Simulation-based Learning Program

Clinical educator workbook: Day 4

Developed as part of the *Embedding Simulation in Clinical Training in Speech Pathology* project 2014 – 2018

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	Simulation 8: Mr James (Jim) Parker
	Simulation 9: Mr Selwyn Walker
	Simulation 10: Ms Emily Gleeson
12:00pm	LUNCH
12:45pm	**Simulation 11:** Mrs Margaret Henderson (therapy session)
3:00pm	Simulated patient feedback
3:15pm	Afternoon tea
3:30pm	**Prebrief Simulation 12:** Mr James (Jim) Parker - Review videofluroscopy
4:30pm	Preparation for Day 5
5:00pm	Close of Day 4

Day 4 Run sheet

Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
8:30am – 8:45am	Clinical educator	Stop-Keep-Start debrief	Teaching room	Students will reflect on experiences of simulation program so far and prepare for the remainder of the program.	Stop-Keep-Start
8:45am – 9:15am	Clinical educator	General preparation time	Teaching room	1. Student pairs to plan for the sessions that they are conducting. 2. Discuss which pair they will be observing.	
9:15am – 11:30am	Clinical educator Simulated patients (Beth, Jim, Emily and Claire the dietitian). NB: Student pairs will assess/review one patient only. They will observe the remaining 3 patient sessions. Simulation unit rotates around	**Simulations 7, 8, 9, and 10** → *Immersion sessions with simulated patients.* Simulation 7 case: Mrs Beth Connor. 32yo female. Inpatient Neurosurgical ward. Admitted pre-operatively for brain tumour resection. → Student pair will conduct a pre-operative communication screen and discuss role of speech pathology in pre-operative / post-operative care. Outline of session included (page 9)	Simulation lab hospital ward	1. Effectively conduct bedside screening assessments of speech, language and swallowing. 2. Identify need for instrumental assessment (namely VFSS) with support from clinical educator. 3. Effective communication with patients and MDT members regarding assessment results and recommendations.	

Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
	hospital bays until all patients are seen. *NB: Patients can be seen in any order. If you have the same simulated patient play Beth and Emily you should put another simulation between these two to allow the actor time to change and prepare.*	Simulation 8 case: Mr Jim Parker. 70yo male. Inpatient general medical ward. Urinary tract infection (UTI), delirium, dysphagia. → student pair will complete clinical swallow examination with Jim and identify need for VFSS with support from clinical educator. Simulation 9 case: Mr Sewlyn Walker. 89 yo Male. Admitted from RACF to Ortho ward post fall and #NOF. Dementia. Clare – Dietitian (DN). → Student pair will discuss diet/fluid recommendations for Selwyn and provide education on dysphagia to DN. Simulation 10 case: Ms Emily Gleeson. 35yo female. Inpatient neurology ward. Admitted post relapse of multiple sclerosis. Dysphagia and dysarthria. → Student pair will conduct clinical swallow examination and informal motor speech assessment. Will also discuss appropriate strategies for speech and swallowing and ongoing speech pathology involvement.		4. Confidently introduce themselves and explain role of speech pathology in patient care. 5. Gather case history information from patient. 6. Suggest compensatory strategies as appropriate.	

Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
		Outline of session included (page 26) **Simulation timing:** 135 mins allowed in total to complete all simulations. For each simulation each student pair will have 1-2 mins for handover to clinical educator prior to each session; 15 mins to conduct the assessment/review and 10mins to discuss the case with the clinical educator and their peers following the simulation (time to move between simulations included in overall time).			
11:30am – 12:00pm	Clinical educator All students – large group discussion	**Debrief simulations 7, 8, 9, and 10** • Complete debrief activities (workbook).	Teaching room		Plus Delta or Pendleton
12:00pm		LUNCH (45 minutes)			
12:45pm – 1:30pm	Clinical educator All students –large group discussion	**Prebrief simulation 11: Mrs Margie Henderson** • Prebrief workbook activities	Teaching room	1. Revisit therapy intervention skills for a patient with aphasia. 2. Develop session plan for specific target area that each student pair will be conducting.	

Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
				3. Discuss the need for contingency plans to be used in response to patient performance during session.	
1:30pm – 2:45pm	Clinical educator Simulated patient (Margie) NB: Each student pair complete 1 x activity (speech, expressive language, receptive language and/or swallowing) with Margie. Students to observe other sessions.	**Simulation 11: Mrs Margie Henderson** Case: Mrs Margaret Henderson. 66yo female. Post left hemisphere stroke. Dysphagia, dysarthria, aphasia. Student pairs each **complete 1 therapy activity from session plan (provided)** with Margie. Therapy to target swallow, speech, receptive language and expressive language. Facilitator will use pause-discuss method to support students during session. Other students to observe session. **Simulation timing:** 75 mins simulation (15 mins per student pair). Change over time between pairs has been included in overall timing.	Simulation lab Hospital ward	1. Clearly explain therapy task requirements to patient with aphasia. 2. Adapt session requirements during session depending on patient performance. 3. Provide relevant, specific feedback during session to support patient.	
2:45pm – 3:00pm	Clinical educator All students – large group discussion	**Debrief simulation 11** • Complete debrief workbook activities.	Teaching room	1. Facilitated discussion regarding the session guided by debriefing tool.	Appreciative Inquiry or Advocacy Inquiry
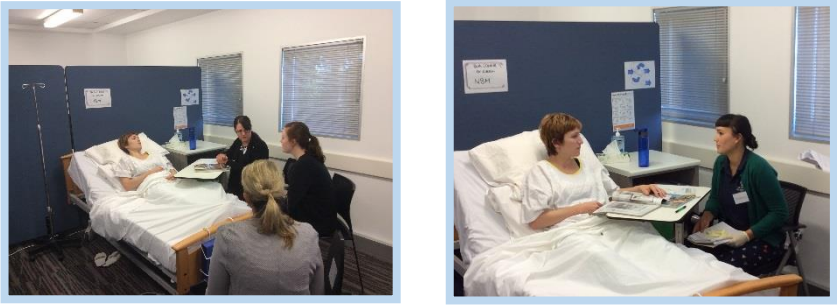
Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
3:00pm – 3:15pm	Clinical educator Simulated patient (Margie)	**Simulated patient feedback** Clinical educator to introduce simulated patient (out of role) to provide students with feedback. Simulated patient to provide feedback to all students using structured *Simulated Patient Feedback to Students* form.	Teaching room		
3:15pm	AFTERNOON TEA (15 minutes)				
3:30pm - 4:30pm	Clinical educator All students – large group discussion	**Prebrief simulation 12: Mr Jim and Mrs Betty Parker** Case: Mr Jim Parker. 70yo male. Inpatient on General Medical Ward following admission for a urinary tract infection (UTI) and associated delirium. Concerned regarding aspiration risk. Dysphagia. Scenario: Following initial clinical swallow examination (on Day 4), a VFSS was conducted. Speech pathology student clinicians will need to discuss the results of assessment and diet/fluid recommendations with Jim and Betty prior to his discharge.	Teaching room	Student tasks: 1. Review the footage and assessment report of the VFSS with support from the clinical educator. 2. Participate in discussion with the clinical educator regarding interpretation of results and tips for educating family members.	

Time	Simulation team	Activity/simulation	Location	Student learning focus	Debriefing tool
		Outline of session (see Day 5 clinical educator Guide, page 7).			
4:30pm – 5:00pm	Clinical educator	**Preparation for Day 5:** • Discharge meeting with Jim and Betty. • Clinical educator to allocate each student a case to discuss for simulation 13 – case summary and handover. NB: there are a total of 7 cases. If you have 8 students, allocate one patient per student but split Margie's case into 2. If you have 7 students allocate 1 patient per student. If you have 6 students, allocate all patients except Selwyn's case (as he has been discharged). **Statistics:** Students document stats from Day 4 in workbook.	Teaching room	1. Document statistics. 2. Practice / role play with pair for simulation 12, Day 5. 3. Review medical chart for case summary and handover for simulation 13, Day 5.	
5:00pm		Close of Day 4			

Stop-Keep-Start		
Debriefing Tool	Clinical educator prompts	Feedback / Notes
Stop - Keep – Start Focusses attention on behaviours to 1. **Stop** doing 2. **Keep** doing, and 3. **Start** doing	Can conduct this as a group, pair or individually: Reflect on your learning from the 3 days so far of the simulation week • Are there behaviours that you think you will stop doing? Have others advised this? • If you stop doing some behaviours, do you think this will open up the opportunity to try something new and different for the remainder of the simulation days? • Are there behaviours that you're doing right that you feel, and others feel you should do more of? • If you 'keep' these behaviours, how might this help your learning for the remainder of the simulation days? • What behaviours do you think you will start in the remainder of the simulation days? Have others suggested behaviours to start? Why do you think this is the case? What benefits do you think this will bring to your learning?	

