Community Feeding Toolkit

**Information about the community feeding service**

The community feeding service is a countywide service run by a Highly Specialist Speech & Language Therapist. Due to the large geographical area covered, most appointments are held in clinic.

When a child is referred for suspected oral/pharyngeal dysphagia the referral will be triaged by a dysphagia trained Speech and Language Therapist. Following this, the referrer may be asked to provide more information. Once sufficient information is available, the referral may be accepted, and then parents will be contacted to arrange an initial appointment. If the referral is not appropriate for the Community Feeding SLT team, we will contact the referral to let them know, and we may suggest another team that could provide support.

At an initial assessment a detailed case history is taken, and the child will be observed eating and drinking. Recommendations are made, and the patient will be either discharged, reviewed (in clinic or by telephone/email) or referred for further investigation (e.g. ENT if a structural cause is suspected or video fluoroscopy if aspiration is suspected and more information is required to inform management).

We will only see a child with sensory feeding issues if advice from the Health Visitor and a period of 6 months of monitoring has not been successful. The purpose of this assessment will be to rule out any organic cause of their feeding difficulties and to reiterate advice already given. We do not offer longer term therapy or monitoring of children with sensory feeding issues as the core criteria for the service is for children with dysphagia.

**How to refer**

If you are working with a child who you feel meets the criteria for a referral to the feeding clinic, please refer using appropriate form. Please include a completed copy of the surveillance form (at the end of this document) to ensure we have enough information and enable us to prioritise the referrals.

If you would like to discuss a child with feeding problems you are working with (for example, to decide whether a referral is needed), please contact the Children’s Integrated Therapies Admin Team (oxonchildrens.therapies@oxfordhealth.nhs.uk) and they will be able to forward your request to the appropriate person.

**Aims of the Feeding Toolkit**

1. To ensure children with feeding problems are adequately supported by the most appropriate profession/service. Children with ‘typical’ developmental feeding difficulties, where there is little or no impact on the child’s overall development, can be supported by a professional who is already involved with the family (for example, a Health Visitor).
2. To ensure the specialist Speech and Language Therapist run feeding clinic is available for children with significant risk of a swallowing problem or chronic feeding difficulties.

**Differential Diagnosis**

When a child is presenting with a feeding difficulty it is important to establish whether this feeding problem is an underlying swallowing problem, or whether it is a developmental difficulty.

Speech and Language Therapists work with children with swallowing problems, known as dysphagia. Children with dysphagia are at risk of aspiration, which is where food/drink/secretions enter the airway instead of the oesophagus (food pipe) and can cause chest health issues. Certain groups of children are more at risk such as ex-premature infants, children with syndromes/neurological conditions and children with structural airway or oesophageal problems.

When children are facing weaning difficulties, or when they have a mild developmental delay, they are best supported by the Health Visiting Team. If a child you are working with shows any signs of aspiration (see below), please refer to the feeding clinic without delay.

**Signs of aspiration (Always Refer to Feeding Clinic)**

Aspiration occurs when food, fluid or saliva enters the airway and lungs which may lead to chest infections. Signs include:

* Coughing/spluttering on food/fluid
* Sounding rattily/chesty after eating/drinking
* Eyes watering when eating/drinking
* Recurrent chest infections/respiratory symptoms
* Breathing changes when eating/drinking

**Role of Professionals in Supporting Feeding Issues:**

|  |  |
| --- | --- |
| **Speech and Language Therapist** | **Health Visitor** |
| * Children showing signs of aspiration when eating/drinking
* Children with a diagnosis which pre-disposes them to feeding problems/dysphagia
* Children who may need adapted feeding techniques (e.g. thickener or modified diet) to ensure safety.
* Children showing severe oral aversion who may require tube feeding for nutrition and have potential to orally feed.
* Children who have an identified risk/evidence of aspiration who needs monitoring.
 | * Children who are struggling with lumps/solids.
* Children reliant on milk only, refusing solids when advice is needed around supporting progression.
* Children with behavioural feeding problems e.g. they will eat certain foods fine but will refuse other foods.
* Children who need advice on how to progress through weaning stages where there may be some elements of a mild developmental delay.
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This toolkit will cover the main early feeding difficulties children can face, advice on questions to ask and management options will be given. Red flags on each page will alert you to when specialist referral is indicated.

Difficulties Transitioning to Solids

Many children face difficulties weaning to solids, for some children these problems persist, and they may require support to progress through the textures. Mild difficulties transitioning to solids are a normal part of an infant’s typical development. Textured food should be introduced around 7 months. If this ‘critical period’ is missed, it can be more difficult for the child to cope with more solid foods.

