



CDI Clinical Practice Guidance Document Cover Sheet

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National Clinical Programme for People with Disability (NCPPD)

Disability Regional Enhanced Services and Supports for Feeding, Eating, Drinking and Swallowing (FEDs)



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1.0 Generic Key Features of Disability Regional Enhanced Supports Services (DRESS)

Please refer to the National Clinical Programme for People with Disability's (NCPD) document on "Generic Key Features of Disability Regional Enhanced Supports Services (DRESS)". This document describes the general pathways to DRESS's, the importance of a human rights-based approach, being person-centred, appropriate terminology, the layered and general framework for services, leadership, staffing, supervision, and management of DRESS's.

Readers are also referred to the National Disability Authority's (2022) "Advice Paper on Disability Language and Terminology" (<https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology>).

1.1 Introduction

The purpose of this document is to support CHOs and Lead Agencies in implementing a consistent approach to the delivery and development of Feeding, Eating, Drinking and Swallowing Management services and supports for children with complex disabilities. The context being post reconfiguration of services under the Progressing Disability Services for Children and Young People (PDS) programme and aligning to this policy. A recent survey by the National Clinical Programme for People with Disability (NCPD) highlights variation in approaches regionally and some reported deficits in FEDS competencies for more complex presentations.

The **Guidance on Specialist Supports 2016**¹ document states the following:

In line with the National Policy on Access to Services for Children and Young People with Disability²:

- Children with non-complex needs will receive their services at Primary Care services level
- Children with complex needs will receive their services at Children's Disability Network Team level (Note: Guidance for decision making on complexity is provided in the National Policy on Access to Services for Children and Young People with Disability and Developmental Delay)
- It is recognised that specialised services and supports will be needed at times for a small number of children whose specific needs require a level of expertise which may not solely be met by these teams.

Specialised services and supports are required to provide;

- Training and consultation for Primary Care services and Children's Disability Network Teams (CDNTs) and/or
- Assessment and direct interventions for children where and when necessary to respond to the exceptional complexity or specialised nature of their needs.

The Children's Disability Network Team or Primary Care services will remain the primary service provider for these children with a disability and their families.

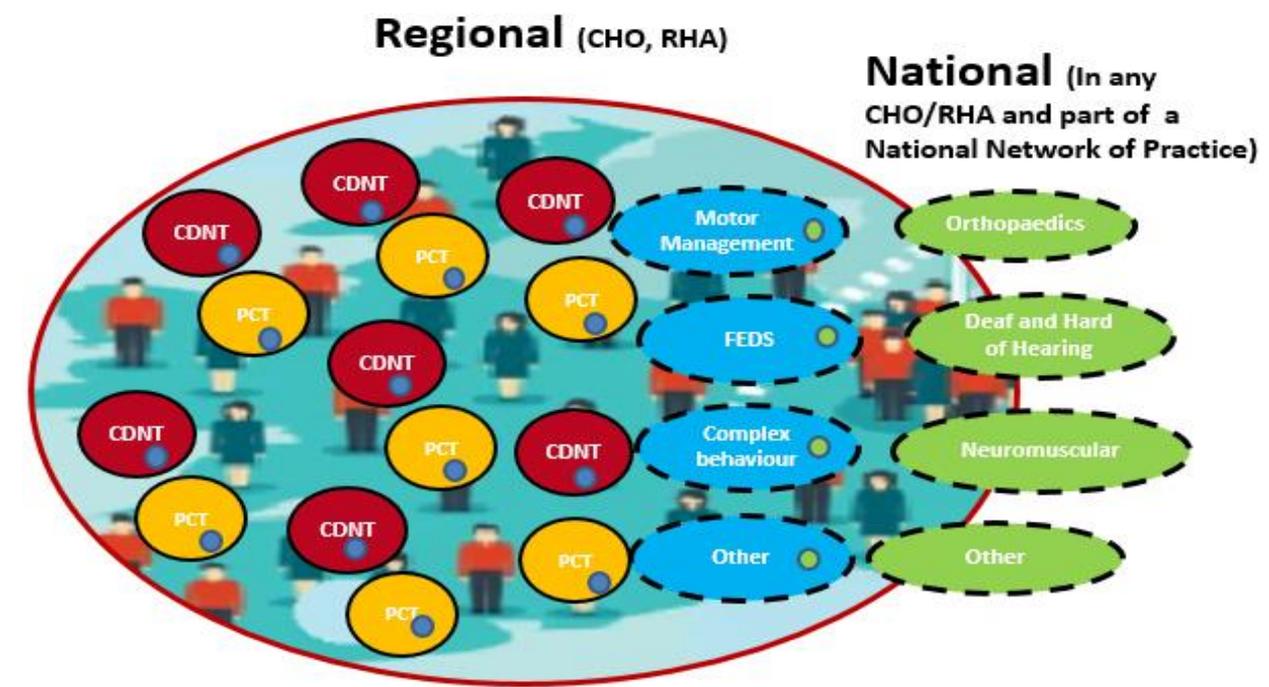
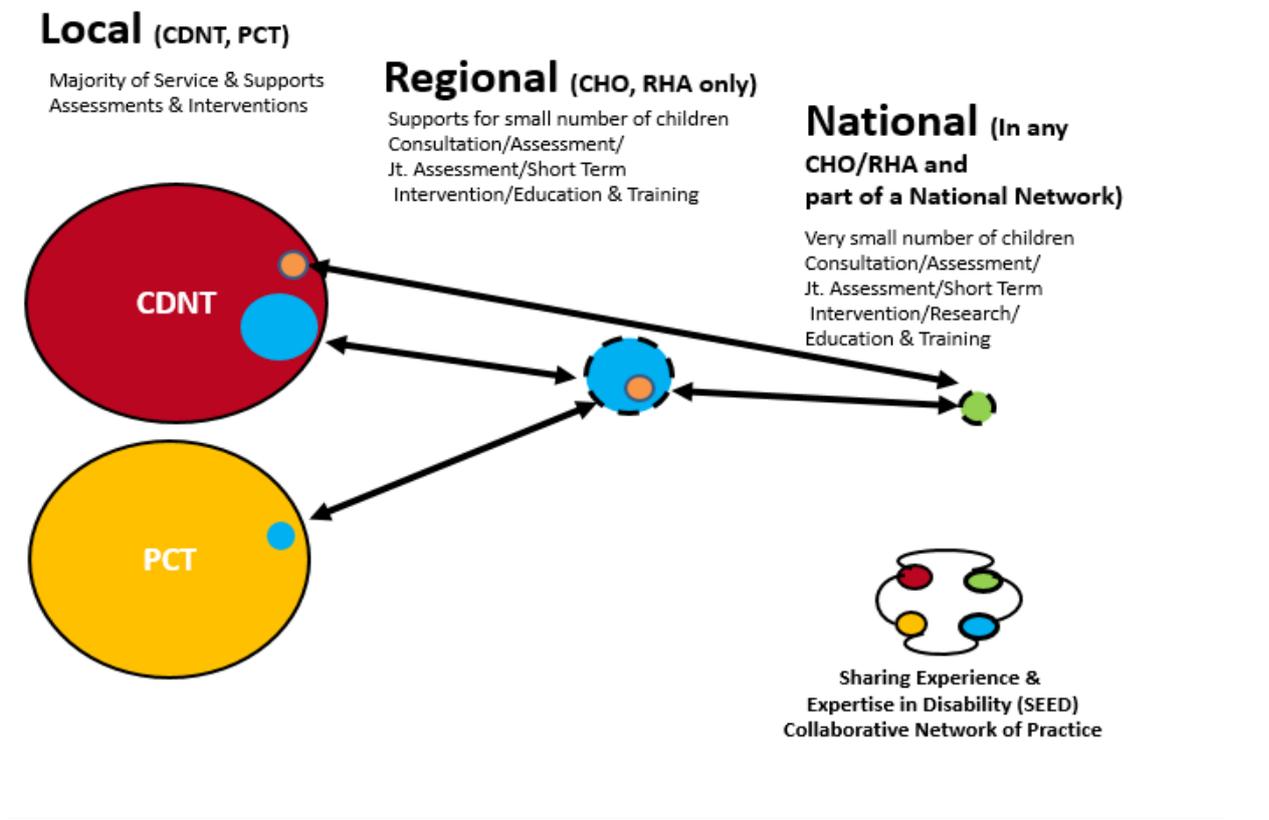
A more detailed description of the role of Specialised Services and Supports is available in the Guidance on Specialist Supports 2016 document.

