

Oral eating and drinking procedure

This is a mandated procedure under the operational policy framework. Any edits to this procedure must follow the process outlined on the [creating, updating and deleting operational policies](#) page.

Overview

This procedure is a practical direction for all staff working in education and care to plan and manage children and young people who require oral eating and drinking support including oral sensitivities or fixation, pica, swallowing disorders, feeding, food phobia and choking.

This procedure must be read along with the department's [health support planning processes](#).

Scope

This procedure applies to educators, early childhood development specialists, principals, directors and education support staff working in education and care and describes:

- how education and care staff manage the health support needs both proactively and reactively in education and care for children and young people who require oral eating and drinking support, including:
 - oral sensitivities or fixation (chewing, sucking, mouthing)
 - pica (non-food items), swallowing disorders (dysphagia)
 - feeding (oral issues and gastrostomy tubes)
 - food phobias or sensory aversion
 - choking
- signs and symptoms of swallowing and feeding disorders including choking and dysphagia
- the emergency response for any person experiencing a choking incident while at an education or care service
- education and training for managing oral eating and drinking
- risk minimisation strategies where a child or young person has feeding difficulties, dysphagia, oral sensitivities, and food or choking phobias.

This procedure applies from the time a child or young person is enrolled until they leave the education or care service.

Treatment and management for oral eating and drinking

Managing oral eating and drinking difficulties and disorders in education and care services makes sure children and young people are:

- safe while eating, including strategies to minimise the risks of choking and aspiration
- adequately nourished and hydrated to enable attendance and full accessibility of the curriculum
- healthy (free from aspiration, pneumonia and other illnesses related to malnutrition or dehydration) to maximise attendance.

Most children and young people in education and care services manage their own eating and drinking. However, some may require supervision, coaching, guidance and support for their safety and wellbeing.

Where a child or young person has a risk of choking or aspiration, requires their food or fluid consistency to be modified or they need to be fed, an [oral eating and drinking care plan \(DOC 142KB\)](#) is needed to make sure they are supported and safe during mealtimes. Children and young people generally do not require an oral eating and drinking care plan for food phobias, eating disorders or oral sensitivities.

Where there is not a care plan in place and the education and care staff are concerned about a child or young person's oral eating and drinking, this must be communicated to parents or guardians (an [oral eating and drinking observation log \(DOC 145KB\)](#) can be used to document and communicate).

[Choking first aid \(PDF 195KB\)](#) must be instigated if a child or young person is choking.

Where a child or young person has invasive or complex healthcare needs, uncertain health or changing health they may be eligible for and supported by either the:

- [Access Assistant Program \(AAP\)](#)
- [RN Delegation of Care Program.](#)

Choking

Alert! Choking is a medical emergency. Call 000 (ambulance) immediately.

When a child or young person is choking it means that an object (food or non-food item) is stuck in the trachea (airway) restricting the air flowing normally in and out of the lungs so they can't breathe properly. Most of the time the object only partially blocks the trachea and can be coughed up, and breathing returns to normal quickly.

Children under the age of 3 are most at risk for choking on food and small objects. However, children with oral fixation (for example pica), and children with a disability or chronic illness may be at a higher risk of choking.

Choking can be a life-threatening emergency when the object is completely blocking the trachea. When the brain does not receive oxygen for more than 4 minutes permanent brain damage or death can result.

Signs and symptoms of a choking emergency include:

- difficulty breathing, speaking, swallowing
- grabbing at throat or waving arms
- coughing, wheezing, gagging
- making a whistling or crowing sound, or no sound at all
- can't talk, cry or make noise
- turning blue – blue lips, face, earlobes, fingernails
- appears panicked
- becomes limp or unconscious
- pale and sweaty.

First aid for choking emergency

Education and care staff must give first aid measures following any relevant care plan or first aid plan. Where this does not specify an individualised first aid response, standard first aid is to be followed.

- [Choking First Aid for adult or child over 1 year](#)
- [Choking first aid for infant under 1 year](#)

1. Encourage the person to relax and ask them to cough to remove the object.
2. If coughing does not remove the blockage CALL 000 (ambulance).
3. Bend the person well forward and give 5 sharp blows on the back between the shoulder blades with the heel of one hand.
4. Check if the blockage has been removed after each blow.
5. If the blockage has not cleared after step 3, give (up to) 5 chest thrusts.
6. Give chest thrusts by placing 1 hand in the middle of the back for support and the heel of the other on the lower half of the sternum. Thrusts should be slower and sharper than CPR compressions.
7. Check if the blockage has been removed after each thrust.
8. If the blockage has not cleared after 5 thrusts, continue alternating 5 back blows with 5 chest thrusts until medical aid arrives. Check if the blockage has been removed after each action.

Pulmonary aspiration

ALERT! Pulmonary aspiration is a medical emergency and can result in death from asphyxiation within minutes. Phone 000 (ambulance).

Pulmonary aspiration is the entry of materials (for example food, drink, stomach contents) from the gastrointestinal tract into the lower respiratory tract. When pulmonary aspiration occurs during eating or drinking this is often referred to as 'going down the wrong pipe or hole'. Consequences of pulmonary aspiration range from no injury to pneumonia or death from asphyxiation (choking). Consequences are often dependent on the underlying health status of the person.