SIMULATION 7: Mrs Beth Connor

Patient information	• Beth is a 32 year old woman, admitted to the NSHS yesterday. • 2 weeks ago Beth had a right ACL knee reconstruction. • She saw her GP following discharge home after her surgery. At this time she was complaining of severe headaches. The headaches had started following her surgery and had persisted for 10 days. • She also reported some blurred vision and ataxia. • She has not had headaches of this nature prior to the ACL surgery. • Beth's GP ordered an MRI of her brain and cervical spine. • The MRI brain report revealed a left cerebellar lesion. • On receipt of the scan results, Beth's GP contacted Dr Watson, Neurosurgeon at National Simulation Health Service (NSHS) hospital. • Beth was subsequently admitted to the Neurosurgical ward and scheduled for an urgent resection/removal of the tumour. • The surgery is scheduled for later today. • Beth has been informed that post-operative radiotherapy may also be required. • To manage the headaches and pain post-surgery Beth has been prescribed: Endone, Diazepam, Nurofen, Panadol and Tramadol.
Overview of the simulation	Students will attend the bedside to complete a pre-operative communication screening assessment. The purpose of this task is to obtain a baseline measurement of Beth's current communication skills. The same assessment will be conducted post-operatively to determine if there have been any changes with Beth's communication skills as a result of the tumour resection/removal. Student clinicians will be required to discuss the post-operative course with Beth regarding her communication skills (e.g., that there will be swelling immediately post-surgery, some symptoms may persist etc.). Beth is very anxious about the surgery and is waiting for Tim (her husband) to arrive at the hospital prior to her surgery. Beth appears like she has a bad headache and needs to put a lot of effort into concentrating on what is being said to her. The volume of her voice is considerably low and she is presenting with a mild-moderate dysarthria. Beth reports that her speech has not sounded 'normal' since her ACL reconstruction surgery and she is speaking more quietly than usual. The student clinicians are required to: 1. Discuss the post-operative course with Beth regarding her communication skills. 2. Complete an informal screening assessment of Beth's speech and voice. The student pair will have a total of 30mins to complete the following: approx. **1-2 mins** to complete a verbal handover to the clinical educator prior to the session, **15mins** to assess Beth and **10 mins** to discuss the case with the clinical educator and other students following the session.

Setting	Beth is resting in bed but awake and willing to participate in the session.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Effectively conduct a pre-operative screening assessment of communication skills. 2. Effectively communicate information to the patient regarding the likely post-operative course in relation to her communication skills.
Debriefing model/s	Plus Delta or Pendleton

Session overview

NB: This overview has not been provided to the students as it is hoped that they will be able to develop a session plan themselves. This is here as a prompt if required.

1. **Introduction and outline of the session:** introduction and acknowledgement that patient is scheduled for surgery later that day. Provide an outline of the session – complete oromotor assessment and communication screen prior to surgery.
2. **Oromotor assessment:** students to conduct pre-operative oromotor assessment. Aware that patient is NBM awaiting surgery (able to use *Informal Motor Speech Assessment – Dysarthria* screening tool)
3. **Communication screen:** using the *Informal Motor Speech Assessment – Dysarthria*, students are to assess Beth's speech and communication skills.
4. **Education and support:** provide education regarding speech pathology services and reasons as to why Beth is experiencing difficulties with her speech and reduced volume of her voice.
5. **Follow-up plan and questions:** Discuss post-operative course for speech pathology – reassessment of communication skills

Patient information	
Name	Beth Connor
Age	32 years
Address	16 Main Avenue, Newtown
Occupation	• Beth works full time as a teacher at the local primary school. • She is a well-respected member of the community.
Personality	• Social, active young woman. • She loves socialising with friends.
Family	• Husband (Tim Connor). They have been married for 2 years. • No children. • Tim is a very supportive husband.
Hobbies	• Beth is a busy teacher but enjoys being active on the weekends – going for walks, bike rides. • Beth and Tim both enjoy playing a variety of sport. • They are both planning to travel at the end of the year. • Beth plays netball weekly.
Medical History	• Beth recently injured her right knee playing netball for your club. • She required a right anterior cruciate ligament (ACL) knee reconstruction surgery to prevent any further ligament damage. • Other than the ACL reconstruction 2 weeks ago, this is the first time that she has had a hospital admission. • She is otherwise fit and healthy with nil other medical conditions. • Previously tolerated a normal diet and thin fluids.

Debriefing Simulation 7

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Effectively conduct a pre-operative screening assessment of communication skills. 2. Effectively communicate information to the patient regarding the likely post-operative course in relation to her communication skills.	**Plus Delta** **Plus** defines **what is going well**. **Delta** defines what needs changing to **improve learning**	**Thinking about that simulation:** - What went well in that simulation? - What did you observe in others that worked well in that simulation? - What do you think you need to change to improve your learning? (as a group or individually)	
OR			
	Pendleton Focusses on the **learner self-evaluating** before the facilitator provides feedback.	**Thinking about that simulation:** • How did you feel in that session? • Tell me what you think went well? • Why do you think this went well? • I think that you went well in ……………, when you ………… (might	

Debriefing Simulation 7

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
	Focusses on **positive aspects** before those aspects which require development.	do this as a group or pointing out specific observations of individuals) • I think this was because you were able to………. because I observed you …………. (be specific in situation observations) • I wonder what you feel you could have done a little better. What do you think? (might do this as a group or pointing out specific observations of individuals) • Why do you think this was the case? • I think that you could have …….. because I observed that you didn't........ (make specific suggestions for reasons) • I wonder if you could improve in this by ……. (name suggestions for change) • Overall, I think you were strong in the areas of ………… (up to 3 areas of strength) and I think it would be great if you could focus on improvement in ………. (up to 3 areas for improvement) • Let's review your progress in the next simulations.	