**Signs & Symptoms:**

* Child is 9m to 12m old
* Refuses solids, milk reliant
* Rejects anything with lumps
* Drinks milk well with no issues
* Gagging on lumps
* Parent reports they are ‘choking’ on foods

**Understanding of Weaning Difficulties**

Children use forward and backward tongue movements during bottle/breast feeding, when they start to transition to solids they often manage runny smooth foods using this same suckling-type feeding pattern. As they develop their core muscle strength and stability they also develop a wider range of tongue movements. To chew/munch foods, even soft lumps, the child must learn to move their tongue to the sides of their mouth, to push the food to the gums to be ‘munched’. During learning, babies frequently cough or gag on lumps that are too large to swallow. This is a protective reflex to prevent choking. Lumpy purees/mixed textures can be challenging. Lumps need to be soft enough to be mushed on the palate with the tongue so that both the lumps and sauce can be swallowed together without triggering the cough/gag reflex. If lumps are too big/hard they must move the lumps to one side and hold them whilst swallowing the sauce, then process the lumps with side to side tongue movement – quite a complex process! Some babies will find this so uncomfortable that it will put them off trying lumpy food again.

It can take some time for children to master chewing. The biggest changes are between 6-10 months. The sides of the mouth only become desensitized if food is moved by the tongue from the centre to the side. Evidence suggests typically developing children only fully master chewing skills by 2- 3 years of age (Arvedson 2006). Parents should be reassured that their child may not be able to manage all foods until these ages, or foods may have to be adapted.

**Gagging/Vs Choking**

Gagging is a normal part of learning to eat and is a protective reflex which prevents choking before children’s chewing skills have developed. Some children gag more than others when weaning. Gagging does not necessarily signify a swallowing problem but choking does. It is important to differentiate between the two (see below). Negative reactions from the parent will communicate to the child that something is wrong. The parent should try to remain calm and avoid panicking, taking the food away or saying anything negative. Gentle reassurance should be given. An example of gagging can be seen here: <https://www.babycentre.co.uk/v25018737/baby-led-weaning-is-gagging-normal-video>

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| --- | --- |
| **Gagging** | **Choking** |
| * Retching/Gagging- mouth open, may make noise like they are going to vomit
* Can go red in the face
* Might cough alongside gag
* Happens when they are trying to swallow
* No obstruction of the airway
 | * Inability to breath
* Silent/partially silent choke
* Airway blocked
* Child may need back blow
* May experience colour change to red initially, then may start to look mottled/blue if obstruction not cleared
* (Parents should carry out first aid when choking is experienced)
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**RED FLAGS (Refer to Specialist SLT clinic)**

* **True choking reported**
* **Child has unexplained chest infections**
* **Child is coughing/spluttering when drinking or coughing on food**
* **Child sounds rattily or chesty are eating or drinking**
* **Wet sounding breathing or voice during or after eating/drinking.**
* **Eyes frequently watering when eating or drinking**
* **Above advice is not effective after 6 months.**

**Advice for children with difficulties transitioning to solids**

* Reassure parents that weaning difficulties are common early feeding difficulties
* In preparation for transitioning to lumpy foods, children can be encouraged to develop side to side (lateral) tongue movements needed for chewing by placing the spoon to the sides of their mouth. This can be done with the food texture they are able to cope with e.g. smooth puree, before introducing lumps.
* Try offering thicker smooth puree before adding lumps. This encourages the tongue to manipulate the food in the mouth more prior to swallowing. This increases the range of lateral tongue movements and in turn develops the tongue movements needed for chewing. Increase the thickness gradually.
* Next try lumps that are all the same size and consistency. Ensure they are not too big or hard and can be ‘mashed’ by the tongue on the hard palate.
* As practice for developing lateral tongue movements try offering some bite and dissolve (melt in the mouth) finger foods. Allow the baby/child to self-feed these or place finger food to the side of their mouth. These foods provide a safer way to introduce foods that require some chewing.
* Feeding Pouches or Baby Safe Feeders are a safe way to introduce your child to

various tastes and textures without the risk of small pieces breaking off which may cause gagging/coughing.

* Advise neutral response to gagging/vomiting and keep mealtimes positive.

Developmental Delay

Some children may have developmental delay affecting gross motor movements, speech and language and feeding. These children may not reach feeding milestones at the same time as other children.

**Signs/Symptoms**

* Child reached motor milestones late
* Gagging on lumps/solids
* Parents concerned they are not eating what they should be
* Child is otherwise well aside from developmental issues.