While there may be observable signs that accompany aspiration events, such as coughing, choking, eye reddening during eating, or a gurgly vocal quality after swallowing, children and young people can also aspirate 'silently', or with no observable symptoms.

Treatment and management are dependent on the medical consequence of pulmonary aspiration. Some treatments may include:

- removal of an object (if able by coughing up, or by bronchoscopy)
- endotracheal suctioning
- medication (if a bacterial infection)
- supportive therapies (fluid management, bronchodilators, physiotherapy)
- referral to speech pathologist.

Where a child or young person is at risk of aspiration this must be documented in an [oral eating and drinking care plan \(DOC 142KB\)](#) and [health support agreement \(DOC 131KB\)](#).

The health support agreement must include signs and symptoms of aspiration and emergency response actions. The [safety and risk management plan \(DOC 143KB\)](#) must include specific risk minimisation strategies for the child or young person in the context of the education and care setting.

Feeding and swallowing difficulties

Speech pathologists specialise in treating children and young people with feeding and swallowing difficulties. The speech pathologist may work as part of a team including occupational therapists, nurses, dietitians and other specialists.

The team will evaluate posture, self-feeding abilities, medical status and nutritional intake and develop an [oral eating and drinking care plan \(DOC 142KB\)](#) that will include recommendations on positioning, equipment, diet and food preparation, feeding plan techniques and precautions.

Treatment for feeding and swallowing difficulties varies depending on the cause, symptoms and the problem, but may include:

- medical intervention (for example reflux medication)
- modified equipment (for example flexi-cup, built up handle spoon)
- nutritional change (different foods, more calories)
- food temperature and texture changes
- postural or positioning changes
- behaviour management or special techniques to help eating drinking and swallowing
- preparation of food and drinks (for example opening or unwrapping, appropriate texture).

Tube feeding

Education and care staff don't need to manage the healthcare of children and young people with invasive or complex healthcare needs.

Children and young people with a nasal or gastric feeding tube will be supported by the [Access Assistant Program](#). A nursing care plan will be developed in consultation with the parent or guardian and nursing staff will give support and help for the child or young person in the education or care service.

The [gastrostomy care instruction \(PDF 335KB\)](#) and [nasogastric care instruction \(PDF 297KB\)](#) have been developed to support staff and give first aid strategies for children and young people with a gastrostomy device or nasogastric tube.

Care plans and support agreements

Adequate nutrition is essential to support children and young people's growth and development and to allow them to participate in and benefit from their educational experiences.

A child or young person may have difficulties with eating and drinking for a variety of reasons and the nature of support will be dependent on the individual needs and requirements. Parents and guardians should be encouraged to consult a health or allied health professional (specifically a speech pathologist) where oral eating and drinking difficulties are identified.

Where a child or young person has a risk of choking or aspiration, requires their food or fluid consistency to be modified or they need to be fed, an [oral eating and drinking care plan \(DOC 142KB\)](#) is needed to make sure the child or young person is supported and safe during mealtimes. Children and young people generally do not require a care plan for food phobias, eating disorders or oral sensitivities.

The matrix below can be used as a guide for the requirement for a care and support plans. It is a guide only. It does not include every scenario for health care plan or support agreement requirements.

| Feeding and swallowing difficulties, food or choking phobias, eating disorder | O&ED Care Plan | Non-specific Health Care Plan | Health Support Agreement | Medication Agreement |
|--|---------------------------|--------------------------------------|---------------------------------|-----------------------------|
| Food or fluid selectivity by type, texture, brand, shape or colour | Not applicable | Not applicable | Yes | Not applicable |
| Food or fluid consistency is modified | Yes | Not applicable | Yes | Not applicable |
| Food or fluids are fed to the child or young person | Yes | Not applicable | Yes | Not applicable |
| Behaviour management (where related only to food intake) | Not applicable | Not applicable | Yes | Not applicable |
| Behaviour management (with an underlying medical/health condition) | Not applicable | Yes | Yes | Not applicable |
| Modified equipment | Not applicable | Not applicable | Yes | Yes |

| Tube feeding | O&ED Care Plan | Non-specific Health Care Plan | Health Support Agreement | Medication Agreement |
|---|---------------------------|--------------------------------------|---------------------------------|-----------------------------|
| Exclusively tube fed | Not applicable | Yes | Not applicable | Not applicable |
| Tube fed, with oral intake of food and/or drink | Yes | Yes | Yes | Not applicable |

| Aspiration: Choking | O&ED Care Plan | Non-specific Health Care Plan | Health Support Agreement | Medication Agreement |
|---|---------------------------|--------------------------------------|---------------------------------|-----------------------------|
| Where there is a known risk | Yes | Not applicable | Yes | Not applicable |
| Where there is a known risk with an underlying medical/health condition | Yes | Yes | Yes | Not applicable |

| Oral sensitivities | O&ED Care Plan | Non-specific Health Care Plan | Health Support Agreement | Medication Agreement |
|---|---------------------------|--------------------------------------|---------------------------------|-----------------------------|
| Where oral sensitivities are diagnosed and sensory activities required at education or care service | Not applicable | Not applicable | Yes | Not applicable |
| Pica where treatment involves medication or supplements only | Not applicable | Not applicable | Yes | Yes |
| Pica where medical or allied health have prescribed treatment or activities | Not applicable | Not applicable | Yes | Not applicable |
| Pica where there is an underlying medical/health condition | Not applicable | Yes | Yes | Not applicable |
| Pica where parent or legal guardian has notified of behaviour therapy and activities | Not applicable | Not applicable | Yes | Not applicable |

Oral eating and drinking care plan

An [oral eating and drinking care plan \(DOC 142KB\)](#) is completed and regularly reviewed by the speech pathologist or treating health professional, in consultation with the parent and/or guardian, where the child or young person requires feeding or modification to their food or drink.

