DYSPHAGIA SUPPORT PLAN

Identified need for support	Goals	Interventions
Impaired swallowing related to: **Medical Conditions** ☐ Muscular dystrophy ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Dementia ☐ GORD - Gastro Oesophageal Reflux Disease ☐ Cancer (Mouth/ Oesophageal) ☐ Old age ☐ Swallowing, biting, or chewing difficulties ☐ Other: _____ **Neurological Conditions** ☐ Spinal Cord Injury ☐ Stroke (CVA) / Head Injury ☐ Complex physical disabilities ☐ Cerebral Palsy ☐ Severe epilepsy ☐ Other: _____	☐ To provide support for the client to safely enjoy meals and drinks ☐ To ensure client is swallowing correctly ☐ To prevent aspiration of food and or fluids ☐ To maintain healthy body weight ☐ Other: _____ **Mealtime Management Plan in place?** ☐ Yes Start Date: _____ Review Date: _____ ☐ No Who to contact with questions or concerns: _____ ☐ Meals that are safe for client 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: _____

Evidenced By:

- ☐ Speech Pathologist Assessment
- ☐ Dietician
- ☐ Medical Practitioner
- ☐ Risk assessment
- ☐ Dietician review
- ☐ Health Care Directive

Date: _____

- ☐ Weight at Commencement of Care:

_____

- ☐ Other: _____
- ☐ Food Preferences (Likes/Dislikes):

_____

- ☐ Food Allergies (state):

_____

- ☐ Medications prescribed for food allergies:

_____

- ☐ Cultural/ Religious preferences:

_____

- ☐ Special dietary Requirements:

_____

Food/Fluids

Preparation and Storage Instructions:

_____

Support Required

- ☐ Position – high fowlers, hips at 90° angle, head titled slightly forward
- ☐ Alert and awake
- ☐ 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)

_____

Clients with Severe Disability

- ☐ Ensure correct positioning/seating
- ☐ Use feeding equipment, including recommended 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 specific interventions

_____

Observe for:

- ☐ Unexpected weight loss/weight gain
- ☐ Symptoms of dehydration such as dark urine, urinating small amounts, being thirsty

		☐ Coughing, choking or frequent throat clearing during or after swallowing ☐ Other specific observations _____

Risk / Response

Signs of mealtime difficulty and escalation requirements:

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

☐ Signs of poor chest health – chest infection, 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 client 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 Dysphagia 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

Dysphagia Support 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**	

Dysphagia Support 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**	

Dysphagia Support 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**	

Dysphagia Support Dietician Directive

Health Professional, RN, Physiotherapist, Occupational Therapist 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**	

Dysphagia Support Mealtime Management Requirements (Summary)

Participant's Full Legal Name			
Participant's Preferred Name			
Date of Birth		**Gender**	
Cultural Background and Preferences			
Preferred Language		**Interpreter Required?**	☐ Yes ☐ No

Mealtime Management Requirements (Summary)		
Mealtime Management Plan in Place	☐ Yes ☐ No	
Reason for Mealtime Management Plan	*e.g., swallowing difficulties*	
Associated Risks	*e.g., choking*	
Are Texture-modified Foods and Fluids Required?	☐ Yes ☐ No	
If yes, detail:		

Mealtime Management Supports

MEALTIME MANAGEMENT PLAN	
Allergies	
Medication prescribed for food allergies	
Likes/Dislikes	
Religious / Cultural Requirements	
Special Dietary Requirements	

Mealtime Management Plan in Place?	☐ Yes	**Start Date:** / / **Review Date:** / /	☐ No
Reason for Plan	*e.g., swallowing difficulties*		
Associated Risks	*e.g., choking*		
Are Texture-modified Foods and Fluids Required?	☐ Yes ☐ No		
Foods Required			
IDDSI Level	*e.g., Level 5 Minced & Moist*		
IDDSI Description	*Description and examples of the food from IDDSI resources* *Include a photo of food at the required texture*		
Example Meals that are Safe for the Participant to Eat			
Preparation and Storage Instructions			
Fluids Required			
IDDSI Level	*e.g., Level 2 Mildly Thick*		
IDDSI Description	*Description and examples of the fluid from IDDSI resources* *Include a photo of fluid at the required texture*		
Preparation and Storage Instructions			
Support Required			
Eating and Drinking Equipment Required			

Assistance Required	*e.g., none (eats independently), prompting, physical assistance*		
Positioning Requirements			
Sensory Requirements			
Environmental Requirements	*e.g., location, people the participant likes to eat with*		
Communication Requirements			
Supervision Requirements			
Other Requirements	*e.g., dietician/nutritionist advice, menu requirements, mobility considerations, oral health considerations, access to food/drinks restricted (note a current behaviour support plan is required)*		
Signs of mealtime difficulties	*e.g., coughing, difficulty breathing*		
Escalation requirements	*Describe what to do if signs of mealtime difficulties are observed*		
Who to contact with questions or concerns			
Preferred Mealtimes	**Breakfast:**	**Lunch:**	**Dinner:**
	Snacks:	**Drinks:**	**Other:**

Document Control

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