2.0 Model for Specialised Services and Supports

Figure 1 outlines a conceptual model for Specialised Services and Supports for children with disabilities.



Figure 1. Model for Specialised Services & Supports



Local – In line with SlainteCare and PDS policy services for children with disabilities shall be available on a needs-basis as close as possible to where children and their families live. PCTs and CDNTs are established on a local geographical basis in line with these policies delivering the majority of services to children with disabilities as outlined above.

Regional – A number of children with greater complexity and rarer presentations will require access to specialised services and supports. By their nature in terms of population demand, critical mass of



throughput needed to maintain competencies and required technical expertise/infrastructure, some of these services will be organised on a regional level, e.g. FEDS Support Services, Medical review, some tertiary specialised services.

National – Some tertiary specialised services may not be available in all regions, e.g. Specialised MDT FEDS team with Paediatric and Dietetic Support, Videofluoroscopy Services. We envisage that centres with a special interest in a particular area will be increasingly organised nationally as a network of practice around a specific functional area of expertise or practice, e.g. FEDs network of practice. We expect that these networks will be supported to collaborate and take a national perspective in terms of population cover, standards, education, research, service development and policy advice. It is expected that these networks will have academic and international linkages. The National Clinical programme for People with Disabilities terms these networks of practice as SEED Networks (Sharing Experience and Expertise in Disability). SEEDs will pull together and serve all parts of the service delivery network (local, regional and national) and serve as a source of sustainable knowledge, education, research and focus on specific functional areas or cohorts.

3.0 Feeding, Eating Drinking and Swallowing (FEDs) Context

3.1 Definition

Feeding, Eating, Drinking, and Swallowing (FEDS): FEDS refers to the total process of feeding, eating drinking and swallowing (IASLT, 2012).

3.2 Prevalence of children with this need

Many children with a range of disabilities present with feeding, eating drinking and swallowing difficulties (FEDS). The incidence of feeding disorders is estimated to be 22-45% in typically developing children and up to 80% in children with developmental delay. Feeding difficulties are frequent in children with neurological impairments and can be associated with undernutrition, growth failure, micronutrients deficiencies, osteopenia, nutritional comorbidities³ and family stress. Gastrointestinal problems including gastroesophageal reflux disease, constipation, and dysphagia are also frequent in this population and affect quality of life and nutritional status³. Gastrointestinal (GI) problems are frequent in children with neurological impairment (NI) and should be considered together with the evaluation of the nutritional status The NI can affect the GI system, most notably oral motor function and motility. Dysphagia in NI children typically presents as feeding difficulties, extended feeding times, malnutrition, and/or a history of aspiration and/or pneumonia³.

