting
- Train classroom staff on the swallowing and feeding plan & emergency plan
- Request Medical Referral (VFSS/MBSS)
- Case manager attends swallow study
- Revise IEP & swallowing and feeding plan following swallow study
Summary of the Procedure: members of the dysphagia team...

- Receive diet orders from physician
- Review diet restrictions with cafeteria manager
- Work with cafeteria manager to ensure the correct diet is served
- Train classroom staff on the revised plan
- Initiate swallowing and feeding plan
- Monitor student for strategies and recommendations on swallowing and feeding plan
- Incorporate oral motor therapy into speech and occupational therapies, classroom and home routines
Forms that go with the procedure

- Follow the forms!
- Email Kim or myself and we will send you the forms.
Breakdown of service delivery for students with dysphagia

- 53% Monitoring/consulting
- 12% NPO monitoring
- 65% All monitoring and consulting

- 31% Direct therapy
- 4% NPO with oral stimulation therapy
- 35% Total direct therapy
Frequency of services

- 3 times per week
- 2 times per week
- 1 time per week
- 2 times per month
- 1 time per month
- 1 time per quarter
- As needed
Frequency of services

- 7% three times per week
- 20% two times per week
- 30% one time per week
- 10% two times per month
- 21% one time per month
- 2% one time per quarter
- 10% as needed
Typical levels of management

- Student is **monitored** on the implementation of the feeding and swallowing plan.
- Student receives **direct intervention** for oral motor skills as well as implementation of swallowing and feeding plan.
- Team works with parents, school and physician on **transition to or from feeding tube**.
- Student is **medically unstable**, work with parents and physician to ensure safe feeding.
- Student has **sensory and/or behavior feeding issues**.
Monitoring to establish safety by:

- Educating staff and parents
- Observing the staff providing intervention using the feeding and swallowing plan and Individualized Health Plan upon completion of training
- Modifying any interventions or equipment
- Documenting current feeding status and progress of the student
- Documenting and researching any complications in the feeding progress
Observing the student feeding in several settings at school (example: cafeteria, snack time in the room)

Developing a new feeding and swallowing plan as needed

Serving as a resource to the staff and parents about feeding issues

Serving as the interventionist as needed
Examples of scheduling dysphagia intervention:

- Case Manager works with the student during lunch 1 day/week. Give feedback to mom weekly. Classroom staff report problems as they occur.
- Consults weekly with teacher and observes monthly.
Examples of dysphagia intervention (cont.)

- Off campus Case Manager monitors 1 and 2x/week for first several weeks. Leaves cell number with teacher and paras. After initial set up, observation of feeding 1x/month or as needed.
- Case Manager observes preschool students during snack time 3x/week and intervenes with the students who need it. Also does 1 on 1 oral motor therapy.
- OT and SLP alternate time observing students at lunchtime to feed or monitor students.
Direct dysphagia therapy treatment plan

- Oral massage
- Jaw work
- Vibration and oral exercises
- Feeding
Oral massage

- Used for defensiveness
- To increase oral awareness
- For tonic bite
- Hyperactive gag
- Muscle tone
- Decrease tooth grinding
- Recommended 3 times per day before speech practice and eating
Oral Massage

- Use a toothette or nuk
- Place toothette inside of mouth between lips and gums
- Roll toothette around entire gum length on top and bottom gum
Jaw work

- Done with a variety of oral motor tools
  - Chewy tubes
  - Bite blocks
- Purpose of jaw work: encourage and practice biting to prepare child for new food textures
Chewy Tubes

- Come in various sizes
- Use chewy tubes with taste as prefeeding activity
- Used to increase jaw strength
- More jaw strength = jaw stability
- Jaw stability = isolated tongue movements for speech and feeding
Chewy tubes in action
Vibration and oral stimulation

- Use vibration each day to desensitize and “wake up” muscles of the oral mechanism
- Vibration can be accomplished using mouth massagers and vibrators
- Can also use vibrating toothbrush
- Can use vibration on tongue, cheeks, inside and outside of mouth
Vibration exercises

- Lip Closure
- Cheek strength
- Lip Strength and Seal
- Lip Awareness
- Tongue Lateralization
- Jaw stability
Oral Exercises

- To get the mouth ready for eating
- Helps with grading and strength of oral movements
- **IMPORTANT**: Just doing oral exercises will not automatically improve eating
- Exercises need to be a part of a therapy protocol
Oral motor exercises

- Work on intrinsic muscles of the oral mechanism
- No need for student to be cognitively capable of responding
- Used by many therapists prior to feeding
- Used in conjunction with jaw work and vibration
- Use Beckman approach—when trained
Oral Motor Exercises

- Lip stretches
- Cheek stretches
- Tongue exercises for:
  - Elevation
  - Lateralization
  - Strength
Oral motor exercises
Feeding activities

- Establish a stable and upright sitting posture for feeding that encourages midline with the feet supported on a firm surface at all times.

- Begin with attention to the oral sensory system via oral massage, vibration, oral exercises, etc. prior to feeding.