**Understanding of Developmental Delay**

Some children have developmental delay with no known cause. This can vary from a mild delay to a severe delay. Feeding develops alongside overall motor development; a child not meeting their milestones is highly likely to experience a feeding delay also. Parents should be given advice on what foods to be offering in these instances.

Children with mild developmental delays often need increased time to develop chewing skills and parents should be re-assured that their child might not be eating the same foods as their peers, due to their developmental delay.

**Children with moderate to severe developmental delay are at increased risk of aspiration.**

**RED FLAGS (Refer to Specialist SLT clinic via SPORFI)**

* **Child has moderate-severe developmental delay - over 6m motor delay**
* **Child has neurological diagnosis or syndrome and developmental delay.**
* **Child has frequent unexplained chest infections/respiratory symptoms**
* **Child is coughing/spluttering when drinking or coughing on stage appropriate food.**
* **Other signs of aspiration (choking, rattily or chesty when eating/drinking, wet sounding breath/voice, eyes watering when eating/drinking.)**
* **Child sounds rattily or chesty after eating or drinking**
* **Wet sounding breathing or voice during or after eating/drinking.**
* **Eyes frequently watering when eating or drinking**

**Advice for children with developmental delay affecting feeding**

* **Think STAGE not AGE**
* Work out the child’s developmental stage depending on motor milestones they have met, match this to suitable foods
* In preparation for transitioning to lumpy foods, children can be encouraged to develop side to side (lateral) tongue movements needed for chewing by placing the spoon to the sides of their mouth. This can be done with the food texture they are able to cope with e.g. smooth puree, before introducing lumps.
* Try offering thicker smooth pure; before adding lumps. This encourages the tongue to manipulate the food in the mouth more prior to swallowing. This increases the range of lateral tongue movements and in turn develops the tongue movements needed for chewing. Increase the thickness gradually.
* Next try lumps that are all the same size and consistency. Ensure they are not too big or hard and can be ‘mashed’ by the tongue on the hard palate.
* As practice for developing lateral tongue movements try offering some bite and dissolve (melt in the mouth) finger foods. Allow the baby/child to self-feed these or place finger food to the side of their mouth. These foods provide a safer way to introduce foods that require some chewing.
* Feeding Pouches or Baby Safe Feeders are a safe way to introduce your child to various tastes and textures without the risk of small pieces breaking off which may cause gagging/coughing.

Behavioural Feeding Difficulties

Children often face behavioural difficulties around food at some stage in their development. In a small number of cases these persist and may require input to work on these behaviours.

**Signs/Symptoms**

* Child will eat certain foods with no issues e.g. crisps, but they refuse other foods.
* Over reliance on milk, refusing solids.
* Tantrums and other negative behaviours associated with mealtimes.

**Understanding of Behavioural Feeding Difficulties**

Children frequently show challenging behaviour as a normal part of their development, often it is a way of showing independence, however sometimes these turn into significant issues for the family. These children often don’t have an issue with the physical act of eating/drinking, it is a psychological response. In some cases this can be traced back to difficult feeding when young (for example, pain associated with feeding due to reflux). Sometimes, when a child will only eat a limited diet, a cycle may develop where the children is only given the foods they like, to make sure that they are eating something. It can be hard to break out of this cycle. Some children will have behavioural feeding difficulties without any other issues, other children will have behavioural difficulties in a range of areas (e.g. not following other parental requests).

**Normal Feeding Behaviours:**

* Refusal of new foods. There is evidence children sometimes need 15-20 exposures of a new foods before they will accept this and eat it. Children are more likely to try new foods if they see another adult or child eat it and if they can eat a small piece without being forced.
* Neophobic stage- children between 2-3 will often refuse new foods, and even foods they previously ate. They are learning to be wary of something that doesn’t look as expected and could be harmful. This wariness can trigger the ‘fight or flight’ response which produces adrenaline and shuts down the digestive process. When the pre-frontal cortex matures they will be more able to reason it through and control these fears.
* Toddlers begin to form food categories so that previously accepted foods are refused if they don’t exactly match their ‘prototype’ because they concentrate on the exact details not general factors. This can also apply to packets. This can explain why predictable looking food e.g. biscuits are a more frequently accepted food than vegetables which all differ in shape, size, colour and texture. Children gradually move out of this stage if they can and want to imitate others.

**Referral Options**

Children with persistent behavioural feeding difficulties are best managed by specialists in behavioural management, such as Clinical Psychologists. The SLT will only see the child if there are signs of a swallowing problem or oral hypersensitivity in combination with a behavioral feeding difficulty.

If you feel that your child, or the child you are working with, requires support with behavioral feeding difficulties, please contact your Health Visitor, GP or Paediatrician for advice.