Research demonstrates FEDs issues among the following cohorts:

- Physical disability
- ASD (approx. 60% population)⁴
- Down syndrome (approximately 40% as babies and young children)⁵
- Severe Profound with physical involvement (approximately 90%)⁶
- Intellectual disability (approximately 60%, based on current populations attending ID services, range of FEDS needs)⁷

A review of 500 children attending early intervention services in Ireland indicated that 29% had feeding difficulties, 14% had behavioural feeding difficulties and a further 35% required varying degrees of nutrition support (including tube feeding and oral nutritional supplements) (? Ref).



3.3 FEDS Categories

Children requiring FEDS services at primary care, CDNT or specialised team level may be broadly subdivided into one of 2 groupings –

- those presenting with an aversive FEDS disorder –these clients may have a restricted diet related to food preferences which may be influenced by sensory and behavioural issues and
- those who present with an oropharyngeal dysphagia – these clients present with a difficulty with the management of food and /or drink in the oral or pharyngeal cavity at the oral or pharyngeal phase of swallowing.

These categories are not mutually exclusive nor do they encompass an exhaustive listing of the FEDS difficulties with which children may present but they represent the broad categories in which services are currently being provided.

3.4 Spectrum of Complexity Presentation

There is a wide spectrum of presentations of FEDS complexity ranging from straight forward issues which are easily addressed with basic FEDS training to very complex presentations requiring an advanced level of expertise and MDT to address comprehensively.

Greater complexity can present in any child. A child with a complex medical history can present with very simple FEDS issues and a child with no medical diagnosis can present with highly complex FEDS issues requiring tertiary level multidisciplinary team management. Each child has to be managed as an individual and **not as a diagnosis**. With this in mind children with the following diagnoses may present with more complex issues:

- Current and multiple medical diagnoses; these children are typically under the care of a tertiary or regional hospital.
- Complex sensory presentations where there is an established risk of malnutrition.
- Progressive conditions where there is a concern about FEDS deterioration.
- Profound and multiple disabilities.
- Weaning from alternative feeding
- FEDS issues in new born babies
- All of the above may present with complex FEDS but may also be quite straight forward e.g. some babies will wean from an NG tube with minimal intervention other than short term advice and support, many children with profound disabilities manage well with texture modification and supportive seating systems etc.

Feeding problems that are not managed appropriately and at an early stage in the child's development can become persistent over time and may result in serious conditions such as malnutrition, nutrient deficiencies, delayed development, poor growth, respiratory illness and excessive family stress impacting on the infant/child's mental health and on the mental health of the parents/carers.

4.0 Levels of Service/Supports/Structure of Services

FEDS management services and supports shall be provided at the level most appropriate to complexity of presentation and in line with available competencies on teams. Services shall be responsive and connected built around child and family need, to support and empower children and families to optimise their health and actively address and minimise their risk factors.