- Use favorite puree (yogurt, applesauce, pudding) in a tuberculin syringe without the needle.
Just a reminder: We are not using syringe feeding as a nutritive way to get a child who is unable to spoon feed liquids eating. It can be used for that purpose also, but at this time, we are using syringe feeding to teach tongue lateralization and jaw movement necessary to collect the bolus and swallow.
Remember: if the child has not been fed orally prior to this, we must have clearance from a physician and/or a MBSS stating that the child is safe with puree consistency.

Begin with .3cc on one side of the mouth while supporting the jaw of the child.
Syringe feeding (cont.)

- Place tip of the syringe into the lower buccal cavity, between the back gum ridge and the cheek on one side of the mouth.
- Release liquid into the buccal cavity and use your supporting hand to assist with jaw closure and your supporting thumb to assist with lip closure if necessary.
Syringe Feeding (cont.)

- Repeat to other side after the liquid is completely swallowed 10 times on each side
- As skills are mastered as evidenced by an automatic swallow without leakage, increase in .1cc increments
- Repeat technique until 1 cc is successfully swallowed 10x on each side to the back buccal cavity
As the skills are mastered in the back position, continue 1cc criteria to one tooth closer to midline on alternating sides of the mouth until presenting the syringe at midline.
Liquids

- Precursor to straw drinking
  - Use bottle that when squeezed, liquid will move up straw
  - Fill bottle with liquid consistency that child is capable of handling
  - As the child is learning to pull the liquid up through the straw with the lips, the therapist can gently assist by squeezing the bottle
Liquids (cont.)

- Working to achieve saliva control, lip rounding, and tongue retraction—do not allow tongue protrusion with the straw resting on the tongue for support.
Straw drinking
- Once child has mastered the squeeze bottle, move to a short and wide straw
- Moves from shorter, wider straws to long complex straws
- Move from straws to open cup
Solids: Initially present solids with a cheesecloth strainer to progress to small cubes of food on a small fork to be placed on the back lower molar

- Allow to chew entire bolus- if the bolus begins to migrate toward midline, use the stick end of a toothette to reposition it on the molar
- Then begin using solids without cheese cloth
- Use easy dissolvable solids first and progress from there
Dysphagia therapy
Documentation

- Documentation must be collected when using oral motor treatment plan to be sure that the program is being followed.
- Be sure all parties are aware of how often exercises must be completed.
- Have a documentation sheet that is used each time exercises are completed.
- Video child eating prior to start of plan, then again 6 months later.
Feed All Students Safely
In our district

- Self contained classrooms for children with severe disabilities
- Classrooms for students with moderate disabilities
- Students remain in class all day
- Students are fed by teachers and paras throughout the day
- Often have parties or activities in class with food
- Some of these students are not followed by the dysphagia team
FASS: Feed All Students Safely

- A program of prevention and awareness
- Involves a short training using a scripted PowerPoint that the SLP and school nurse present to teachers and paras that work with students of moderate to profound disabilities
Dysphagia case manager and school nurse will visit every self contained classroom on his/her campuses.

- Explain the **FASS** procedure to the teachers.
- Every teacher of the moderately – profoundly impaired students will be in-serviced on the **FASS** procedure at least once during the school year.
- Follow up visits as necessary.
Food Safety for students with severe disabilities

- These children often function like a child of a much younger age
- Precautions for feeding these children are similar to precautions for feeding a toddler, or a child age 5 and younger
Food Safety for Children with Severe Disabilities

- Do not feed these children:
  - Whole grapes - cut these in half
  - Nuts
  - Marshmallows
  - Hard candies, lollipops or gum
  - Peanut butter
  - Hot dogs or meat sticks that have not been cut lengthwise
Food Safety (cont.)

- Do not feed these children:
  - Raw fruits and vegetables (bananas and kiwi are O.K.)
  - Popcorn, chips, nachos or hard taco shells
  - Foods with pits such as olives and cherries
  - Leafy green vegetables
  - Meat that has not been cut into small pieces
  - Stringy foods
  - Chewy foods such as fruit snacks or caramel
Precautions:

- Children should always be supervised when eating.
- Children should have the muscular and developmental ability needed to chew and swallow the foods chosen. Remember, not all children will be at the same developmental level. Children with special health care needs are especially vulnerable to choking risks.
- Children should have a calm, unhurried meal and snack time.
- Children should not eat when walking or playing.
Precautions:

- Cut foods into small pieces, removing seeds and pits. Cook or steam vegetables to soften their texture. Cut hot dogs lengthwise and widthwise.
- Model safe eating habits and chew food thoroughly.
- Offer plenty of liquids to children when eating, but solids and liquids should not be swallowed at the same time. Offer liquids between mouthfuls.
- Think of shape, size, consistency and combinations of these when choosing foods.
Teachers role in FASS
Teachers role in FASS

Working as an Interdisciplinary Team
Nurses role in the FASS procedure

- Nurses work closely with SLP’s regarding food safety issues in the classrooms.
- Nurses will review emergency plans with teachers to be sure food safety is addressed if needed.
In Summary......

- Important facts from today:
  - System supported procedure
  - Follow the forms
  - Monitor the students
  - Feeding therapy
  - Prevention in the form of FASS
Questions????

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References

- Behr, D., (2008) Ages and Stages, LLC.