Debriefing Simulation 7

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes

Clinical educator self-evaluation at conclusion of simulation

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?

SIMULATION 8: Mr James (Jim) Parker

Patient information	• Jim is a 70 yo gentleman who presented with a 2 day history of frequent urination, fever and confusion. • Betty took Jim to the Emergency Department of the National Simulation Health Service (NSHS) – the local tertiary hospital. • Jim was diagnosed with a urinary tract infection and associated dehydration and admitted to the ward for IV antibiotics and monitoring. • His levels of alertness and confusion have been fluctuating since he was admitted. • Jim has developed a cough and fever. Signs of a chest infection were seen on a chest x-ray that the doctors ordered. • The doctors are worried that Jim has been having trouble swallowing and asked speech pathology to conduct an assessment. • Jim has a previous history of smoking for about 30 years (around 10 cigarettes a day) from the age of 20 through to 50 years. Jim quit smoking about 20 years ago. • He has a history of recurrent chest infections.
Overview of the simulation	Student clinicians will attend the bedside to conduct a clinical swallow examination of Jim. Following the assessment, the student clinicians will be required to discuss the results of the assessment with the patient and recommend a safe oral diet. With support from the clinical educator, the student clinicians will identify whether there is a need to conduct an instrumental swallow assessment. During the speech pathology assessment, Jim is cooperative with the student clinicians. He is alert but remains vague during conversation secondary to improved but not resolved cognitive dysfunction. The student clinicians are required to: 1. Conduct a clinical bedside swallowing examination. 2. Discuss the results of the swallowing assessment with the patient and recommend a safe oral diet and fluids based on the results. 3. Identify the need for an instrumental assessment of swallow with support from the clinical educator. A pair of student clinicians will have approx. **1-2 mins** to complete a verbal handover to the clinical educator, **15 mins** to assess Jim and **10 mins** to discuss the case with the clinical educator and other students.

Setting	 Jim is in his bed awaiting the arrival of the student clinicians.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Effectively conduct a clinical swallow examination. 2. Appropriately discuss swallow assessment results with the patient 3. Recommend an appropriate, safe oral diet for the patient based on results. 4. Identify the need for an instrumental assessment of swallow with support from clinical educator.
Debriefing model/s	Plus Delta or Pendleton

Session overview

NB: This overview has not been provided to the students as it is hoped that they will be able to develop a session plan themselves. This is here as a prompt if required.

1. **Introduction and outline of the session:** introduction and provide an outline of the session – complete oromotor assessment and swallow assessment.
2. **Oromotor assessment:** students to conduct oromotor assessment. Aware that patient has been having difficulty since admission with eating and drinking (able to use *Clinical Swallow Exam screening assessment*).
3. **Swallowing assessment:** Students are to assess Jim's swallowing.
4. **Education and support:** provide education regarding speech pathology services and reasons as to why Jim may be experiencing dysphagia currently.
5. **Follow-up plan and questions:** Discuss modified diet and fluids that Jim is required to commence on following swallowing assessment results. Advise Jim that he will require a VFSS assessment as there are concerns regarding current swallowing ability and pre morbid history of chest infections and smoking history.

Patient information	
Name	James Edward Parker
Preferred Name	Jim
Age	70 years
Address	15/238 Daniel Street, Newtown
Occupation	• Wife (Betty Parker). They have been married 32 years. • They have 3 sons that live nearby. • All of their sons are married with children. Jim and Betty have 5 grandchildren in total.
Personality	• Retired Carpenter
Family	• Pleasant but easily frustrated at times particularly when Jim can't hear what has been said. • Cooperative however Jim would much rather Betty handles everything.
Hobbies	• Sunday BBQ lunch with the family each week • Lawn Bowls. Jim plays at the local club 1-2 times per week. • Catching up with friends. Especially for a beer at the bowls club on a Friday afternoon.
Medical History	• Mild-moderate hearing loss in both ears although Jim refuse to wear hearing aids. • Jim has normal eyesight for his age and does not need glasses. • Diabetes Type 2 – although this is well managed through medication (*Metformin Hydrochloride* tablets twice daily). • Jim has a previous history of smoking for about 30 years (around 10 cigarettes a day) from the age of 20 through to 50 years. Jim quit smoking about 20 years ago. • He has a history of recurrent chest infections.