**RED FLAGS (Refer to Specialist SLT clinic via SPORFI)**

* **Child has shown signs of aspiration (True choking, rattily or chesty when eating/drinking, wet sounding breath/voice, eyes watering when eating/drinking.)**
* **Child has a history of a swallowing problem before food refusal.**
* **Signs of hypersensitivity-does not mouth toys, gag when sees food, refuses to touch foods etc.**

**Advice for children with behavioural feeding difficulties**

(*from nutrition & dietetics department ‘Help for Children with extreme faddy eating’ booklet)*

* Offer 3 meals a day – breakfast, lunch and dinner, and 2 or 3 nutritious snacks. Offer 2 courses at a meal, one savoury and one sweet.
* Try to eat meals and snacks at the same time each day
* Offer small portions so that your child is not overwhelmed
* Give drinks at the end of meals or snack time to avoid children filling up on them
* Limit milk intake once your child is 1 to 600 mls a day
* Give all drinks from a cup or beaker rather than from a bottle after they are 1
* Persevere in offering new foods – a child may need to try it more than ten or even twenty times before they start to like the taste
* Try to eat in a calm, relaxed area, without television or toys
* Sit together at the table and eat at the same time as your child whenever possible, as he will learn from you
* Present food in fun and attractive ways
* Try not to rush or drag out mealtimes. If your child has not eaten their food after twenty to thirty minutes, take it away without comment
* Offer your child food without coercion (never try to force feed)
* If your child refuses to eat food put in front of them at mealtimes, take it away without comment, and do not offer any other food until the next planned meal or snack time. You may still offer a pudding at mealtimes if the main course is refused
* Do not use foods as rewards. Better rewards are praise and star charts for good mealtime behavior
* Try involving children in shopping, food preparation and table laying
* If your child is only eating small amounts, and you are worried about their weight gain, you can give high fat foods and snacks, offer a pudding at each meal, and add extra fats such as grated cheese or butter or cream to their food.
* Get their weight and growth checked by their health visitor if you are still worried

Sensory feeding difficulties

Children with a sensory based feeding difficult might limit the type of food or liquid that they are willing to eat or may display aversive behaviours around eating. Sensory factors are fundamental to motor function, as children develop, they learn about the physical properties of food which allows them to eat or drink them appropriately.

**Hyposensitivity:** Children can have different responses to sensory input during eating. Some may have lower responses to taste, temperature or the perception of chewing/sucking. These children may crave foods that provide increased input such as strong flavours, crunchy textures, extreme temperatures. Children with lower responses to food may overfill their mouth to increase the sensory input.

**Hypersensitivity:** Some children have the opposite reaction and are highly sensitive to sensory input. They may have an excessive response to taste, temperature, or touch in and around the mouth. The neophobic response is also stronger in sensory hypersensitive children because they react more strongly to stimuli in their environment.

When children display an extreme emotional or behavioural response to food they may be classed as sensory or orally ‘defensive’ because they are defending their mouth from an uncomfortable experience. Children who are sensory defensive may avoid many textures and tastes. They often vomit when they cough to clear food from the tongue. Babies with reflux are more likely to vomit/cough on lumps due to a hypersensitive gag reflex.

**Things a child may do if they have a sensory feeding issue:**

* Refuse certain foods or drinks
* Gag on certain textures particularly mixed consistency food e.g. lumpy purees
* Hold food in the mouth without swallowing
* Overfill their mouth (low sensation)
* Seek or avoid foods with strong sensory factors (taste, temperature, texture)
* Dislike toothbrushing, mouthing toys or any touch around the mouth unless it is their own fingers

**RED FLAGS (Refer to Specialist SLT clinic via SPORFI)**

* **Child has shown signs of aspiration (True choking, rattily or chesty when eating/drinking, wet sounding breath/voice, eyes watering when eating/drinking.)**
* **Signs of hypersensitivity-does not mouth toys, gags when sees food, refuses to touch foods etc.**

