



## Chapter

# DEVELOPING A DISTRICT PROCESS TO ADDRESS FEEDING

As educational programs work to develop a process for assessing children with feeding difficulties and designing programs to meet their unique needs, the following questions come under consideration:

- How will referrals be made to the feeding team?
- What resources are available within the school district and where will inter-agency coordination be necessary?
- Who will determine whether further medical information is needed?
- Who is qualified to interpret medical reports?
- Who will be responsible for developing feeding protocols?
- How will feeding procedures and diet plans be included in the IEP/IFSP?
- Who will implement staff training of mealtime plans?
- How will follow up and reevaluation of feeding protocols be assured?
- What steps should the district take when it's determined that a child cannot be fed safely at school?

These are just some of the complex issues which must be considered in determining an appropriate program for any given student. Each local education agency must make decisions about how to handle these questions.

The role of the feeding team is to evaluate students who have eating problems and to develop mealtime plans in collaboration with the child's IEP/IFSP team. Feeding teams also work with special education administrators to develop a district process which considers the district's legal mandates and liability issues.

As with any evaluation for a child on an IEP/IFSP, a feeding evaluation must be conducted in accordance with IDEA. It is critical that the administrator be a part of the decision-making process when issues of student safety are involved. Communication between the feeding team and program directors is essential to insure that the district does not commit to a course of action without administrative approval. For these reasons, it is important for school programs to develop processes and procedures for referral, evaluation, plan development, implementation and continued support and monitoring by the feeding specialist/team.

This chapter outlines the steps involved in referral and evaluation of children who are at risk for feeding problems. The summary of the main components of the process, on the following page is followed by a narrative explanation of each component.

## DEVELOPING A DISTRICT PROCESS TO ADDRESS FEEDING

Sample forms are included throughout the text to flag points within the process where a form may be needed. Titles are noted in bold. Blank copies of those forms have been provided in the section entitled, **Sample Forms**.

Examples of completed feeding protocols are included in the section called **Sample Feeding Protocols**. Again, these protocols are meant only to serve as examples of what an individually designed protocol might look like for a given child.

The **Planning Checklist** at the end of the manual is intended as a tool for use in developing a district referral process. It may also be used as an instrument in evaluating existing procedures to insure inclusion of critical components.

## **Summary Components of a Process for Referral and Evaluation by the Feeding Team**

1. Feeding Team Members are assigned and a regular meeting time established. Agency staff are informed about the team, criteria for referral, and the procedures for requesting a feeding evaluation.
2. Permission to Evaluate and Release of Information forms are sent to the child's parent for signature permitting the referral for evaluation and for releasing information to be obtained from medical or other sources.
3. Referral received by Feeding Team: Initial information is shared at the regularly scheduled meeting of the Feeding Team, the referral is documented and a case manager is assigned.
4. When permission is received, the Feeding Team case manager sets up a time for observation and file review.
5. Observation takes place and anecdotal data is recorded.
6. Form for documenting feeding concerns is given to teacher and parent.
7. Further observation by additional Feeding Team members takes place, if needed.
8. Further evaluation by medical or other outside resource is recommended, if needed.
9. An alternative plan is developed if the parent or physician refuses to have additional medical evaluation performed, or if the results of the evaluation prohibit the child from being fed orally at school.
10. Recommendations are made to the school-based educational team and a feeding plan is developed and included in the student's IEP/IFSP.
11. Staff is trained and follow-up reviews planned on a schedule decided by the Feeding Team.

- 1. Feeding Team members are assigned and a regular meeting time established. Agency staff are informed about the team, criteria for referral and the procedures for requesting a feeding evaluation.**

The Feeding Team is comprised of individuals who are knowledgeable about safe feeding for children with special health concerns. The team may include the speech-language pathologist, occupational and physical therapists, a nurse, a Registered Dietician, a special education teacher, and others knowledgeable about feeding and swallowing disorders. While there may be some overlap in knowledge among the team members, each discipline brings unique training and expertise to the task of the feeding evaluation. The following page shows a listing of the special expertise that each discipline brings to the team.

Feeding Teams may choose to meet on a regular basis (i.e. monthly) or only when a referral for evaluation is made. When the school district does not employ all the essential members of a Feeding Team, it may be necessary to contract with another local agency to provide the expertise needed. Education Service Districts, regional programs, community health programs or local hospitals are potential resources for interagency cooperation.