Debriefing Simulation 8			
Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Effectively conduct a clinical swallow examination. 2. Appropriately discuss swallow assessment results with the patient 3. Recommend an appropriate, safe oral diet for the patient based on results. 4. Identify the need for an instrumental assessment of swallow with support from clinical educator.	**Plus Delta** **Plus** defines **what is going well**. **Delta** defines what needs changing to **improve learning**	**Thinking about that simulation:** • What went well in that simulation? • What did you observe in others that worked well in that simulation? • What do you think you need to change to improve your learning? (as a group or individually)	
OR			
	Pendleton Focusses on the **learner self-evaluating** before the facilitator provides feedback.	**Thinking about that simulation:** • How did you feel in that session? • Tell me what you think went well? • Why do you think this went well?	

Debriefing Simulation 8			
Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
	Focusses on **positive aspects** before those aspects which require development.	• I think that you went well in ……………, when you ………… (might do this as a group or pointing out specific observations of individuals) • I think this was because you were able to………. because I observed you …………. (be specific in situation observations) • I wonder what you feel you could have done a little better. What do you think? (might do this as a group or pointing out specific observations of individuals) • Why do you think this was the case? • I think that you could have ……… because I observed that you didn't........ (make specific suggestions for reasons) • I wonder if you could improve in this by ……. (name suggestions for change) • Overall, I think you were strong in the areas of ………… (up to 3 areas of strength) and I think it would be great if you could focus on improvement in ………. (up to 3 areas for improvement) • Let's review your progress in the next simulations.	

Debriefing Simulation 8			
Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
Clinical educator self-evaluation at conclusion of simulation			

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?

SIMULATION 9: Mr Selwyn Walker

Patient information	• Mr Selwyn Walker is an 89 year old male from Uptown who was admitted to the National Simulation Health Service (NSHS) hospital following a fall at his Residential Aged Care Facility (RACF).
	• Selwyn was taken to the Emergency Department by ambulance and admitted to the NSHS Orthopaedic ward.
	• An x-ray in the Emergency Department confirmed a left # neck of femur injury (#NOF). Selwyn underwent surgery to fix his fracture and his post-operative recovery has been hindered and complicated by delirium.
	• His medical history includes dementia, transient ischaemic attack (TIA) (1yr ago), Fall (1 year ago) - right ulna # and TBI (cerebral contusion on CT head) – nil residual deficits; AF, MR.
	• Selwyn lives in a nursing home and previously required assistance for all personal ADLs.
	• Previously able to tolerate a soft diet and thin fluids.
	• During his hospital stay, Selwyn has made some progress however this was impacted by his fluctuating level of consciousness and post-operative delirium on the background of his dementia.
	• On discharge it is likely that Selwyn will require ongoing physiotherapy and speech pathology to maximise patient function and to optimise his diet and fluid intake.
	• Initially speech pathology found he presented with mild-moderate oropharyngeal dysphagia characterised by signs of aspiration on thin fluids and difficulty with mastication of standard textures. Bedside examination of swallowing revealed reduced lip seal, increased oral transit time and mild-moderately delayed swallow initiation.
	• He was placed on a soft cut up diet with extra sauces and gravy, and mildly thick fluids and has received ongoing dysphagia reviews.
	• For a period of reduced levels of alertness during his stay, speech pathology downgraded Selwyn to a minced & moist diet and moderately thick fluids to ensure swallow safety; however he has now resumed the soft cut up diet and mildly thick fluids and appears to be tolerating well.
	• On trials of thin fluids Selwyn has demonstrated overt clinical evidence of aspiration (significant coughing and a wet/gurgly voice post swallow) and he remains unsuitable for upgrade at present.
	• He appears to manage the mildly thick fluids and soft cut up diet with nil clinical evidence of penetration +/- aspiration (noting that silent aspiration is unable to be excluded on a clinical bedside assessment) and appears suitable to continue on this diet/fluids.
	• Speech pathology recommend that the RACF speech pathologist complete a follow-up assessment of Selwyn within 1-2/52 of discharge to check tolerance of the diet/fluid recommendations and determine if suitable for upgrade of fluids.
	• The dietitian is concerned regarding Selwyn's low oral intake given his pre-morbid history of dementia.
	• Over the last month, Selwyn has experienced gradual weight loss of between 4-5kg.

	• The dietitian is becoming increasingly concerned and would like to prescribe daily intake of Resource 2.0 supplementation. • The dietitian is a recent new graduate and would like to speak with the treating speech pathologist about the possibility of upgrading Selwyn to thin fluids to ensure he is able to commence his nutritional supplementation.
Overview of the simulation	The student clinicians will attempt to review Selwyn at the bedside prior to his discharge back to the RACF. Selwyn has already been moved to the discharge lounge however the treating dietitian is present and wishes to discuss the management of Selwyn's oral intake. The dietitian is wanting to prescribe thin fluid supplements and will question whether or not Selwyn needs to remain on the modified fluids. The student clinicians will need to educate the dietitian on dysphagia and advocate for the needs of their patient to justify why he should remain on thickened fluids at the present time. The student clinicians are required to: 1. Discuss the current concerns of the patient with regards to his dysphagia with the dietitian. 2. Provide education to the dietitian about dysphagia and management of dysphagia. A pair of student clinicians will have approx. **1-2 mins** to complete a verbal handover to the clinical educator, **15 mins** to conduct the session and **10 mins** to discuss the case with the clinical educator and other students.
Setting	Jim will not be in his bed. The dietitian, Claire will be in the room.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Effectively communicate information regarding patient's swallowing to the dietitian. 2. Effectively explain need for continued modified fluids.
Debriefing model/s	Plus Delta or Pendleton