The oral eating and drinking care plan should outline (where relevant) the:

- level of support needed (degree of supervision or help)
- type of support needed:
 - equipment
 - environment
 - positioning
 - mealtime processes and after mealtime care
 - more time needed for mealtimes.
- preparation and presentation of food and drink (the [International Dysphagia Diet Standardisation Initiative \(IDDSI\) Framework](#) gives descriptors for levels of food and fluid):
 - food texture or consistency
 - fluid thickness (refer to the [IDDSI flow test](#) for measuring liquid thickness)
 - rate and order of intake
 - strategies for spoon and finger food, and drinking
- communication strategies and needs (including education and care staff, parent and guardian, child or young person, medical or allied health professional)
- emergency response plan and emergency contacts
- risk-minimisation plan to make sure risks are assessed and minimised
- learning targets
 - increasing independence
 - behaviour management
 - increasing intake
- any requests for documentation and/or observations by education and care staff
- more information and recommended training for education and care staff to support the child or young person.

The speech pathologist or health professional completing the [oral eating and drinking care plan \(DOC 142KB\)](#) can give training, more information, clarification or demonstration as needed. Education and care staff will be accommodated to attend the hospital for education and training where health professionals can't attend the education or care service.

Non-specific health care plan

In some circumstances a [non-specific health care plan \(DOC 127KB\)](#) may be developed by the treating health professional in consultation with the parents and guardians where a child or young person has oral eating and drinking difficulties.

Where a child or young person has invasive or complex health care needs, uncertain health or changing health they may be eligible for and supported by the [Access Assistant Program](#).

Individual first aid plan

In some circumstances an [individual first aid plan \(DOC 123KB\)](#) may be developed by the treating health professional in consultation with the parent or guardian where a child or young person requires a first aid response that is not the standard first aid response for their health condition.

Health support agreement

Where a parent or guardian has identified a child or young person requires eating and/or drinking support, education and care staff should encourage them to consult with a speech pathologist and/or health professional for an appropriate diagnosis and treatment plan. Until a formal diagnosis and care plan is in place a [health support agreement \(DOC 131KB\)](#) must be developed.

In all circumstances where a child or young person has an [oral eating and drinking care plan \(DOC 142KB\)](#) the education or care service must complete a health support agreement in consultation with the parent or guardian. This should include completing a [safety and risk management plan \(DOC 143KB\)](#) to identify risk minimisation strategies, management and treatment of the child or young person in the context of the education or care service.

The health support agreement should clearly identify cultural, spiritual and language needs and where a child or young person's oral eating and drinking difficulties are unstable.

Where the health support agreement is being completed for an Aboriginal child or young person this should be developed in consultation with the primary caregiver, who is not always the parent. Extended family members and Aboriginal community education officers or Aboriginal health workers may also help in the development of the health support agreement to make sure they are culturally appropriate and meaningful.

The development of health support agreements must be completed with an assurance that the content is understood and culturally valid. Children and families from culturally and linguistically diverse backgrounds may require support persons and access to interpreter services and community liaison officers.

A health support agreement and safety and risk management plan should be reviewed in consultation with the parent and/or guardian in each of the following circumstances:

- when the oral eating and drinking care plan has been reviewed and updated
- as soon as practicable after a medical incident at the education or care service
- before the child or young person participates in an offsite activity (for example camps or excursions) or at onsite special events (for example class parties, cultural days, fetes, incursions). Where the safety and risk management plan has not addressed risk minimisation strategies for offsite activities an [offsite safety and risk management plan \(DOC 142KB\)](#) may be developed.

Oral eating and drinking observation log

An [oral eating and drinking observation log \(DOC 145KB\)](#) is recommended to be completed where education and care staff notice a change in the child or young person's eating and drinking abilities or behaviours during or after mealtimes. For example:

- a change in the child or young person's ability to chew or swallow or manage food and drink
- tires, is increasingly fatigued or loses consciousness during or after meals
- frequent and repeated coughing, spluttering, gagging, gurgling, near choking, or distress during or after meals
- rapid weight loss.

The oral eating and drinking observation log can be used as a communication tool between the education or care service, the parent or guardian and speech pathologist or health professional to:

- communicate with parents and guardians (where changes in mealtime or eating and drinking abilities are noted, this may include both positive and negative changes)
- initiate a review of the [oral eating and drinking care plan \(DOC 142KB\)](#)
- give information and/or evidence for the review of the oral eating and drinking care plan (may be used to document eating and drinking all observations over a specific timeframe, for example 1 day, 5 days).