The team works with administrators to develop procedures for making agency staff aware of the team, its criteria for referral, and procedures for requesting an evaluation by the team.

## **Contributions of Various Disciplines to Feeding Team Expertise**

**Registered Nurse** • Liaison with the medical community, interpretation of medical records, need for additional medical evaluation, impact of medications and medical conditions on the child's eating and safety. Ability to legally delegate, train and monitor associated nursing tasks.

**Registered Dietician** • Provides consultation on growth gain parameters, adequacy of nutrient intake and recommended medical nutrition therapy plan; may work with the school kitchen staff to provide special foods or special consistencies.

**Occupational Therapist** • Knowledge of fine motor skills needed for self-feeding, sensory-motor aspects of eating, adaptations and modifications to feeding equipment.

**Parent or Caregiver** • Background information on current home practices at meal-time, medical and birth history, other information about the child. For the EI child, the parent takes a more active role on the feeding team as the primary feeder.

**Physical Therapist** • Expertise in positioning and its impact on feeding.

**Special Education Administrator** • Knowledge of district responsibilities under the Individuals with Disabilities Education Act (IDEA), ability to allocate funds for outside referrals or special equipment, and to coordinate services from other agencies as needed.

**Special Education Teacher** • Understanding of the child's cognition, learning needs, and level of ability to actively participate in the feeding activity; knowledge of the child's daily routine.

**Speech-Language Pathologist** • Knowledge of oral-motor function and therapeutic approaches to training new feeding skills. Expertise in developing a communication systems/process for the child during feeding, as well as throughout the child's day.

**Child's Teacher** • Knowledge of student's behavior, school schedule, culture and routines, designation of classroom resources.

**Other Specialists as Appropriate** • Consulting Teacher, Behavior Specialist, etc.

2. **Permission to Evaluate and Release of Information forms and parent questionnaires are sent to the child's parent for signature permitting the referral for evaluation and for information to be obtained from medical or other sources.**

Parental notification and signed consent, as mandated by special education law, should be completed prior to any referral for evaluation. This process is the same as the process used to gain permission for an intellectual evaluation. The educational team uses the district's **Prior Notice About Evaluation** form. A sample of the form recommended by the Oregon Department of Education's Office of Special Education is included under **Sample Forms**.

Because feeding is an issue which is very important to families, the educational team may want to send a cover letter describing the reasons why a feeding evaluation is desired and why permission is needed. If for any reason, the parent has not been a part of the team process up to this point, the teacher or other school contact person, should telephone the parent in advance to discuss the referral. This allows the parent to ask questions, and may prevent undue concern on the part of the parent about the process. A sample of a letter to a parent regarding a feeding evaluation is included on the following page.

Should the team require medical records or a conversation with the child's doctor, a district form requesting permission to release and exchange information, such as the **Permission to Release Information** form is sent to the parent for a signature. Some medical facilities, such as the Shriners Hospital for Children, require the use of their own form for this purpose. A copy of the Shriners' form is also included in the **Sample Forms** section.

## Sample Parent Letter

Date \_\_\_\_\_

Dear Parent:

This is a follow-up letter to our conversation regarding our concerns about \_\_\_\_\_'s eating. In that conversation, I recommended a feeding evaluation by the Feeding Team. The purpose of the evaluation is to develop a feeding plan to ensure that your child eats as safely as possible at school.

The feeding evaluation would be comprised of three parts: a review of records, interviews with you and school staff who help your child at lunch time and observations of your child eating at school. You may be asked to sign a Release of Information form, permitting the team to contact your child's doctor for medical reports. The team may make trial modifications to seating, adaptive equipment, or the environment as a part of the assessment.

As part of the educational team, you will be included in planning the evaluation and in developing the final feeding plan for your child, based upon the results of the evaluation.

As we discussed, the feeding evaluation was recommended for your child because \_\_\_\_\_ (summary of feeding concerns).

When this evaluation is completed, we will have additional information about her eating difficulties, and what to do to improve her safety when she eats at school.