Session overview

NB: This overview has not been provided to the students as it is hoped that they will be able to develop a session plan themselves. Information provided here is to be used as a prompt if required:

1. **Introduction:** introduction of self to treating dietitian.
2. **Overview of Selwyn's dysphagia management:** students to provide treating dietitian with an overview of Selwyn's dysphagia management since his admission to hospital. Advise the dietitian what modified diet and fluids Selwyn has been discharged back to the residential aged care facility on.
3. **Education:** if asked, students are able to provide the dietitian with education regarding dysphagia and discuss why Selwyn would not be suitable to have supplements that were not thickened.
4. **Discussion of discharge plans and recommendations:** Students are to discuss with the dietitian what the discharge plan and recommendations are at this point.
5. **Follow-up plan and questions:** Discuss need for Selwyn to be reviewed by a speech pathologist at the residential aged care facility within the next few days.

Debriefing Simulation 9

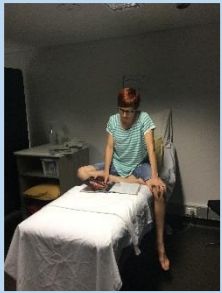| Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Effectively communicate information regarding patient's swallowing to the dietitian. 2. Effectively explain need for continued modified fluids.	**Plus Delta.** **Plus** defines **what is going well**. **Delta** defines what needs changing to **improve learning.**	**Thinking about that simulation:** • What went well in that simulation? • What did you observe in others that worked well in that simulation? • What do you think you need to change to improve your learning? (as a group or individually)	
		OR	
	Pendleton Focusses on the **learner self-evaluating** before the facilitator provides feedback.	**Thinking about that simulation:** • How did you feel in that session? • Tell me what you think went well? • Why do you think this went well? • I think that you went well in ……………, when you ………… (might	

Debriefing Simulation 9

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
	Focusses on **positive aspects** before those aspects which require development.	do this as a group or pointing out specific observations of individuals). • I think this was because you were able to………. because I observed you …………. (be specific in situation observations). • I wonder what you feel you could have done a little better. What do you think? (might do this as a group or pointing out specific observations of individuals). • Why do you think this was the case? • I think that you could have …….. because I observed that you didn't........ (make specific suggestions for reasons). • I wonder if you could improve in this by ……. (name suggestions for change). • Overall, I think you were strong in the areas of ………… (up to 3 areas of strength) and I think it would be great if you could focus on improvement in ………. (up to 3 areas for improvement). • Let's review your progress in the next simulations.	

Debriefing Simulation 9

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes

Clinical educator self-evaluation at conclusion of simulation

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?

SIMULATION 10: Ms Emily Gleeson

Patient information	• Emily is a 35 year old woman who was admitted to the NSHS yesterday.
	• She suffered a sudden decline in her functioning of her lower limbs whilst at work yesterday.
	• She does not have a previous history of dysphagia and is able to manage normal food and fluids without any difficulty.
	• There are no concerns regarding Emily's cognition or language skills.
	• She is presenting with some mild dysarthria
	• The nurses have contacted the speech pathologist to review Emily's swallow as both Emily and the nursing staff have been noticing she has been coughing frequently on her cup of tea/water/juice in the past 24 hours. This is particularly problematic for Emily when she drinks larger or multiple mouthfuls.
	• The doctors have anticipated that Emily will remain in hospital for 4 or 5 more days to monitor her symptoms and disease progression.
	• Emily is concerned regarding this and the other physical changes as these are the most severe symptom changes that she has had to date.
	• Student clinicians are meeting Emily for the first time on the acute Neurology ward in the hospital.
	• Students will attend the bedside to complete a swallowing assessment and communication screening assessment.
	• Emily presents with: o some difficulty managing large amounts of thin fluids
Overview of the simulation	Student clinicians will attend the bedside of Emily to complete a bedside communication and swallow screening assessment following her recent relapse. Student clinicians will be required to gather a comprehensive case history regarding Emily's disease progression, conduct the bedside screening assessments, explain the results with Emily and discuss the longer-term role of speech pathology in her care. The student clinicians are required to: 1. Collect important case history information about Emily's disease progression to date and typical speech and swallowing function. 2. Complete a bedside oromotor and motor speech assessment. 3. Conduct a clinical swallowing examination including the use of compensatory strategies. 4. Recommend compensatory strategies to be used for both speech and swallowing to maximise Emily's function. A pair of student clinicians will have approx. **1-2 mins** to complete a verbal handover to the clinical educator, **15 mins** to assess Emily and **10 mins** to discuss the case with the clinical educator and other students.