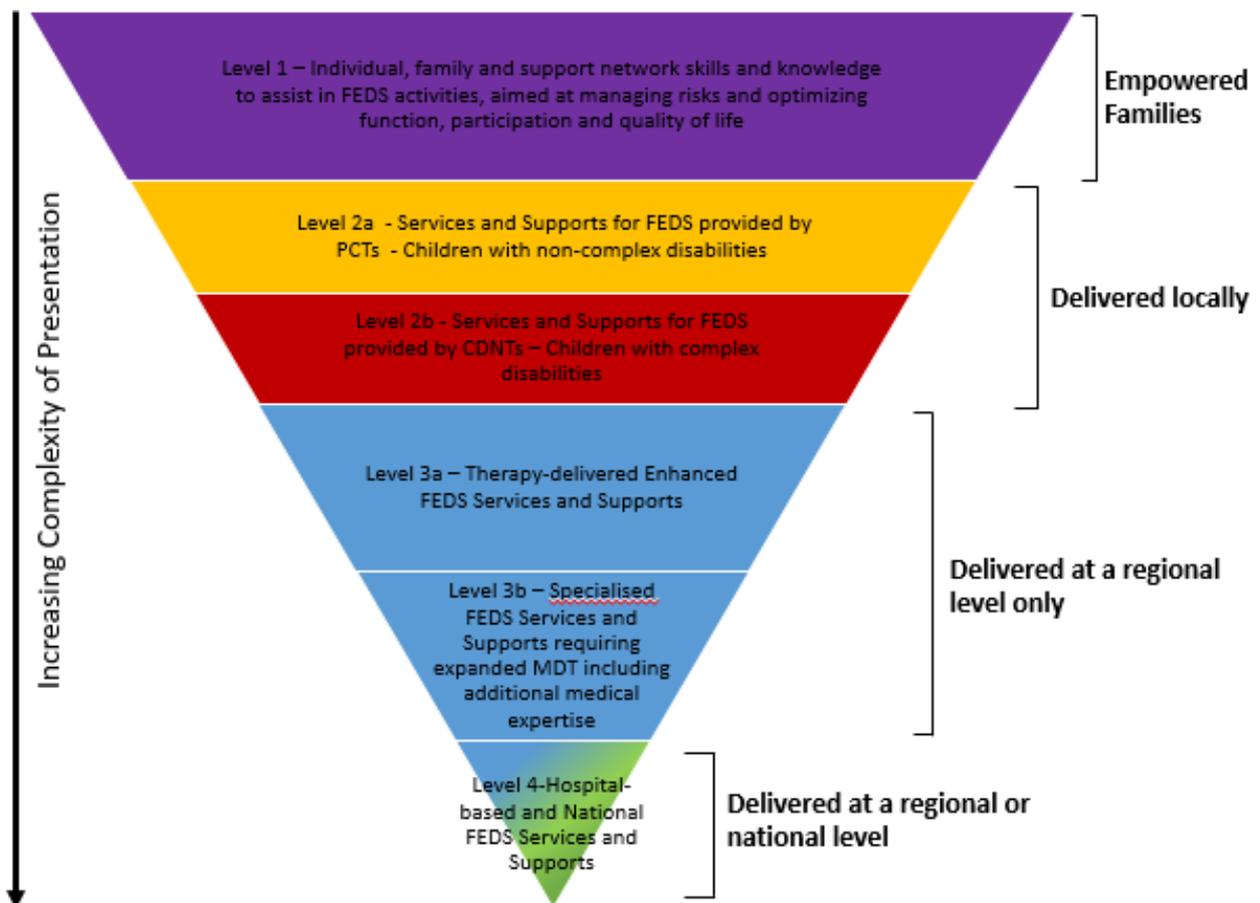


Figure 2 outlines a layered Model of FEDS Management Services and Supports with a variety of service provision in accordance with complexity.

4.1 Layered rather than Stepped Approach

Several existing models of service and extant literature recognise the value of a tiered approach to service provision. In some instances, this is described as “stepped-care”. However this can be misleading as it is sometimes understood that different levels – steps – can only be provided once lower steps have been tried. In fact, a layered model, where people may receive services and supports on different “steps” – e.g. a CDNT, regional supports and a hospital based assessment – at the same time, is preferred and avoids the cessation of one “step” and waiting for another “step” to commence, which may also mean that people are put on waiting lists for the next step. This model allows for children to have the majority of services and supports delivered locally but importantly, when required, to have additional services and supports from appropriate personnel working with the local teams to manage more complex issues.

Figure 2. Model of Services and Supports for FEDS Management



Level 1 - Individual and family activities aimed at optimizing function, participation and quality of life

This level reflects the principles and policy of PDS in term of empowering families, children and support networks (SNAs, extended family, etc.), in so far as possible, to develop skills and mechanisms which will allow them to manage and minimise the impact of impairments, societal and



environmental barriers which contribute to the experience of disability. The focus here is to build self-efficacy and leverage family and personal strengths to optimise function and participation for children with disability, from childhood through adolescence and transitioning to life as an adult. In terms of FEDs, activities relate to children, families and support networks (SNAs, HCAs, feeding assistants, etc.) possessing the knowledge and skills to engage in or assist in safe feeding practices, minimise FEDs related risks, optimising function and facilitating participation and quality of life. All levels of service need to incorporate the principle of empowering and building capacity within families and support networks as part of their family centred care plans.

Levels 2a & 2b - Primary Care Teams and Children's Disability Network Teams

Following a referral to community based services the first point of contact for the child and family will be the Children's Disability Network Team CDNT (if complex needs) or Primary Care Services (if non-complex needs) in accordance with the National Policy on Access to Services for Children & Young People with Disability & Developmental Delay.

The majority of the child and family's needs related to the child's FEDs needs should be addressed at this level by the PCT or CDNT, in partnership with the family, at home or at local service and at their school, preschool etc. This is in the spirit of family centred practice where therapists work in partnership with the family and others to support the needs of the child in their own environment. These teams are responsible to set and implement goals which include FEDs related goals, and in the case of CDNTs within the model of Family Centred Practice and Interdisciplinary Team working.

The PCT and CDNT will require the competencies to address a range of FEDs needs. Typically these services and supports will include assessment and the delivery of therapy programmes and interventions (universal, targeted and specific individual) in multiple environments and coordinating additional aspects of FEDs management and related service, engaging and working closely with specialised services as necessary around increased complexity.

Depending on presenting complexity and locally available competencies (which are envisaged to grow and develop in time post reconfiguration) a PCT or CDNT may need to engage with other levels of FEDs management service or support. This may range from a simple consultation to a joint assessment and care planning, to referral for a specialised component of service such as a FEDs MDT assessment or videofluoroscopy investigations.

Accessing and engagement with specialised services and supports shall always be conducted in the most streamlined manner possible for children and families through direct engagement with the appropriate level of service available in a region. If the skills/team are available at CDNT/PCT level then children with complex FEDs needs can and should be managed at this level in accordance with the skillsets required to manage presenting needs.

Responsibilities of the Children's Disability Network Team (Will need equivalent paragraph for PCT agreed with Primary Care)

- It is the responsibility of the CDNM to ensure that there are structures in place to ensure safe FEDs practice i.e. Supervision arrangement in place, competency level of therapists is monitored and reviewed, access to advanced FEDs practitioner/s identified to support the management of complex FEDs cases.
- The child's main team are responsible for supporting the family in the assessment and management of their child's FEDs needs.



- Support will be provided at CDNT level by an appropriate clinician who is a member of the CDNT with an identified competency level working in collaboration with other members of the team.
- According to the best practice, it is imperative that the clinicians operate within a team environment⁸. This means consulting appropriate team colleagues throughout the assessment, treatment and monitoring phases, taking information to inform intervention, and providing important information to the team as required. If a team is fragmented members have a duty to seek out relevant professionals and engage in communication with them for the benefit and good quality treatment of the service user.
- All therapists undertake an experiential review of their skillset in the area of FEDS with their FEDS clinical supervisor. This will assist in identifying where support in the area of FEDS is available at CDNT level and the grade of that competency e.g. basic, intermediate, advanced as per IASLT 2015 guidelines (Appendix X). Where clinical skills meet pre-set criteria a clinician may provide support and training to colleagues in the CDNT
- Where competency gaps exist staff shall seek to undergo and be supported to undergo appropriate training and supervision relative to presenting case load.