Eating and drinking management

Supply of food and equipment

It is the responsibility of the parent or guardian to give appropriate food and drink for the child or young person during attendance at the education or care service. Some education and care services may give food and drink to the child or young person.

If the food or drink provided does not meet the requirements of the [health care plan](#) or [health support agreement \(DOC 131KB\)](#) the following strategies can be implemented:

- contact the parent or guardian to request food or drink is brought in
- contact the parent or guardian to negotiate accessing food or drink from canteen or other appropriate source
- ask the parent or guardian to give appropriate food or drink that can be stored at the education or care service for use in emergencies.

Where the [oral eating and drinking care plan \(DOC 142KB\)](#) identifies specialised food, thickeners or equipment for oral eating and drinking management it is the parent's and guardian's responsibility to give this to the education or care service.

Where equipment is needed for the child or young person there must be arrangements in place for the equipment to be cleaned and maintained. The arrangement must be clearly documented in the [health support agreement \(DOC 131KB\)](#). This could be the responsibility of either the:

- education or care service – with a staff member nominated to be responsible for cleaning the equipment
- parent or guardian – the equipment is sent home with the child or young person and returned to the education or care service
- where this option is selected, contingency arrangements should be identified if the equipment is not returned to the education or care service.

Mealtime routines

Predictable or regular mealtime routines can help children and young people with oral eating and drinking difficulties to become comfortable and familiar with what is expected of them and what to expect from education and care staff helping them.

The [oral eating and drinking care plan \(DOC 142KB\)](#) will give guidance around mealtime routines that should be followed for the child or young person. Specific requirements and instructions for education and care staff to follow for each child or young person will be documented in the [health support agreement \(DOC 131KB\)](#).

General processes can be implemented to make sure successful mealtimes for children and young people with eating and drinking difficulties, combined with the specific requirements documented in the care plan and support agreement.

Before the meal

- communicate to the child or young person what is going to happen
 - use language they will understand and/or visual cues to help them prepare for eating and drinking
- encourage the child or young person to be involved in meal preparation where possible
- be aware of the total environment in which meals occur
 - comfortable, calm, enjoyable, distraction-free environments
 - loose clothing and hair may drape over the child or young person or food –tie back where possible.

During the meal

- allow the child or young person to pace their meal as much as possible (children and young people with swallowing difficulties require more time to chew, swallow and fully clear their mouth before their next mouthful)
- encourage further swallows for the child or young person to clear their mouth before presenting the next bite or sip
- if the health care or support plan includes the introduction of new foods, do this when the child or young person is calm, alert and hungry
- keep foods at serving temperature (especially for slow eaters)
- keep mealtimes enjoyable.

After the meal

- finish the meal with a signal to clearly indicate mealtime is over
- particularly for children and young people who have difficulty understanding or those with visual, hearing or sensory impairments.

Food and drink preparation

When preparing food or drink for children and young people with oral eating and drinking difficulties, education and care staff must make sure any specific requirements documented in the [oral eating and drinking care plan \(DOC 1442KB\)](#) or [health support agreement \(DOC 131KB\)](#) are strictly adhered to.

The [IDDSI Framework](#) gives descriptors of food and fluid on a continuum of 8 levels (0 to 8) and the [IDDSI flow test](#) instructs how to test for the correct liquid consistency.

Safe food handling principles and standard infection prevention precautions must be adhered to (including not preparing food or drink if you are ill (diarrhoea or vomiting), wash and dry hands thoroughly, make sure clothes and equipment are clean).

Refer to the [Eat well SA schools and preschools healthy eating guidelines \(PDF 2.2MB\)](#) for more information.

Positioning

Good positioning is essential for safe eating, drinking and swallowing. The child or young person's [oral eating and drinking care plan \(DC 142KB\)](#) will describe the specific requirements on positioning, or a [transfer and positioning care plan \(DOC 180KB\)](#) may be needed.

Work with the health professional where transfer and positioning needs are identified to make sure care plan directions are met.

A stable, upright and well-aligned position allows more energy and effort to be spent on the process of eating, drinking and swallowing. Awkward or inappropriate positioning can lead to food or fluid being inhaled (aspiration) and choking.

Some children and young people with eating and drinking difficulties may have physical impairments that interfere with their ability to maintain a stable position. For example muscle tone or weakness, difficulty controlling and coordinating movements.

[Guidelines for optimal positioning at mealtimes \(PDF 177KB\)](#) at mealtimes for children and young people with eating and drinking difficulties include:

- upright, with shoulders over hips, level shoulders and slightly forward
- bottom and hips well back into the chair to give a stable base for the trunk (for example use of pelvic strap)
- knees at around 90 degrees and comfortably apart (for example a pommel or padded wedge or block may be needed to help separate the knees)
- feet comfortably apart and resting on the floor or a support where possible (for example a footstool or footplates on a wheelchair or highchair)
- head centred over the shoulders with an elongated neck, in a relaxed, upright and slightly chin-tuck position (remember head back will open the airway and swallowing is extremely difficult and unsafe)
- shoulder straps, chest harness give added support where advised

- head and neck positioning can be helped by a well-positioned head rest or even the use of a rolled towel, small cushion or even a neck brace (where advised)
- generally arms forward on the table or tray
- where possible the child or young person should be encouraged to move slightly forward towards the food, spoon, or drink as this is part of the normal active process for eating or drinking
- often a small wedge cushion or angled seat base can help for children and young people who have better trunk control and more active movement
- for children and young people who can't do this, make sure positioning is good and head on neck alignment is suitable for swallowing (elongated neck and slight chin tuck).