I am enclosing a "Prior Notice about Evaluation" form for you to sign and return to me. Your signature allows us to refer your child to the Feeding Team and to share information with them. I am also enclosing a copy of the "Parent Rights Under IDEA" pamphlet, which explains that you may refuse an evaluation at any time if you so desire. Please call me at \_\_\_\_\_ if I can answer any additional questions about the evaluation.

Sincerely,

Enclosures: Prior Notice About Evaluation  
Parent Rights Under IDEA

**3. Referral received by Feeding Team: Initial information is shared at the regularly scheduled meeting of the Feeding Team, the referral is documented and a case manager is assigned.**

Referrals may originate with the student's parent, teacher, therapist, or another adult when there is reason to suspect that a child has a feeding or swallowing disorder. Children may also be referred to the Feeding Team when they are considered to be at risk for feeding-related problems due to a changed health condition or other circumstance. This could be a result of a diagnosis of a seizure disorder, a change in medication affecting the child's level of alertness, a change in seating such as a new wheelchair, or observation of a change in the child's behavior. A newly enrolled student whose IEP/IFSP includes a feeding protocol would also be referred to the team for evaluation to ensure that the plan is still appropriate and can be implemented at the new school. Information needed at referral would include the child's age, educational placement, diagnosis of disability, medical history and current status (including allergies and current medications) and of course, the reason for referral. Referral questions may cover such topics such as how best to position a child for feeding, what modifications of feeding utensils might help a child to meet a self-feeding goal, and what to do if a child has a seizure while eating in the lunchroom. It is useful to document this information using a standardized form developed by the team, such as the **Feeding Referral Form**. A sample of a referral form, which has been completed for an individual child, is presented on the following page.

Based upon the referral information, members of the Feeding Team decide who will act as primary case manager for the purpose of the feeding evaluation and any follow-up activities. The case manager oversees the evaluation process, communicates with the parents or teacher, and sees the process through to its completion. For example, if the primary concern is related to positioning, the physical therapist may be assigned to be the case manager. If the reason for referral is a need for medical information, the nurse may take the lead role in the evaluation.

## FEEDING REFERRAL

Date: 10/13/99 Student: Jessica Johnson DOB: 11-12-88

Regionally Eligible? Yes  No  School Booneville Elem. Grade 5 Teacher Wiley

Address 123 Applegate Valley Rd., Booneville, OR

Parent Name(s) Janet & Paul Johnson Parent Telephone 123-4567

Primary Physician/Pediatrician Jill Freitas, M.D. Phone 123-8901

Referring Person Wayne Wiley, DLC Teacher

Reason for Referral/Specific Problems Eats very slowly. Lunch takes 1 hour.

Seizures and fatigue interfere with feeding.

Wayne Wiley  
Referring Staff Member Signature

Marcia Beal  
Principal Signature

**Medical History**

Primary Diagnosis CP (Spastic Quadriplegia)

Secondary Diagnosis Seizure Disorder

Cognitive Function Not able to test

Alertness/Attention Drowsy, frequent seizures

Language Comprehension Minimal expressive communication

Visually Impaired No, but does not use Hearing Impaired No

Parent Impression of Swallowing/Feeding Difficulties Concerned that Jessica isn't getting  
adequate calories, worried about nutrition & health status

Respiratory Status Frequent congestion & coughing

History of Aspiration/Pneumonia Hospitalized for pneumonia 2/92, 1/96

Reflux or Regurgitation Rarely noted

Tube Feeding  Oral feeding  Combination  Was the child ever an oral or g-tube feeder? No

Allergies None known

**Medications**

Name and Dosage Depakote 125 mg. sprinkle on first bite of food, 3x daily

**Nutritional and Dietary Status**

Calorie Intake Nurse is assessing

Fluid Intake Average 3 oz. with meal

**Summary of Past Feeding Difficulties** Mother reports difficulty with feeding as an  
infant, bottle-fed until age 4. Remedial feeding program w/ OT consult 30.min. 2x monthly

**4. When permission is received, the Feeding Team case manager sets up a time for observation and file review.**

The team case manager contacts the child's parent or school to identify a time and place to observe the child eating in his/her typical environment. A review of the child's file also takes place as a part of the collection of background information. Medical history and previous recommendations for treatment, are noted along with IFSP/IEP feeding goals and any other pertinent information.

A thorough **Nursing Assessment**, one in the **Sample Forms** section, should be conducted when gathering medical information. A form such as this is recommended for documentation of the **Nursing Assessment**.