Level 3a- Therapy-Delivered Specialised FEDS Services and Supports to a number of CDNTs

CDNTs and PCTs, depending on complexity of presentation and competency within teams, may require access to specific FEDS expertise in an area. This will range from therapy-delivered services (Level 3a) to a more expanded structure requiring additional medical and other competencies, e.g. paediatric support (Level 3b).

The FEDS enhanced supports team could be engaged in the following situations (example):

- For service users who are on the CDNT/PCT caseload with a level of FEDS needs which cannot be fully managed locally within the CDNT/PCT
- When interventions at CDNT/PCT level are not effective
- When CDNT/PCT primary therapist requires additional skills to manage complexity of issue
- When more in-depth assessment is required for case formulation
- When CDNT/PCT primary therapist has identified a need for support in developing skill level for a specific service delivery or in relation to a specific FEDS issue

The role of the Regional Enhanced FEDS support Team is as follows:

- The Team may provide support to other professionals (particularly SLTs) to upskill in their FEDS competency level by working with the FEDS team as a primary therapist to manage FEDS cases.
- It is envisaged that the FEDS team will provide education and upskilling across a region as required
- Supporting community-based PEG management where required
- Targeted information and education coordinated regionally and sometimes nationally linking with other Services and Supports as appropriate

Regional Enhanced FEDS support team members will have additional expertise and experience to address complex FEDS needs, to coordinate specific FEDS clinics and to facilitate pathways for children accessing regional and national specialised services where required.



Engagement with FEDS specialised supports shall be in as streamlined a fashion as required. This may range from;

- A simple phone call or virtual consultation being the first choice of engagement, to;
- A scheduled joint assessment and care planning, to;
- Delivery of specific interventions with expertise, to;
- Referral to and preparation for attendance at a regional or national specialised service.

At all stages the primary duty of care will lie with the PCT or CDNT for ongoing management with agreed individual service and intervention responsibilities clearly documented in an overall service and support plan.

Level 3b - Specialised FEDS Services and Supports requiring expanded MDT including additional medical expertise

Level 3b requires an expanded team including medical and other professional expertise, e.g. Paediatrician with a special interest in Community Child Health and/or Special Interest in Neurodisability, Psychiatry. Currently access to these supports is variable in regions with some teams having access to dedicated expertise and working closely with for example Paediatric Consultants and other teams availing of primarily local hospital-based paediatricians with a mixture of community and acute commitments.

Typically support at this level will involve MDT approach and specific clinics for assessment, diagnostics, coordination of more complex aspects of FEDS management such as videofluoroscopy assessments and interpretation.

Level 4

Some tertiary specialist FEDS services must be hospital-based by their very nature, e.g. videofluoroscopy assessments, PEG insertion, respiratory, gastroenterology. Others services may have components of service delivered across both acute and community, some in an integrated way, e.g. in-reaching of regional FEDs team to acute hospital, providing support for highly complex, low incidence presentations, providing second opinions, advice on progressing clients where progress is limited, links to and with hospital services, training, education and research. These services involve a range of more advanced expertise, experience and technical capabilities and facilities in specific specialised areas.

5.0 Services/Professional Inputs Required for FEDS Services

For children presenting with an oropharyngeal dysphagia the recommended team formulation is SLT, Dietician, OT, and Paediatrician. Nursing, psychology, physiotherapy, social work and seating support may be required depending on the individual needs of children and families. Additionally, gastroenterology, radiology, respiratory medicine input may be required for complex presentations.

For children presenting with an aversive FEDS difficulty the recommended team is Dietician, OT, SLT and Psychology. Paediatrician and social work support may be required depending on the individual needs of children and families. Additionally, depending on needs support may be required from Psychiatry. The key to treating aversive FEDS is prevention. Early intervention is key, with SLTs in maternity hospitals and units advising on and assessing readiness to feed and giving advice about responsive feeding. Also SLTs in CDNTs and PCTs being involved in health promotion education such as mother and baby groups for at risk populations.



Other community and primary care personnel may have an important role to play in managing FEDs issues, namely; General Practitioner, Public Health Nurse, and Community Medical Officers.

Beyond the professional team members other important stakeholders in managing FEDs issues include family and staff involved in supporting delivering care to children, e.g. education, respite. Practitioner. Family and support workers are often an extremely important stakeholder in the FEDs process as they will be present for mealtimes and may be involved most regularly in the feeding process.

A coordinated child and family-centred team based approach to managing FEDs issues is strongly advocated.