**Advice for children with sensory feeding difficulties**

* Write a list of foods that your child accepts and introduce foods that are similar- you could start with the same food but a different brand. The next step may be a different flavour of the same food or try adding a spread/topping to an accepted food e.g. cheese spread on toast.
* Always provide an accepted food (in its usual form) alongside new foods so that they child can see there is always something they are comfortable with on their plate.
* Encourage all interaction with new foods. The child may work through a hierarchy of looking, touching, holding, licking, biting and spitting out, chewing and spitting out, before they feel ready to swallow it. They must be supported to feel comfortable to be able to do this at their own pace.
* Research has shown that some children may need exposure to a new taste/food 10-15 times before readily accepting the food into their diet. If a child initially seems to refuse a new food continue to offer tastes with no pressure to allow the child to continue to try this in a non-threatening way.
* Never force feed a child- this is a negative experience and is likely to make feeding difficulties worse. A child may become more aversive if forced to eat and will end up taking less food, rather than more.
* Introduce foods through play, often called ‘messy play’. Children learn about the world through play and they can learn a lot about different foods through messy play. Children should be encouraged to explore foods with their hands, experiencing the feel, the smell and the look of foods. As children become more comfortable around food they are more likely to try a small taste out of curiosity. Adults should play alongside children in messy play activities and follow the child’s lead- avoid asking the child to try a taste, the child will do so when they feel ready.
* For a child who is highly reactive to sensory input try to create a relaxed calming environment- soft lighting, soft music, bland flavours, neutral temperatures. The feeder should speak slowly and give warning about what is happening.
* For a child who is seeking more sensory input an environment should stimulate- bright colours, well lit, animated voices, and crunchy/spicy foods. Some children may benefit from some sensory stimulating activities such as bouncing prior to a mealtime as this ‘wakes’ up their system.

SURVEILLANCE SHEET: FEEDING DIFFICULTIES

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name |  | Completed by |  |
| D.O.B/Age |  | Job Title |  |
| NHS Number |  | Date |  |

|  |  |
| --- | --- |
|  | **Notes / Examples** |
| **Early feeding history**  | *(e.g. breast/bottle feeding, tongue tie, reflux, milk allergies)* |
| **How/when did you know your baby was ready for weaning?** | *(e.g. able to sit unsupported)* |
| **How did you start weaning your baby?**  | *(e.g. positioning, equipment, environment, communication)* |
| **What food/textures does your baby enjoy?** |  |
| **What food/textures does your baby struggle with?**  | *(and how do they communicate this?)* |
| **Is your baby gagging on certain foods?**  | *(If yes, how do you respond?)* |
| **Does your child show distress at mealtimes?**  | *(e.g. refusal, tantums, throwing food)*  |
| **Is your child neophobic? (fearful of trying new/different foods)**  |  |
| **Is your baby following their expected growth/height trajectory?** |  |
| **Is your baby showing signs of motor developmental delay?**  | *(If yes, are feeding difficulties in-line with their developmental stage?)* |
| **Does your baby have issues with increased/decreased tone?**  |  |
| **Are any signs of aspiration observed when the baby eats or drinks?**  | *Select: Coughing, voice change, colour change, eye blinking/watering, change in breathing rate, fatigue, distress* |
| **Has there been any choking?**  |  |
| **Has your baby had many lower respiratory chest infections?** | *(Provide dates if known)* |

|  |  |
| --- | --- |
|  | **Prior to referral** |
| **What has been tried so far to help develop their feeding skills?**  |  |
| **How concerned are you about your baby’s delayed feeding difficulties?**  |  |
| **How long has your baby been struggling with feeding?** |  |

|  |  |
| --- | --- |
| **CRITERIA FOR REFERRAL** | **CRITERIA FOR MONITORING** |
| REFER to feeding team if parent/carer reports:* **Choking episodes**
* **Unexplained chest infections**
* **Signs of aspiration**
* **Advice is not effective after 6 months and high level of parental concern**
* **Failure to meet expected weight/height development – \* also refer to dietetics**
* **Child has moderate-severe developmental delay e.g. more than 6m motor delay**
* **Child has neurological diagnosis or syndrome and developmental delay**
* **Issues with hypo/hypertonia that are suspected to be interfering with feeding**
 | **MONITOR** for 3-6 months if parent/carer reports:* **No choking episodes**
* **No history of unexplained chest infections**
* **No signs of aspiration**
* **Difficulties experienced for less than 6 months**
* **Meeting expected weight/height development**
* **Low level of parental anxiety**
* **Feeding difficulties are in line with their developmental stage (not age)**
* **Behavioural difficulties associated with mealtimes**
* **Neophobic**
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| --- | --- | --- | --- | --- | --- | --- |
| **Action:** | **Refer to SLT** | Yes / No | **Monitor** | Yes / No | **Follow up in weeks / months** |  |

**Useful Websites for Further Information and Advice**

[www.childfeedingguide.co.uk/](http://www.childfeedingguide.co.uk/)

[www. infantandtoddlerforum.org/](https://infantandtoddlerforum.org/)

[www.firststepsnutrition.org](http://www.firststepsnutrition.org)

[www.autism.org.uk/about/health/eating.aspx](http://www.autism.org.uk/about/health/eating.aspx)