**5. Observation takes place and anecdotal data is recorded.**

As team members observe the child, they record their observations using a form designed to look more closely at the child's feeding, such as the attached sample, entitled, **Observation of Feeding in School**. This observation notes factors such as the environment where feeding takes place, the actions of the person feeding the child, cues or prompts used, characteristics of the food being given, and the child's behaviors before, during and after feeding.

**OBSERVATION OF FEEDING IN SCHOOL**

Name Jessica Johnson DOB: 11-12-88 Teacher Wayne Wiley

Date of Observation 10-26-99 Evaluator R. Rowe, OTR

Cognition/Attention/Pacing Drowsy, semi-dozing (See Brazelton Scale) Feeder attempted to gain attention via verbal prompt: "Jessica, time to eat" plus touch signal to back of hand.

Positioning Seated in reclined position in wheelchair w/trunk supports, head -rest

Child's Communication Methods Receptive: Verbal prompts, plus touch signals  
Expressive: Facial Expression, coloration, body posture

Precautions Observe for seizure activity, stopped feeding for seizures, resumed feeding shortly afterward.

Utensils Equipment Small, rubberized spoon, cut-out plastic cup

Consistency/Textures Thick puree of school lunch

- Oral Defensiveness Moderate
- Temperature Warm
- Taste Classroom staff state spicy food upsets her stomach

Liquids: Thin Not given Thickened Does best with "Thick-It"

Food Likes and Dislikes Likes ice cream

Allergies No known allergies

Feeding Procedures (Time, Methods, Approach) Feeder gave verbal prompt, delivered bites of food to roof of mouth, scraping spoon off on upper teeth. Waited while J. moved food to back of throat via tongue thrusts. Gave drinks at intervals.

Unusual Feeding Methods Tilted back in chair with chin up to open throat

Oral Care after Feeding Drink given at end of meal, Toothettes used to cleanse food from teeth and gums

Postprandial Distress Food build-up on roof of mouth, J. unable to remove completely

Tolerance to Oral Care: No Problem  Defensive  Explain J. appeared to tolerate well.

Recommendations: Immediate action: Discontinue reclined position, place neck roll behind head for chin tuck. Institute 1/2 hour break post-seizure. Feeder sit below J. to view upper palate. Institute use of Safe Feeding Checklist prior to feeding. Complete full Feeding Team evaluation.

**6. Form for documenting feeding concerns is given to teacher and parent.**

Family members and teaching staff who feed the child are encouraged to record anecdotal information about each day's feeding using a form such as the sample on the following page entitled, ***Daily Feeding Log***. The feeding log establishes data as to the frequency and type of problems experienced by the child during feeding on a daily basis. This data can form a critical part of the team's evaluation.

**7. Further observation by additional Feeding Team members takes place, if needed.**

Upon review of the information collected in the initial referral, review of records, feeding observation and feeding log, the team determines what additional information is needed to identify and prescribe a protected feeding protocol for the child. The team identifies which team members are most appropriate to perform the next step in the evaluation of the child's feeding. For example, if there are concerns about the child's oral-motor function, the speech-language pathologist may be asked to observe. If there are questions about positioning or sensory issues, the physical therapist or occupational therapist may be requested. If concerns revolve around respiration or other health-related issues, (e.g. seizures, choking, vomiting,) the nurse may be asked to see the child. Frequently two or more team members will go together to jointly observe the child. An instrument such as the ***Standard Oral Motor Evaluation*** form or the ***Infant and/or Severely Neurologically Involved Oral Motor Evaluation*** form may be used to guide the observation.

The team members look at all aspects of a child's feeding. They take note of the child's physical characteristics such as muscle tone, head control, respiration patterns during feeding, tactile defensiveness, oral-motor reflexes, and how the child manages his/her saliva. Cognitive aspects, such as alertness, responsiveness, developmental level, communication modes; and environmental factors, such as sensitivity to sounds, distractibility or orientation to peers are all among the variables that are considered in a feeding evaluation. Positioning and seating are evaluated by the physical and occupational therapists, with consideration for the child's comfort, safety and optimal function. Food temperature, texture, and taste are noted to determine whether these affect the child's ability to eat safely. For example, many children with reduced sensation are better able to swallow food that is cold. Varying consistencies of foods and liquids may be tried to identify which ones the child is best able to manage and swallow. Data on the child's weight, height and caloric intake may be taken in order to determine how feeding problems are affecting health and physical development. Again, the classroom staff may be asked to keep a feeding log to document how the child eats on a day-to-day basis, making note of any unusual events.