6.0 FEDS Pathway

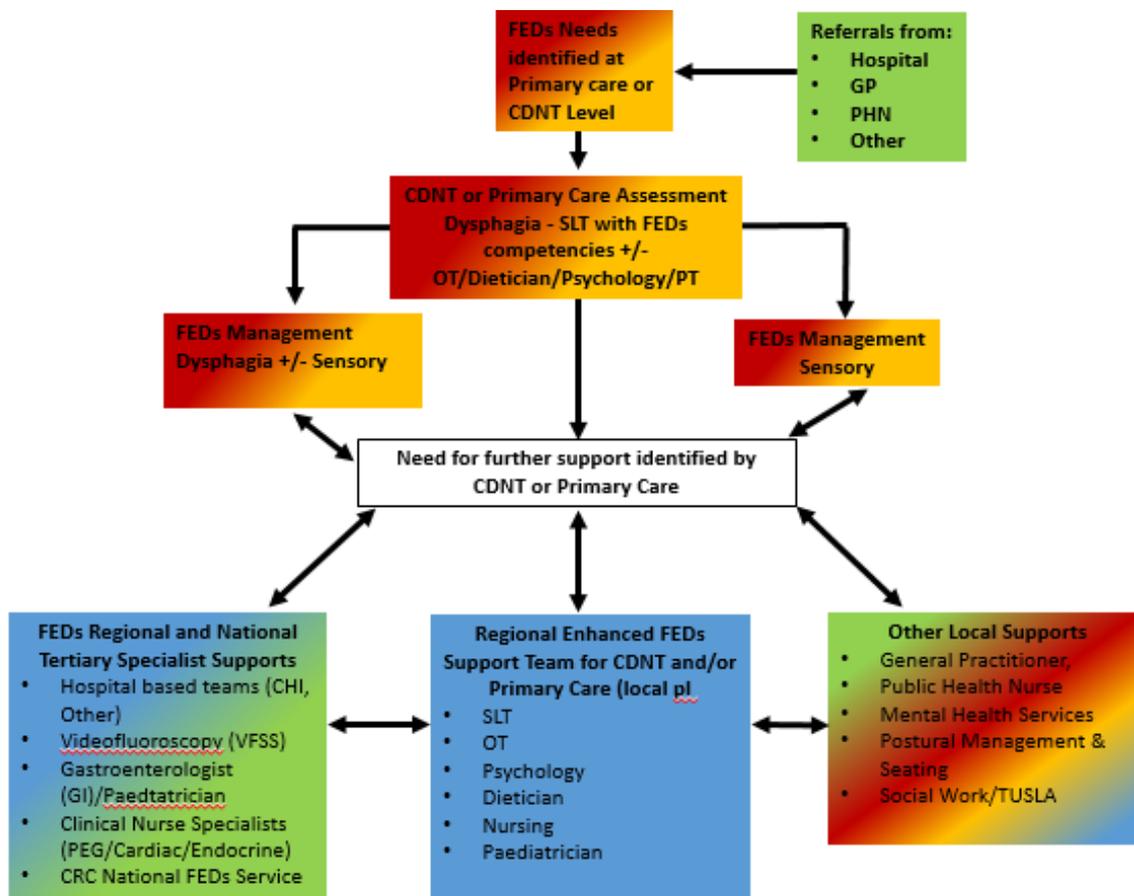
Development of an 'end-to-end' model and pathway for the integrated prevention and management of Feeding, Eating, Drinking and Swallowing (FEDs) related difficulties in children with disabilities will support health and social care professionals to provide holistic child and family-centred services and supports as close to home as possible.

FEDS management services and supports shall be provided at the level most appropriate to complexity of presentation.

Figure 3 presents the broad outline of a FEDs pathways (oromotor, sensory).



Figure 3. Feeding, Eating, Drinking and Swallowing Pathways



6.1 Pathways

1. Following referral to community based disability services, the need for FEDS assessment is identified at local CDNT/PCT. A review of accepted FEDS referrals will be carried out by a Senior SLT with appropriate FEDS competencies and team colleagues and allocated to the appropriate level of FEDS service. Referrals of high-risk FEDS needs may need to be immediately escalated to the Enhanced FEDS support team and/or Regional and/or National FEDS supports if indicated.
2. The FEDS assessment is completed at the CDNT/PCT level by a dysphagia trained SLT (with necessary team members including dietician, OT, physio, psychology as appropriate)
3. If oropharyngeal dysphagia is indicated from this assessment the service user will receive appropriate management from the CDNT/PCT led by a dysphagia trained SLT including support from OT, Dietician, Psychology and PT as required. Service users with dysphagia may also present with oral sensory difficulties/aversion.
4. If dysphagia is not indicated but the service user does present with oral sensory difficulties/aversion the service user will receive appropriate management from the CDNT/PCT including OT, SLT, Dietician and Psychology as required.



5. At any stage during the assessment and management process the CDNT/PCT or team member may identify the need to access further support depending on level of experience and competency in the area.

6. This support can then be sought from the relevant Specialised FEDS Support Team or regional or national supports available. These supports will then be integrated into the service user's management plan at CDNT/PCT level. Duty of care for all service users will remain at the level of CDNT at all times.

Of note:

As outlined in the 2016 Guidelines on Specialist Supports it is the responsibility of CHOs to ensure that pathways are in place for FEDS Services and Supports. Where deficits exist, CHOs are expected to engage with relevant stakeholders in terms of pathway access and development.

7.0 Competencies

IASLT Competencies for FEDS staff are outlined in Appendices 1. (Note: FEDS competencies for other professional groups are currently being developed by those groups).

If not already completed in an area, the NCPPD recommends that staffing resource of clinicians with advanced/intermediate FEDS competencies be mapped and ring-fenced under an Expression of Interest (EOI) process in order to staff the Enhanced FEDS support teams and protected time ring fenced for this service.

