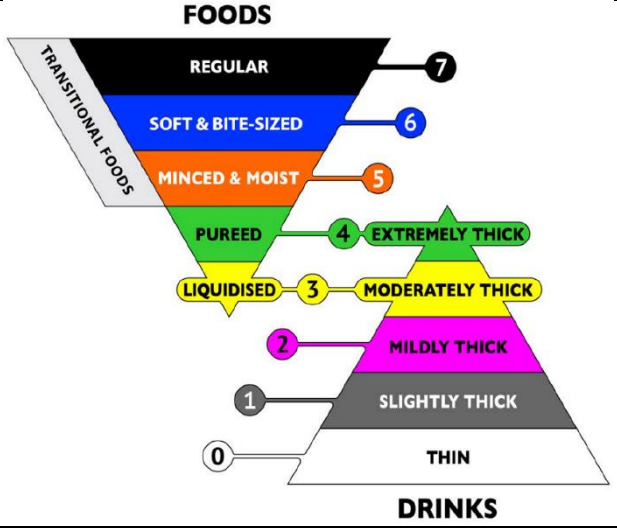
NDIS LWB 5524 Mealtime Management - Plan

- This plan can only be completed by a Health Professional such as a Speech Pathologist / Accredited Practising Dietitian or Occupational Therapist with the person and/or guardian
- This plan needs to be reviewed at least annually by a Health Professional or, as determined in the review section or, when the person's needs change, or the plan no longer appears to support them.

Important: All staff providing support with eating and drinking must understand this Mealtime Management Plan before attempting to modify foods or fluids. Contact the plan author for any changes or if the person is having difficulty.

Name:		**CIRTS No:**	
Weight:		**Height:**	
Date of Plan:		**Review due:**	
Food Allergies:	☐ No ☐ Yes: ➔ Refer to NDIS LWB 5582 Allergy Response Plan for response strategies.		
PRN Medication ☐ Yes➔ refer to medication chart **Epi Pen Required** ☐ Yes➔ must be available			
Severe Dysphagia ☐ No ☐ Yes			
Enteral Feeding	☐ No ☐ Yes➔ use NDIS LWB 5623 Enteral Feeding and Management - Protocol		
Oral Intake *(must be completed by the Health Professional)*			**N/A** ☐
Foods:			
Fluids:			
Texture Modified Foods or Drinks? ☐N ☐Y if Yes, indicate IDDS Level below ⬇			
IDSSI Level for Foods:			
IDSSI Level for Drinks:			

Note: Where a diagnosis of Severe Dysphagia has been determined by AQHP, the plan author or a speech pathologist will be required to train staff in the person's requirements and sign off on staff training in Staff and Health Professional Declaration section.
For any other person with a Mealtime Management Plan – A Frontline Leader who has completed the mandatory LWB My Meals My Way Masterclass can orientate staff in the requirements of the Mealtime Management Plan and sign off on staff orientation in Staff and Health Professional Declaration

Prescribed Mealtime support *(completed by Health Professional)*	
Dietetic recommendations for eating (amounts):	
Dietetic recommendations for drinking (amounts):	
Special Diet:	
Prescribed modified eating utensils:	
Alertness:	
Safe Positioning – During the Meal:	
Safe Positioning – After the Meal:	
Position for staff to maintain during the meal – e.g. to left, to right, hand on hand, sitting beside.	
Assistance required to eat / drink:	
Oral Care after meals:	

[1]Medication requirements – instructions for crushing / giving with foods:		
Level of Supervision required	**while eating and drinking:**	
	to prevent grabbing foods and fluids:	
	to prevent re-distribution of foods or fluids:	
	after meals:	

Preferences *(completed by Health Professional with input from the person and staff)*	
Cultural Considerations:	
How I like to be Involved - Menu planning, participation in making the meal, setting the table	
Where I Like to Eat - table setting, preferred seat, noise level, companions	
Food I Like:	
Drinks I Like:	
Food & Drinks I prefer to avoid:	
Preferred Eating Utensils: (if none prescribed)	
How Long I Usually Take to Eat :	

[1] Medication must be prescribed and administration signed for in the person's Compact Medication Chart

How I Communicate (refer to Client Profile for more detailed information)	
I am Full:	
I Would Like More:	
I Need Help:	
I Like Something:	
I Dislike Something:	
I am in Pain, Feel Sick:	
Other:	
Preferred places to eat out:	
How I like to travel there:	
What I need to take with me (equipment / communication):	
What support I need to order:	
What support I need to pay for my meal:	

Provide photographs, as relevant, of:

- food and fluids correctly modifed
- the person in the correct position
- correct equipment setup
- correct use of equipment
- being assisted by staff correctly

Photographs *(increase size as needed)*

Mealtime Management Plan developed by: *(completed by Health Professional(s))*			
Name:		**Profession:**	
Phone Number :		**Date:**	
Signature:			
Name:		**Profession:**	
Phone Number :		**Date:**	
Signature:			

Review of Plan *(completed by Health Professional)*			
☐ **Set review:**	**Date:**	**Profession:**	
Signature:			

☐ **Signs a review of this plan should occur immediately:** This plan will be reviewed following:

- a problem being identified while following this plan
- a new risk being identified via completion of the Nutrition and Swallowing Risk Checklist
- the person's needs changing
- advice from the person's GP/ Allied Health Professional
- other *(Health Professional please specify)*

Consent - I have reviewed this Mealtime Management Plan and hereby consent to the strategies detailed here to be implemented in order to assist in the management of my meals.

Name	Relationship to Person	Signature	Date
	Self (if able to sign)		
	Authorised Decision Maker *Must sign if person does not self-consent*		

Staff and Health Professional Declaration *All staff who work with this person to sign. Where training and/or orientation has been provided, the Frontline Leader or Allied Health Professional (for HIDPA -Severe Dysphagia) should also sign to indicate staff have been trained and can support the person safely.*

I have read and understood this Mealtime Management Plan and have received training in food and fluid modification relevant to the person's support needs. I agree to follow this plan.

Staff Name	Signature	Date	Frontline Leader/Health Professional Name	Signature	Date

Upload to CIRTS as follows:

Plans & Assessments > New Plan > Plan name – [select from drop down] Mealtime Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD

Review – *(completed by Health Professional)*

- A Health Professional must review Plans at least annually or as often as determined by the Health Professional. The Health Professional should also include signs that, if observed by staff, indicate an immediate review should take place. LWB Disability Support Staff must also monitor the person's health in the context of the STOP AND WATCH principles outlines in the NDIS LWB 5501 Health and Wellbeing - Procedure
- Plan Reviews can only be completed by the health professional who originally developed the plan or another health professional with equivalent qualifications. If the health professional has changed since the original plan was developed, they may wish to develop a new plan.
- If the current plan no longer meets the needs of the person, a new plan is required.

Treating Health Professional Declaration

I have today reviewed this plan and confirm that it remains appropriate to meeting the needs of the person.

Health Professional Name and Title	Health Professional Signature	Date