The position of the support person helping the child or young person during mealtimes is also important. They should be seated at head level with the person they are helping and their chair directly in front, or facing them across the table. This aids with communication and social interaction and allows the support person to effectively monitor the feeding and respond quickly if the child or young person is experiencing difficulty.

Adequate time must be taken to make sure the child or young person is positioned correctly for mealtimes, and recommended positioning equipment is used correctly.

Equipment

Adapted mealtime equipment may be prescribed for a child or young person with eating and drinking difficulties by the speech pathologist or health professional. The child or young person's [oral eating and drinking care plan \(DOC 142KB\)](#) will describe the specific equipment requirements.

Types of adapted mealtime equipment are endless and could include:

- drinking equipment:
 - spout cups – help deliver liquid to the middle of the tongue
 - cut-out cups – designed for cut out space for the nose when cup is tipped helping keep the head and neck in a safe position when drinking
 - regulating cups – allow only a small amount of liquid per sip
 - spill resistant cups – help prevent spillage
 - weighted cups – to help with minimising hand tremors
 - straws with non-returnable valves – liquid stays in the straw rather than returning to cup or bottle where the child or young person has difficulty with sucking
 - hands free drinking systems – can be placed on a table or mounted to personal equipment (wheelchair).
- cutlery:

- plastic-coated spoons – reduce damage to teeth and gums and generally have shallower bowl than a regular spoon
- maroon spoons – recommended where there is difficulty using lips to get the food from a regular spoon
- cutlery with large grip – built-up handle, angled neck – increases independence to feed self
- plates, bowls, trays:
 - plates and bowls with built up edges – increases independence to scoop out food
 - plate guards – prevent spillage and allow scooping of food
 - insulated plates and bowls – retains heat to keep the food warm over a longer period of time
- clothes protectors to help with spillage and excessive loss of saliva.

Medication administration

Administration of medication in the education and care setting must be done following the [medication management procedure](#) procedure. Where medication is prescribed for a child or young person as a management strategy for their eating and drinking difficulty a [medication agreement \(DOC 177KB\)](#) must be completed by the treating health professional. An [oral eating and drinking care plan \(DOC 142KB\)](#) cannot be used as a medication agreement.

Mental health and oral eating and drinking

Difficulty swallowing is a common symptom of anxiety, or having oral eating and drinking difficulties may contribute to increased anxiety for children and young people, as well as their parent or guardians.

In some cases anxiety may become debilitating, preventing the child or young person from engaging in daily activities at home, at school or socially.

Some symptoms of stress and anxiety may be mistaken for eating and drinking difficulties in children and young people. Education is important to make sure staff can identify anxiety symptoms from those of eating and drinking disorders, ensuring appropriate treatment (refer to training and education for more information).

High levels of anxiety are often seen in parents and guardians of children and young people with oral eating and drinking disorders. Regular and ongoing communication with parents and guardians is important to reassure them of the strategies in place to manage the child or young person with an emphasis on the ability of the education or care service to provide a safe environment.

Training and education

All education and care settings must have at least 1 designated first aider who is trained in [HLTAID004 Emergency First Aid Response in an Education and Care Setting](#) in attendance at all times who is immediately available to administer first aid.

The speech pathologist or health professional responsible for developing the [oral eating and drinking care plan \(DOC 142KB\)](#) may offer advice on implementation of the plan and may give training and education on techniques and equipment.

Education and care staff providing support and help to children and young people with eating and drinking difficulties are encouraged to undertake the [Novita Children's Services Oral Eating and Drinking Support \(OEDS\) workshop](#). The workshop includes practical, relevant information about safe practices and worksite risk management for children and young people needing help and support with oral eating and drinking. Training and education can be arranged by contacting Central Intake Novita, email training@novita.org.au or phone 1300 668 482. This training is funded by education and care services.

The [Ellyn Satter Institute](#) has resources and links for education and care services that may help education and care staff that care for a child or young person requiring oral eating and drinking support.

[Feeding Matters](#) have a range of webinars and virtual workshops that can be viewed on demand and used as learning opportunities to support and manage children and young people requiring help with oral eating and drinking.

Communication and risk minimisation

Communication

Communication strategies for education and care services where a child or young person requiring support and help with eating and drinking should include:

- staff awareness and understanding of management strategies and emergency response for individuals
- regular communication with parents and guardians to give assurance that appropriate management, risk minimisation and emergency response strategies are in place
- education or care service complete an [oral eating and drinking observation log \(DOC 145KB\)](#) to communicate changes in mealtime behaviours and/or eating and drinking abilities
- parents and guardians to communicate any changes to the child or young person's care to make sure education and care staff are up-to-date
- where age appropriate, communication to peers to identify early signs of a medical emergency and risk minimisation strategies.