An EOI for oropharyngeal dysphagia FEDS service in a region will include:

- SLTs with intermediate/advanced level of FEDS competency
- OTs with advanced level of FEDS competency
- Dietitians

An EOI for aversive FEDS service will include:

- SLTs with intermediate/advanced level of FEDS competency
- OTs with advanced level of FEDS competency
- Dietitians
- Psychologists

It is envisaged that FEDS competencies will grow locally and regionally as services develop in line with these pathways. The NCPPD recommends that a national network of practitioners and organisations with specialist interest and competence in FEDs be established and supported (SEED network).

8.0 Service Configuration and Governance

The NCPPD will engage with the overarching Specialised Services and Supports Task Group and relevant other stakeholders in relation to potential challenges around configuration, governance and management of specialised services and supports that have been raised and develop a common and strategic approach to implementation planning and service development.



Therapy capacity providing Level 3 enhanced Specialised Services and Supports to CDNTs and PCTs shall be structured in such a way to ensure service quality and sustainability. This entails dedicated WTE posts, delivered by therapists with competencies in FESD management, who are supported to maintain and develop these competencies on an ongoing basis (including increased clinical specialist capacity).

The exact determination of the allocation and spread of Enhanced FESD Management structures for a particular cluster of network teams or region will depend on local mapping and profiling. This will require a pragmatic approach with factors such as geographical spread, service delivery logistics and population profile being relevant.

Operational management and clinical governance arrangements for these structures shall be clearly outlined.

It is acknowledged that the structures to deliver specialised FESD pathways may vary slightly in regions related to existing capacity and service arrangements. However, every child with FESD needs should have access to the FESD services and supports outlined above and all future service developments shall be in accordance with the models outlined in this document.

The NCPPD's Interim Guidance on Clinical Supervision provides advice in relation to Clinical Supervision arrangements to support CDNTs.

9.0 Review

The NCPPD recommends a review of the implementation of the recommendations of this document within 2 years of formal approval.

10.0 Acknowledgements

In addition to the overarching Task Group and FESD Working Group for this work (Appendices 2 & 3) the National Clinical Programme for People with Disabilities (NCPPD) would like to acknowledge the many individuals in acute and community services and management who reviewed and gave feedback on this document and pathways.



11.0 References

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Appendix 1 - IASLT Competency levels for FEDS

Table 1: Knowledge base and Skills required at a basic level

<i>Knowledge Base</i>	<i>Resultant Skills Base</i>
<p>Knowledge</p> <ul style="list-style-type: none"> • Anatomy and physiology of the head and neck • Neurology and neurophysiology including the neurology of swallowing and the coordination of respiration, swallowing and phonation • Oral motor function and its impact on speech, feeding and swallowing skills • The normal swallow • Developmental sequences • The aetiology of dysphagia and its implications for management • Key terms in dysphagia • The referral process and case history • Associated legal issues • Ethics of decision making • Risk management including health and safety • Awareness of the needs of clients with complex conditions including tracheostomy, ventilator dependant and rare conditions • Awareness of roles of multidisciplinary members <p>Assessment</p> <ul style="list-style-type: none"> • Clinical assessment including manual oral motor examination and assessment of a pharyngeal swallow • Be familiar with commonly used assessments which will include a trial of food consistencies 	<p>It is expected that graduates from an SLT qualifying course will be able to</p> <ul style="list-style-type: none"> • Carry out a detailed case history on a client with a non-complex condition (i.e. excluding complex conditions e.g. tracheostomy, neonates) • Carry out an assessment on a client with a non-complex condition to detect the presence or absence of dysphagia, this may include oropharyngeal examination, assessment of dry swallow and trial of food consistencies • Make recommendations for management of a client with a non-complex condition with feeding and swallowing difficulties • Recognise the limitations of his/her competencies and make appropriate onward referral to SLTs more experienced in this area • Consult and liaise with other members of the multidisciplinary team including their speech and language therapy supervisor. <p>AT this level SLTs should not be conducting or interpreting Videofluoroscopies independently.</p> <p>IASLT recommend that SLTs at this level maintain supervisory/advisory links with a senior, more experienced therapist for consultation and discussion. This will facilitate transition to the next level of knowledge/skills. Therapists at this level must not undertake tasks that they do not feel competent to perform.</p>



<ul style="list-style-type: none">• Be aware of the need for further instrumental assessment e.g. videofluoroscopy, FEES <p>Management</p> <ul style="list-style-type: none">• Management strategies including compensatory techniques e.g. physical positioning and modifying food and liquid consistencies• Service delivery including multidisciplinary working and case load management issues• Prognostic indicators• Consideration of environmental factors and the role of carers• Consideration of negative psychosocial impact of feeding and swallowing disorders on the individual and carers• Awareness of non-oral feeding options• Direct treatment (See section on treatment/page 31) including oral motor and sensory treatment programmes	
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Transition to LEVEL 2 Intermediate

In order to make a transition to the next level of knowledge and skills, SLTs will need to undertake and demonstrate involvement in a variety of CPD activities [IASLT 2007].

It is expected that this would take a minimum of 12 months clinical experience. At the end of this time, with appropriate support and resources, the person should be able to demonstrate the necessary skills.

