MEALTIME MANAGEMENT SUPPORT PLAN

Identified need for management	Goals	Interventions
Difficulty swallowing related to: **Associated Risks** ☐ Choking **Medical Conditions** ☐ Muscular Dystrophy ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Dementia ☐ GORD - Gastro oesophageal reflux disease ☐ Cancer (Mouth/Oesophageal) ☐ Other: _____ **Neurological Conditions** ☐ Spinal Cord Injury ☐ Stroke (CVA) / Head Injury ☐ Disability ☐ Other: _____ **Evidenced by:** ☐ Speech Pathologist Assessment ☐ Dietician ☐ Medical Practitioner ☐ Other (Health Practitioners): _____ Texture Modified Foods required: ☐ Yes ☐ No If yes, detail: _____ ☐ Risk Assessment Date: _____	☐ To provide support for the participant to safely enjoy meals and drinks. ☐ To ensure participant is swallowing correctly ☐ To prevent choking, aspiration of food and/or fluids ☐ To maintain healthy body weight ☐ Other (please state): _____ **Mealtime Management Plan in place?** ☐ Yes Start Date: _____ Review Date: _____ ☐ No Who to contact with questions or concerns: _____ ☐ Meals that are safe for participant to eat: _____	☐ Mealtime Management Plan - Fluids Required thickeners IDDSI Level (0-4) e.g. level 2 mildly thick. IDDSI Description of Fluids (Refer to IDDSI Framework): _____ ☐ Modified Diet (meal texture ISSDI Level (3-7) e.g. Soft, puree, minced, IDDSI Description of Food (Refer to IDDSI Framework): _____ ☐ Equipment required for eating and drinking (list): _____ **Assistance Required** ☐ Independent ☐ 1:1 supervision ☐ Prompting and encouraging independence ☐ Fully fed **Environmental Requirements** (e.g., Location, people the client likes to eat with if independent) _____ **Preferred Mealtimes** ☐ Breakfast: ☐ Lunch: ☐ Dinner: ☐ Snacks: ☐ Drinks: ☐ Other: _____ **Food/Fluids**

☐ Dietician Review Date: _____ ☐ Health Care Directive Date: _____ ☐ Weight at Care Commencement: _____ ☐ Other: _____ ☐ Food Preferences (Likes/Dislikes): _____ ☐ Food Allergies (list): _____ ☐ Medications prescribed for food allergies: _____ ☐ Cultural/Religious preferences: _____ ☐ Special dietary requirements: _____		Preparation and Storage Instructions: _____ **Support Required** ☐ Positioning - High Fowlers ☐ Sensory Requirements - Alert and Awake ☐ Communications Requirements – Prompting ☐ Other Requirements: _____ ☐ Feed slowly and patiently if fed, wait for one mouthful to be finished before another ☐ Limit conversation/distractions ☐ Check oral cavity empty on completion of meal ☐ Sit upright for at least 20 minutes after food/fluids consumed ☐ If voice gurgly during or after feeding, encourage an extra swallow or cough and swallow to clear ☐ Attend to oral hygiene plan ☐ Monitor temperature and weight (state frequency) **Participants with Disability** ☐ Ensure correct positioning/seating ☐ Use feeding equipment, including assistive technology such as spoons, plates, plates, cups and straws ☐ Promptly report any swallowing difficulty observed e.g. Coughing, choking, to speech pathologist, medical practitioner ☐ Other participant specific interventions _____ **Observe for** ☐ Unexpected weight loss ☐ Symptoms of dehydration such as dark urine, urinating small amounts, being thirsty ☐ Coughing, choking or frequent throat clearing during or after swallowing ☐ Other participant specific observations

Risk / Response

Signs of mealtime difficulty and escalation requirements:

☐ Aspiration, coughing, choking, gurgling and/or respiratory distress

☐ Signs of poor (chest health, short of breath

Undertake emergency First Aid, refer to Health Practitioner. Call Ambulance and transfer to hospital, if any of the above risks occur to ensure participant safety and well-being.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Mealtime Management Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

Mealtime Management Medical Practitioner Directive

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Mealtime Management Speech Pathologist Directive

		Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Mealtime Management Dietician Directive

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Mealtime Management Health Practitioner Directive
Registered Nurse, Physiotherapist, Occupational Therapist

		Date:	
Diagnosis/Medical History			
Specific Care Orders/Treatment Plan			
Risks and Complications			

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

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