Risk minimisation strategies

In consultation with the parent or guardian individual risk minimisation strategies should be documented in the [safety and risk management plan \(DOC 143KB\)](#) where a child or young person has feeding difficulties, dysphagia, oral sensitivities, food or choking phobias.

Risk minimisation and prevention strategies should be considered for all in-school and out-of-school settings.

General prevention strategies for education and care services to minimise the risk of:

- a choking incident may include:
 - avoiding food that pose a choking risk to small airways (under 3's most vulnerable), for example popcorn, hotdogs, grapes
 - encouraging children and young people to sit down for meals and snacks and not talk with food in mouths
 - beware of toys and items that may be a choking hazard, for example deflated balloons, beads, small toy parts, batteries, coins, bottle caps, pebbles or stones in gardens
 - making sure safe, age-appropriate toys are available by following manufacturers age recommendations
 - making sure all education and care staff are trained in first aid, including choking first aid and understand the emergency response process for a choking emergency
 - review of [hazard alerts](#) and implementation of any actions
- an adverse event for a child or young person who has feeding difficulties, dysphagia, oral sensitivities, food or choking phobias may include:
 - (all of the above listed under choking)
 - making sure appropriate supervision of children and young people at risk
 - identification and documentation of specific habits or behaviours in the health care or support plan
 - recommendations made by the speech pathologist or health professional about mealtime management requirements are clearly documented, available, and strictly adhered to, including food preparation, positioning, environment, equipment.

Oral eating and drinking background

Syndromes and disorders

Certain syndromes and disorders may affect eating behaviour, including (but not limited to):

- [Prader-Willi Syndrome](#) – a complex genetic disorder with a symptom including a chronic feeling of hunger, leading to excessive eating and obesity
- Down's Syndrome – may have a small oral cavity and delayed development of teeth, resulting in difficulties chewing
- people with cerebral palsy, epilepsy or degenerative disorders may have difficulties eating and swallowing
- [hyperphagia or polyphagia](#) – eating excessively without feeling full can be characteristics of other syndromes – can result in food grabbing, eating inedible objects, obesity and behavioural problems
- autism – children and young people with autism commonly show eating difficulties such as food refusal, selective eating, over-eating and behavioural problems at mealtimes.

Eating disorders

An [eating disorder](#) is a serious mental illness with significant complications. The mortality rate for people with eating disorders is the highest of all psychiatric illnesses with the peak period of onset during adolescence.

The [Diagnostic and Statistical Manual of Mental Disorders \(DSM-5\)](#) recognised 4 eating disorders:

- other specified feeding and eating disorders (OSFED)
- bulimia nervosa
- binge eating disorder
- anorexia nervosa.

For information about eating disorders refer to [National Eating Disorders Collaboration \(NEDC\)](#).

Feeding

[Undernourishment](#) can lead to poor brain and linear growth and may affect the child or young person's mental health. Feeding disorders are not limited to children and young people with disabilities, however between 80% and 90% of children with disabilities have some level of eating or drinking difficulty. As the level of disability increases so does the severity of the oral feeding difficulty.

Refer to these resources for more information:

- [poor nutrition can put children at higher risk of mental illness](#)
- [paediatric feeding disorders and severe developmental disabilities.](#)

A feeding disorder is a child or young person's refusal or inability to eat certain food groups, textures, solids or liquids for a period of time (generally at least 1 month) causing weight loss, inability to grow naturally, and/or developmental delays. A feeding disorder can be caused by structural or functional abnormalities that affect physiology, or behavioural as a result of psychosocial or emotional difficulties. Most children and young people have multiple components to their feeding disorder.

Feeding disorders in children and young people may include (but are not limited to):

- extreme food selectivity (beyond pickiness) by type (excludes more than 1 food group), texture (only eats smooth or crunchy foods), or by brand, shape or colour
- gags when food is brought near the mouth
- has trouble paying attention long enough to eat a meal
- taking more than 30 minutes to eat a meal.

Medical interventions, such as nasogastric or gastrostomy tubes, are used when children and young people can't take adequate nutrition by mouth (also referred to as enteral nutrition or feeding, tube feeding, PEG feeding, gavage).

Some of the most common conditions that need enteral nutrition include (but are not limited to):

- congenital (present from birth) abnormalities of the mouth (cleft lip or palate), oesophagus, stomach, intestines, or heart
- sucking and swallowing disorders, which are often related to prematurity, brain injury, developmental delay, or certain neuromuscular conditions such as cerebral palsy
- failure to thrive, which is a general diagnosis that refers to a child's inability to gain weight and grow appropriately. Poor growth can be the result of an underlying medical condition such as cystic fibrosis, certain heart defects, cancer, intestinal problems, severe food allergies, or metabolic disorders, among other things
- extreme difficulty taking medicines
- inability to burp to reduce reflux (stomach contents and acid moving backward from the stomach into the oesophagus).

Swallowing (dysphagia)

A swallowing disorder is called [dysphagia](#) and includes any problem with sucking, swallowing, drinking, chewing, eating, controlling saliva, taking medication or protecting the lungs from food and drink 'going down the wrong way'.

There are 3 phases of swallowing:

- oral (preparation and transit)
- pharyngeal
- oesophageal.

Dysphagia can occur in 1 or more of those phases.