### DAILY FEEDING LOG

Student Jessica Johnson      DOB 11/12/88      School Booneville Elementary

**FEEDING REMINDERS**

1. Check Daily Feeding/Swallowing Protocol for setup, precautions prior to feeding.
2. Do not feed the child in isolation. Always have backup in case of emergency.
3. Make sure glasses are on and hearing aids are in place.
4. Keep child in upright position for 20 minutes after feeding.
5. **Contraindications for feeding.** Document and do not feed present meal if the child . . .
  - a. is having a seizure,
  - b. coughs, gags, chokes frequently during feeding,
  - c. has increased congestion or drooling,
  - d. is sleepy or is not alert,
  - e. appears ill or has fever, fatigue, or vomiting,
  - f. attempts many swallows without success,
  - g. has difficulty breathing,
  - h. has unusual skin color, i.e., pale, gray, or bluish tinge,

	Specify	% of Meal	% of Liquids		Food Consis-	Liquid Consis-		
10/27/99	<i>lunch</i>	<i>75%</i>	<i>50%</i>	<i>Pizza</i>	<i>puree</i>	<i>fruit nectar</i>	<i>Ate well</i>	<i>DR</i>
10/28	<i>lunch</i>	<i>75%</i>	<i>75%</i>	<i>Corn dogs</i>	<i>puree</i>	<i>nectar</i>	<i>Good eating!</i>	<i>BL</i>
10/29	<i>lunch</i>	<i>50%</i>	<i>50%</i>	<i>Tacos</i>	<i>puree</i>	<i>nectar</i>	<i>Seizure, coughing</i>	<i>CJ</i>
11/30	<i>ABSENT</i>	-----	-----	-----	-----	-----	-----	-----
11/2	<i>lunch</i>	<i>50%</i>	<i>50%</i>	<i>Toasted Cheese</i>	<i>puree</i>	<i>rice milk</i>	<i>Fatigued, coughing</i>	<i>BL</i>
11/3	<i>ABSENT</i>	-----	-----	-----	-----	-----	-----	-----
11/4	<i>lunch</i>	<i>50%</i>	<i>50%</i>	<i>Sloppy Joes</i>	<i>puree</i>	<i>nectar</i>	<i>Coughing</i>	<i>DR</i>
11/5	<i>lunch</i>	<i>75%</i>	<i>30%</i>	<i>Goulash</i>	<i>ground</i>	<i>juice</i>	<i>Difficulty w/jc</i>	<i>BL</i>
11/8	<i>lunch</i>	<i>50%</i>	<i>75%</i>	<i>Sandwich, corn</i>	<i>puree</i>	<i>rice milk</i>	<i>Didn't like</i>	<i>CJ</i>
11/9	<i>lunch</i>	<i>50%</i>	<i>50%</i>	<i>Chili, corn bread</i>	<i>puree</i>	<i>rice milk</i>	<i>Delayed (seizure)</i>	<i>DR</i>
11/10	<i>lunch</i>	<i>100%</i>	<i>Nut</i>	<i>Butter shake</i>	<i>with rice milk</i>		<i>Drank all!</i>	<i>BL</i>

**8. Further evaluation by medical or other outside resource is recommended, if needed.**

When the team determines that they do not have enough information about a child or when there is conflicting information, they may wish to obtain an evaluation from an outside source before establishing a protected feeding plan. For instance, if something about the child is noted during the feeding observation, such as a change in skin tone or increased congestion during feeding, a medical assessment of the child's ability to manage and swallow food would be indicated. Further evaluation may include, but would not be limited to, a medical examination such as a video x-ray of the child's swallow, known as a videofluoroscopy or swallow study. The referral is made via the parents to the child's primary care physician, with signed permission from the parents for the school team to communicate with the doctor about their concerns. Sample letters to the parent and the physician are included in **Sample Forms. Criteria for Recommending Modified Barium Swallow Study** is a checklist which may be enclosed with the letter to the physician in order to clearly convey the concerns of the team when a request is made for the study. The physician then decides whether to write a prescription for the child to have the study performed. Cost of the study may be paid by the family's health care plan or by the school, but the family may not be required to pay for the evaluation. The child travels to the medical facility for the study, which is performed by a radiologist, often in conjunction with a SLP or OT. A doctor later interprets the study and sends a report to the school team as requested.