Setting		Emily will be in her room either sitting at the edge of the bed reading a magazine or on an electronic device.
Learning objectives		After participation in this clinical simulation, students will be able to: 1. Gather relevant case history information about a patient's disease progression to date and typical speech and swallowing function. 2. Effectively conduct a bedside oromotor and motor speech assessment. 3. Effectively conduct a clinical swallowing examination including the use of compensatory strategies. 4. Suggest appropriate compensatory strategies to be used for both speech and swallowing to maximise function.
Debriefing model/s		Plus Delta or Pendleton

Session overview

NB: This overview has not been provided to the students as it is hoped that they will be able to develop a session plan themselves. This is here as a prompt if required.

1. **Introduction and outline of the session:** introduction and provide an outline of the session – brief case history of presenting complaint, complete oromotor assessment, swallowing assessment and communication screen.
2. **Case history:** students to obtain important information from Emily pertaining to the current presentation and admission. Current difficulties with speech and swallowing.
3. **Oromotor assessment:** students to conduct an oromotor assessment. Aware that patient is on a normal diet and thin fluids but having some difficulty with large bolus of thin fluids (able to use *Informal Motor Speech Assessment – Dysarthria* screening tool).
4. **Swallowing assessment:** students to conduct swallowing assessment to determine Emily's safety to remain on thin fluids during this current relapse. Provide compensatory strategies to manage current dysphagia for larger bolus size (reduce bolus size, positioning).
5. **Communication screen:** using the *Informal Motor Speech Assessment – Dysarthria*, students are to assess Emily's speech and communication skills.
6. **Education and support:** provide education regarding speech pathology services and reasons as to why Emily is experiencing difficulties with her speech and swallowing. Discussion regarding dieseas progression if required.
7. **Follow-up plan and questions:** Discuss course for speech pathology over the next 4-5 days of hospital stay.

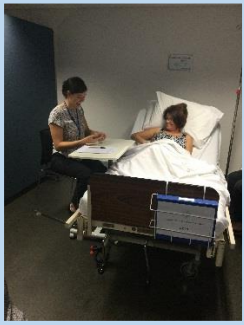| Patient information	
Name	Emily Gleeson
Age	35 years
Address	5/185 Central Avenue, Middleton
Occupation	• Emily works full time as a medical receptionist in the city
Personality	• She is a pleasant and easy going young lady • Emily loves socialising with friends
Family	• Emily lives with her partner (Simon) of 7 years • They live in an apartment in the city • Not married • No children
Hobbies	• Emily has a busy and active social life • She enjoys eating out regularly, travelling, catching up with friends, attending live music concerts and going to the beach • She does not allow her multiple sclerosis to stop her from doing anything or change her social life. • Simon and her friends are all very accepting of Emily's condition. • Do regular exercise and often at the gym
Medical History	• Emily has a 12 year history of relapsing, remitting multiple sclerosis • This is the first time that she has had a longer hospital admission for her multiple sclerosis. • Emily is otherwise a fit and healthy 35 year old. • Her multiple sclerosis is managed with regular GP visits and Neurology appointments

Debriefing Simulation 10

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Gather relevant case history information about a patient's disease progression to date and typical speech and swallowing function. 2. Effectively conduct a bedside oromotor and motor speech assessment. 3. Effectively conduct a clinical swallowing examination including the use of compensatory strategies. 4. Suggest appropriate compensatory strategies to be used for both speech and swallowing to maximise function.	**Plus Delta** **Plus** defines **what is going well**. **Delta** defines what needs changing to **improve learning**	**Thinking about that simulation:** - What went well in that simulation? - What did you observe in others that worked well in that simulation? - What do you think you need to change to improve your learning? (as a group or individually)	
		OR	
	Pendleton Focusses on the **learner self-evaluating** before the facilitator provides feedback.	**Thinking about that simulation:** • How did you feel in that session? • Tell me what you think went well? • Why do you think this went well? • I think that you went well in ……………, when you ………… (might	

Debriefing Simulation 10

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
	Focusses on **positive aspects** before those aspects which require development.	do this as a group or pointing out specific observations of individuals) • I think this was because you were able to………. because I observed you …………. (be specific in situation observations) • I wonder what you feel you could have done a little better. What do you think? (might do this as a group or pointing out specific observations of individuals) • Why do you think this was the case? • I think that you could have …….. because I observed that you didn't........ (make specific suggestions for reasons) • I wonder if you could improve in this by ……. (name suggestions for change) • Overall, I think you were strong in the areas of ………… (up to 3 areas of strength) and I think it would be great if you could focus on improvement in ………. (up to 3 areas for improvement) • Let's review your progress in the next simulations.	