Oral

May include:

- problems closing lips to keep food in mouth
- trouble chewing or moving food and liquid from the mouth to the throat
- can't control food or liquid so it goes into the throat too quickly
- food stuck in cheek (pocketing)
- having residue left in mouth after swallowing.

Pharyngeal

May include:

- having a hard time starting a swallow
- getting food or liquid into the airway (pulmonary aspiration)
- having food or liquid stay in the throat after swallowing (residue).

Oesophageal

May include:

- food getting stuck as it moves from the throat to the oesophagus
- poor movement of the oesophagus so food doesn't pass easily into the stomach
- food coming back up (reflux)
- pockets in the oesophagus that catch food.

Causes

Causes of dysphagia can range from developmental, structural, and complex medical through to sensory, behavioural and emotional. Symptoms and effects of dysphagia include eating slowly, difficulty swallowing, gagging and choking through to vomiting, food coming out of the nose and pulmonary aspiration.

Signs and symptoms

Signs and symptoms of swallowing and feeding disorders vary based on the medical condition and age of the child or young person, but may include:

- back arching
- gagging
- breathing difficulties when feeding (may be signalled by increased respiratory rate)
- skin colour change (turning blue)
- coughing and/or choking during or after swallowing
- dehydration
- difficulty chewing foods or spitting out partially chewed foods
- difficulty initiating swallowing
- difficulty managing secretions (drooling)
- disengagement cues, such as facial grimacing, finger splaying, or head turning away from food source
- congestion, particularly after meals (including noisy or wet vocal quality)
- frequent respiratory illnesses
- loss of food or liquid from the mouth when eating
- refusing foods of certain textures or types
- taking only small volumes, over-packing the mouth, and/or pocketing foods
- vomiting
- weight loss or lack of appropriate weight gain.

Oral sensitivities (chewing, sucking, mouthing, pica)

The oral system is responsible for sending signals to our brain, organising information and receiving input. All children and young people need this awareness and input for development. Oral fixation can occur when a child or young person is either over responsive (hypersensitive) or under responsive (hyposensitive) to receiving information from the oral system. This is also sometimes referred to by the term 'oral sensory seeker'.

Signs and symptoms of a child or young person with oral defensiveness can include:

| HYPERsensitivity | HYPOsensitivity |
|---|---|
| <ul style="list-style-type: none"> • don't like brushing their teeth, eating or washing their face | <ul style="list-style-type: none"> • pica - licking, biting and chewing on non-food objects |
| <ul style="list-style-type: none"> • difficulty sucking, chewing or swallowing | <ul style="list-style-type: none"> • biting (including themselves, or other children) |
| <ul style="list-style-type: none"> • may have frequent choking incidents | <ul style="list-style-type: none"> • little awareness of what is going on in mouth |
| <ul style="list-style-type: none"> • don't like eating food with certain temperatures or textures (food aversions), or strong flavours | <ul style="list-style-type: none"> • messy eater (often leaves food in or around the mouth after eating) |
| <ul style="list-style-type: none"> • gagging when eating | <ul style="list-style-type: none"> • can overfill their mouth resulting in choking |
| <ul style="list-style-type: none"> • require liquid for food to go down | <ul style="list-style-type: none"> • drooling |
| <ul style="list-style-type: none"> • may use teeth to remove food from fork or spoon | <ul style="list-style-type: none"> • prefers strong flavours |
| <ul style="list-style-type: none"> • may have other tactile sensitivities throughout the body | <ul style="list-style-type: none"> • difficulty distinguishing between different tasting foods |

Chewing on or eating non-food substances is a condition called pica. It can sometimes be associated with a nutritional deficiency but are most common in children and young people with autism, intellectual disabilities, where they have suffered neglect or abuse, or epilepsy. It is estimated that 25% to 33% of young children have pica. [Read more about pica on the Encyclopaedia of Mental Disorders.](#)

Chewing and sucking can form an important part of a child or young person's self-regulation of anxiety and attention levels. Chewing gives proprioceptive (body awareness) feedback to satisfy the sensory input that children and young people may seek orally. It indirectly gives calming and attention regulation through the trigeminal nerve pathways (transmitting sensations from the face to the brain).

Before beginning a treatment plan for oral sensitivities or pica it's recommended the parent or guardian consult a health professional (doctor and/or dentist) to rule out any medical issues that may be the underlying cause.

Oral sensitives

A speech pathologist and/or other health professionals can complete a sensory evaluation to determine individual needs for a child or young person that may have oral sensitivities.

A [non-specific health care plan \(DOC 127KB\)](#) may be developed that includes recommendations, interventions, techniques and precautions. This may include oral sensory activities (chewing gum, drinking through a straw), textured foods (crunchy snacks that require a lot of chewing) or equipment (fidgets or non-food items to chew on).

Some oral sensory activities can be included in classroom activities, for example blowing bubbles or whistles.

Pica

Given the risk of medical complications associated with pica (for example poisoning, nutritional deficiencies, constipation, infections, tearing of the oesophagus or intestine) close medical monitoring is needed.

Seek medical attention immediately if a harmful substance has been consumed. Phone 13 11 26 to speak with the Poisons Information Centre. For life-threatening or urgent medical attention, phone 000 (ambulance).