Several things may happen when a child is referred for a video swallow study:

- a) the parent or doctor agrees, and the study is performed;
- b) the parent or doctor refuses to have the study done;
- c) the study finds the child safe for eating orally and recommendations for safe feeding are made to the team;
- d) the study finds the child is unsafe to eat orally and recommendations are made for an alternative plan.

An interim plan is needed until evaluation by the medical agency is completed. The plan should be developed by the IEP/IFSP team, with the Feeding Team, to provide for the child's nutritional and hydration needs while waiting for medical information. For example, the team may decide to have the child attend school on a modified schedule to enable him/her to eat at home before and after school. This would constitute a change in program requiring a revision of the IEP. Another alternative might be to have the child drink a specially thickened milkshake in place of eating lunch at school. A damp washcloth or "Toothette" may be recommended to moisten a child's mouth when he is prevented from drinking orally for reasons of safety. Alternatively, the team may determine that the best course of action is to provide home instruction for the interim period. This would qualify as a change in placement, requiring notification and IEP revision. An interim plan must be designed to meet the unique needs of the individual child, given what is known up to that point about his/her feeding abilities, nutritional needs and family preference, within the context of the school program. The interim plan will be in place until a decision is made by the Feeding Team that the child is safe to feed orally at school. A sample interim or alternative plan is shown on the following page.

## ALTERNATIVE PLAN

To be attached to the IEP

Student: Jessica Johnson

Date: 11/23/99

Placement: DLC classroom, Booneville Elementary School

### Support/Procedure/ Service:

1. Jessica will attend school between the hours of 10:00 and 2:00
2. Jessica will be fed meals at home, before and after school.
3. While at school, comfort measures will be given as follows:
  - a) Moist washcloths applied to lips and inside of mouth
  - b) Moistened Toothettes used to stimulate inside of cheeks and gums, and to clean mouth.
  - c) Apply ointment to lips
4. Call parents if Jessica shows signs of thirst which persist after routine care.

### Schedule/Frequency:

Moist washcloths, 2x daily during school day

Toothettes one time daily at noon, and as needed to freshen breath

Ointment as needed to moisten lips

### Responsible Staff:

DLC classroom staff

### Monitoring and Documenting Procedures:

1. The Specialized Health Care Procedure Record form (page 32 of the state Feeding Manual) will be used to record activities daily. (Sample form attached.)
2. School nurse will visit classroom weekly to monitor program and provide information and consultation to classroom staff.

Participants in planning meeting:

General Education Teacher: Alix Allen

Special Education Teacher: Wayne Wiley      Parent(s): Janet and Paul Johnson

District Representative: Albert Chown      Other/Title: Kay Smith, DD Case Manager

Other/Title: Constanza Valencia, RN      Other/Title: Ray Rowe, OTR

Other/Title: Nguyen Roberts, PT      Other/Title: Susan George, SLP

**9. An alternative plan is developed if the parent or physician refuses to have additional medical evaluation performed, or if the results of the evaluation prohibit the child from being fed orally at school.**

It is the parent's legal right to refuse to allow their child to be evaluated, either by the Feeding Team or by an outside source, such as a doctor. Should parents refuse to have their child evaluated, it is the responsibility of the school Feeding Team to work together with the parent and the IEP/IFSP team to develop an alternative plan, (like the interim plan discussed in step #8,) to enable the child to benefit from his/her special education program. This document would be attached to the student's IEP/IFSP. In the case of a child on a 504 plan, the alternative plan would be a part of the plan developed to enable the child to attend the school program. There may be a case where the team has determined that the child is unsafe to be fed orally at school. This may be due to a medical evaluation which shows that the child is at risk for health problems when eating orally. Alternatively, it may be due to the absence of an evaluation when the team has grave concerns about a child's safety. Again, the team is responsible to make every effort to accommodate the child within his/her school program without putting the child's safety in jeopardy, or the school at risk of liability. For a child who has a gastrostomy tube (g-tube), an alternative plan may involve training by a nurse to give the child g-tube feedings at school. In the absence of a g-tube, the child's schedule may be modified to enable him/her to attend school for a shortened day without needing to have a meal or a drink at school. The nurse, in conjunction with the rest of the Feeding Team, works to develop an alternative plan which meets the needs of the child as shown on the previous page.