Table 2: Knowledge and skills on transition to level 2

<i>Knowledge Base</i>	<i>Resultant Skills Base</i>
<p>Knowledge</p> <ul style="list-style-type: none"> • Evidence based practice across relevant areas at this level of expertise • Current specialist procedures • Prognostic indicators • Associated legal issues and ethical decision making • The needs of clients with complex conditions including tracheostomy, neonates, progressive illness, ventilator dependent and rare conditions • Identifying own role within the multidisciplinary team and understanding the roles of other team members • Current neurophysiological developments e.g. oesophageal function • Factors pertaining to aspiration • understanding of current terminology in the field of dysphagia • Specialist equipment including appropriate seating and utensils for the client group • Local dysphagia policy • Evidence based practice in relation to non-oral feeding options • Knowledge of a range of formal and informal procedures • Knowledge of psychosocial factors related to dysphagia 	<p>While maintaining an awareness of when to seek advice/support from a more experienced practitioner it is expected that a therapist working without supervision would be able to</p> <ul style="list-style-type: none"> • Prioritise and manage a dysphagia caseload within the context of a larger case load • Use compensatory techniques within therapy • Optimise the environment for the client and carers in relation to eating and drinking • Contribute to the decision making process regarding risk factors and non-oral feeding • Advise on risk management • Apply management strategies including compensatory techniques, therapeutic exercises, positioning and food consistencies • Interpret videofluoroscopy and recommend appropriate management where appropriate • Select appropriate assessment procedures • Train other professionals and carers • Advise and support clients, relatives, carers and professionals in the multidisciplinary team • Co-ordinate a multidisciplinary approach • Provide basic training within the multidisciplinary team



<p>Assessment</p> <ul style="list-style-type: none">• Independent recommendation for instrumental assessment <p>Management</p> <ul style="list-style-type: none">• Management strategies e.g. compensatory techniques, therapy exercises• Participation on team consultations in relation to non-oral feeding methods	
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Transition to Level 3 Advanced

- Peer recognition confers this status in response to the demonstration of highly developed specialist knowledge and skills normally with reference to one particular client group
- Special responsibilities in supervisory, teaching and advisory roles would also be expected
- At this level therapists have a key role in promoting knowledge and interest in current research and encouraging collaborative and research work with other professionals
- Therapists would be working independently but still seeking peer supervision and discussion to maintain and develop clinical skills.
- A therapist may be considered to have reached this level through attendance at recognised/approved professional courses and/or extensive clinical practice.
- There should be a sense of progression over time, accruing experience of extensive clinical and research work in dysphagia coupled with an awareness and ability to inform on issues at an appropriate level

Table 3 Knowledge base and skills for therapists transitioning to Level 3 advanced

<i>Knowledge Base</i>	<i>Resultant Skills Base</i>
<ul style="list-style-type: none"> • Current research with respect to advanced practices in the assessment and management of clients with dysphagia • Complex conditions e.g. tracheostomy, neonates, progressive illness, ventilator dependents and rare conditions 	<p>A therapist working at this level in the clinical area of dysphagia would be expected to be able to</p> <ul style="list-style-type: none"> • Manage complex conditions as above • Lead a multidisciplinary team • Clinically supervise others • Train others in dysphagia • Advise on service planning and development • Identify research needs and take initiatives forward • Share clinical expertise and facilitate development in others



Appendix 2 -Specialised Services and Supports Task Group Members

Membership	Representation
Mac MacLachlan (Chairperson)	Clinical Lead, National Clinical programme for People with Disability (NCPD)
Mike Walsh	Programme Manager, NCPD
Lorraine Dempsey	Parent and Lived Experience
Fionna Brennan	Child Health Ireland
Edel Quinn	CHO Heads of Service Disability
Briega Byrne	Progressing Disability Services Project Managers
Ann McGreal	Children's Disability Network Team Managers
Maeve Raeside	National Primary Care Operations
Tony McCusker, Laura Molloy (initially)	National Mental Health Operations
Ann Bourke, Angela O'Neill	National Disability Operations
Denise McDonald*, Siobhan Gallagher	Medical Subcommittee to NCPD* and Consultant Paediatricians
Therese O'Loughlin, Riona Morris (initially)	Umbrella Bodies Disability
Gillian O'Dwyer	Heads of Discipline, HSCP
Renjith Joseph	Physiotherapy Subcommittee to NCPD Disability Advisory Group (DAG)
Karen Henderson	Speech and Language Therapy Subcommittee to NCPD DAG
Mary McGrath	Occupational Therapy Subcommittee to NCPD DAG
Karen Cowan	Dietetics Subcommittee to NCPD DAG
Liam O'Callaghan	Nursing Subcommittee to NCPD DAG
Kate Falvey	Psychology Subcommittee to NCPD DAG
Rose Bradley	Social Work Subcommittee to NCPD DAG



Appendix 3- Feeding, Eating, Drinking and Swallowing (FEDs) Working Group

Membership	Representation
Mike Walsh (Chairperson)	Programme Manager NCPPD
Karen Henderson	Speech and Language Therapy Manager, Cheeverstown Services
Ciara Murphy	Clinical Specialist FEDs Team CRC, previously Senior Speech and Language Therapist, Enable Ireland.
Denise McDonald	Consultant Paediatrician, CHI.
Heather O'Tuairisg	Senior Occupational Therapist, CRC FEDs Team
Olivia Kelly	Senior Community Dietician, CDNT Tullamore
Lorraine Dempsey	Parent and Lived Experience
Caitriona Wright	Early Childhood Practitioner, CDNT, Enable Ireland, Tallaght
Muireann McCleary	Speech and Language Therapy Manager and FEDs Team CRC
Ruth Kevlin	Principal Psychologist and FEDs Team CRC
Siobhan Gallagher	Consultant Paediatrician, University Hospital Limerick & CHO 3 Disability Services
Veronica Kelly	Consultant in Paediatric Neurodisability CHI and CRC
Mairead O'Sullivan	Senior Paediatric Dietician, Children's Disability Network 3 Kilkenny, Enable Ireland