Pica can occur as a result of a nutritional deficiency, disability or mental and emotional disorders. The diagnosis and treatment for each individual will be different. Appropriate interventions and precautions should be included in a [non-specific health care plan \(DOC 127KB\)](#) and/or [health support agreement \(DOC 131KB\)](#) and may include treatment for complications acquired from eating non-food items.

Treatment techniques may include:

- prescription of vitamin or mineral supplements
- behaviour therapy
- discrimination training between edible and inedible items
- self-protection devices that prohibit placement of objects in the mouth
- oral sensory activities
- environmental risk assessments or scans.

Food aversion or choking phobias

Food aversion or choking phobia is known as cibophobia. [Read more about cibophobia on the Fear of website.](#)

Cibophobia and the fear of eating in public or eating disorders (such as anorexia) are not the same. The fear of eating in public is a social anxiety disorder. People with eating disorders fear the effects of food on the body image, whereas people with cibophobia have a fear of the food itself, or of swallowing the food. This often stems from a negative or traumatic episode (choking, vomiting, allergic reaction) after eating or drinking. In some cases cibophobia may be associated with or result in anorexia, bulimia or other eating disorders.

Cibophobia might be about a particular food, brand or whole group of food such as meat, fruit or vegetables.

Treatment for food or choking phobias and/or eating disorders generally involves cognitive-behavioural therapy in combination with other treatments, for example hypnotherapy. These therapies aim to change the attitude and beliefs relating to the phobia. Other treatment options include relaxation training and/or desensitisation.

A [non-specific health care plan \(DOC 127KB\)](#) should be developed and any recommendations, interventions, techniques and precautions for the child or young person should be documented in the [health support agreement \(DOC 131KB\)](#) and [safety and risk management plan \(DOC 143KB\)](#).

Some treatment options may include

- pureeing foods
- supervision while eating or prefers to eat alone
- eating smaller amounts over a longer period
- relaxation techniques before eating
- liquid forms of medications (if needed).

Definitions

Access Assistant program (AAP)

Supports children and young people with a disability and/or who have complex health support needs, so they can participate in the preschool or school curriculum.

allied health professional

Trained professionals (other than doctors, nurses and dental professionals) that can manage physical or mental health through diagnosis, treatment or rehabilitation. Allied health professionals include (but are not limited to) counsellors, dietitians, occupational therapists, physiotherapists, psychologists, social workers, speech pathologists.

aspiration

Also: pulmonary aspiration. The entry of material (food, drink, stomach contents) from the throat into the larynx (voice box) and lower respiratory tract (the portions of the respiratory system from the trachea (windpipe) to the lungs).

cibophobia

Also: food phobia, swallowing phobia. The fear and avoidance of food, chewing or swallowing fluids usually as the result of a negative or traumatic episode such as choking or vomiting after eating or drinking.

dysphagia

Difficulty or discomfort in swallowing solids or liquids.

education and care service

Includes children's centres, preschools, schools, family day care, home based childcare, respite care programs.

oral sensitivities

Also: oral sensory processing, mouthing, chewing. Oral sensitivity is defined as an atypical response to oral stimulation. Atypical responses include hyporeactive responses, hyperreactive responses, or sensory defensiveness.

pica

The persistent craving and compulsive eating of non-food substances. Classified as a feeding and eating disorder of childhood.

tube feeding

Also: nasogastric tube, gastrostomy tube, enteral nutrition, enteral feeding, PEG feeding, gavage. A medical device used to give nutrition to patients who cannot get nutrition by mouth, can't swallow safely, or need nutritional supplementation.

Supporting information

[HSP120 Health support agreement](#)

[HSP121 Safety and risk management plan](#)

[HSP124 Individual first aid plan](#)

[HSP125 Guide to planning health support](#)

[HSP210 Oral eating and drinking care plan](#)

[HSP211 Oral eating and drinking observation log](#)

[HSP220 Transfer and positioning care plan](#)

[Choking first aid for adult or child over 1 year](#)

[Choking first aid for infant under 1 year](#)

[Planning and documentation for oral eating and drinking \(flowchart\)](#)

Related legislation

[Code of Practice First Aid in the Workplace 2012](#)

[Work Health and Safety Act 2012](#)

[State Records Act 1997](#)

[Disability Discrimination Act 1992](#)

[Disability Standards for Education 2005](#)

[National Disability Insurance Scheme Act 2013](#)

[Education and Early Childhood Services \(Registration and Standards\) Act 2011](#)

[Education and Care Services National Law 2010](#)

[Education and Care Services National Regulations](#)

and within those regulations in particular: [Regulation 12\(b\)\(i\)](#); [Regulation 77](#); [Regulation 78](#); [Regulation 79](#) ; [Regulation 90](#); [Regulation 91](#); [Regulation 95](#); [Regulation 96](#) ; [Regulation 136](#); [Regulation 153\(1\)\(j\)](#); [Regulation 162\(c\), \(d\) and \(e\)](#); [Regulation 168\(2\)](#) ; [Regulation 177\(1\)\(c\)](#); and [Regulation 183\(2\)\(a\), \(b\) and \(c\)](#)

Related policies

[Duty of care policy](#)

[First aid and infection control standard](#)

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