In a case where there is a difference of opinion between the parents and the school about whether a child should be fed at school, it is recommended that a written statement be sent to the parents stating the decision of the school, why that decision has been made, and offering to meet with the parents to discuss the decision further. It is critical that the administrator be involved in this decision.

If, in the opinion of the team, a child's health and safety are being routinely compromised, it is recommended that those concerns be resolved before the child is allowed to eat at school.

**10. Recommendations are made to the school-based educational team and a feeding plan is developed.**

When the results of the feeding evaluation indicate safe methods for feeding, a feeding protocol is developed for attachment to the child's IEP/IFSP. The Feeding Protocol should contain a plan for staff training, documentation or data-keeping, and ongoing monitoring by the feeding specialist/team. A format such as the **Daily Feeding Protocol** is used to document the protocol and may be signed by the parent at an IEP/IFSP review to indicate that the parent has participated in developing the plan for feeding their child. Other information such as the **Guidelines for Facilitating Safe Feeding** (see **Resources**) may be given as part of the staff training. The designated feeder may be asked to use a daily feeding log or the **Safe Feeding Checklist** to document concerns or events that may occur during adherence to the feeding protocol. Samples of completed feeding protocols may be found in the **Sample Feeding Protocols** section.

**11. Staff is trained and follow-up reviews planned on a schedule decided by the Feeding Team.**

When a feeding protocol has been developed, school staff must be trained in its implementation. Training is provided by the Feeding Team member or members having the most expertise about the child and his/her unique feeding needs. Ideally, training would include this suggested training sequence:

**Suggested Training Sequence**

- a. Specific inservice training, which includes a review of the written feeding protocol, presented by the specialist.
- b. Demonstration of the feeding protocol by the feeding team.
- c. Hands on experience by the feeder under the supervision of the trained specialist.
- d. Training should continue until the feeder demonstrates proficiency. Feeders sign the protocol indicating that they have been trained and agree to implement the student's written protocol as directed by the feeding specialist/team.
- e. **Observation of Trained Feeder** form to be completed at each observation by feeding team or by designated school team member. Copies of the form are distributed, with (at minimum) the original going to the feeding team supervisor, one to the trained feeder, one for feeding team records.
- f. At the beginning of each school year, training and/or a refresher to be completed by feeding team or designated school team member.
- g. Periodic review of the written feeding protocols for the assigned student by the feeding team, at least annually.
- h. To ensure effective and safe feeding programs, monitoring should take place on a regular schedule. The feeding team should plan occasional "drop-in" visits to ascertain that the feeding protocol is followed at all times.

The **Feeding Training and Monitoring Log** is another instrument which may be used in documenting training and follow-up review. Under IDEA, children having feeding goals on their IEP/IFSP require review of these goals and progress reports on the same schedule as their same-age peers.

## A Final Word...

This has been a discussion of the issues involved in developing a district process for referral and evaluation of students who have special feeding needs. Each school district will develop their own procedures for the process, contingent upon their local model of service delivery, resources, geography and the many other factors that come under consideration. Forms suggested in this guide are to be regarded merely as examples and are in no way to be considered mandated for use.

The basic elements of any district process, identified in this document will generally remain the same across school districts. These components are listed in the form of a worksheet entitled, **Planning Checklist**. The checklist is designed as a tool for school districts to use as they develop their own procedures for referral and evaluation of students by the Feeding Team. The checklist may also be useful for established teams to use in evaluating their existing procedures to insure inclusion of critical components or to clarify areas of confusion.

Schools today face a myriad of challenges from all sides. Educators are daily confronted with what seem like ever-higher hurdles between themselves and their ability to provide effective educational services to children. We are continually amazed, refreshed and inspired by the dedication and vigor of the professionals we meet in school programs throughout the state. It is our hope that this document will assist school districts as they struggle with the complex and important challenge of feeding children safely in school.