Debriefing Simulation 10			
Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
Clinical educator self-evaluation at conclusion of simulation			

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?

SIMULATION 11: Mrs Margaret (Margie) Henderson

Overview of the simulation	This scenario is set whereby the student clinicians have met Margie earlier when she was admitted to hospital and they assessed her speech, language and swallowing. In this session they will be conducting a therapy session at the bedside with her. Margie remembers the student clinicians and has been receiving bedside therapy from a different clinician since the initial assessments were conducted. Margie has been upgraded recently to thin fluids and a soft diet since the students last reviewed her. Margie continues to present with dysphagia, aphasia and dysarthria. The student clinicians are required to: 1. Implement a therapy task with Margie for her speech, language and or swallowing difficulties following her stroke. 2. Provide appropriate feedback during the tasks to support Margie during this treatment session. Student clinicians will have approx. **15 mins** per student pair to provide treatment for Margie's speech, language and swallowing difficulties. Each student pair will treat a different practice area (speech, receptive language, expressive language and swallowing).
Setting	 Margie will be in bed for the therapy session.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Clearly explain therapy task requirements to a patient with aphasia. 2. Appropriately adapt session requirements within-session to reflect patient needs. 3. Provide relevant, specific feedback during and post therapy tasks to support a patient to participate effectively within the session.
Debriefing model/s	Appreciative Inquiry or Advocacy Inquiry

Therapy session plan

Patient name: Mrs Margaret (Margie) Henderson   **Date of Session:** DD / MM / YY

Session goals:
1. To introduce a rehabilitation swallowing technique (effortful swallow) to ensure that Margie's swallow function is safe and efficient.
2. To complete impairment based therapy tasks targeting receptive and expressive language and motor speech skills.

Session element	Goal / activity	Time	Materials	Criterion	Theoretical basis & rationale
1. Swallowing	• Students to teach Margie the steps required for an effortful swallow.	10 mins	Effortful swallow handout (located at the back of the student workbooks).	n/a	• Margie presents with oropharyngeal dysphagia. One component of her dysphagia is characterised by pharyngeal weakness, noted particularly with solid food. An effortful swallow is recommended to assist pharyngeal clearance of solids.
2. Receptive Language	• Student clinicians to engage Margie in semantic network with choice therapy task to target her auditory comprehension skills. • Semantic network - student clinicians to present Margie a picture with written choices. Margie is to point to the correct word when she is asked for each category e.g., Is it a panther, a wolf or a tiger? Semantically related and unrelated distractors will be used.	10 mins	Resources: semantic network task (located at the back of the student workbook). Pens / paper	90% accuracy	• Margie presents with impaired auditory comprehension skills. Semantic network therapy tasks target neural networks to improve lexical semantics. • Using the semantic relatedness of distractors can assist to grade task demands and increase / decrease complexity in relation to patient performance.
3. Expressive Language	• Students to engage Margie in a cued naming (single word retrieval) task using pictures to target improved verbal expression skills. • Student clinicians to use given cueing hierarchy to support	10 mins	Resources required: Picture cards, Cueing hierarchy Pens / paper	90% accuracy in naming pictures	• Margie presents with impaired verbal expression skills. Picture naming tasks target neural networks to improve lexical semantics • Cueing can provide support Margie to achieve success in session and may assist in identifying appropriate

Session element	Goal / activity	Time	Materials	Criterion	Theoretical basis & rationale
	Margie to name pictures of basic, everyday objects. • Students may provide more or less support depending on Margie's needs and should identify the most beneficial types of cues to use with Margie based on performance.		(located at back of student workbook)		strategies for Margie to use for word finding difficulties • Students can use amount and type of prompting to grade task demands and increase / decrease task complexity relative to patient performance.
4. Motor Speech	• Student clinicians to engage Margie in a dysarthria therapy task targeting impaired subsystems. Appropriate target areas for Margie would include lip and tongue. This will improve overall intelligibility. • Student clinicians to start with single syllable words and increase complexity of task to CV, CVC and monosyllabic words depending on Margie's needs. • Students say the stimulus item. Margie repeats the item 1 to 5 times.	10 mins	Resources: Dysarthria therapy resources (students will need to source appropriate therapy items from the university clinic). Pen / Paper	90% intelligibility	• Margie presents with moderate motor speech impairment. Targeting therapy at the impaired subsystems will help improve intelligibility of her speech sounds. • Increasing / decreasing the number of syllables or length of sequence will assist in grading task demands relative to patient performance. • Modelling / repetition of targets by clinician should be faded as possible to increase Margie's independence in task.

Note: The above therapy activities are suggestions only. Students are encouraged to discuss appropriate therapy options with you, their clinical educator and to source therapy worksheets and activities from the university clinics as required.

PLAN:
(1) Ongoing monitoring of swallow and communication and provision of therapy while on ward.

Debriefing Simulation 11

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Clearly explain therapy task requirements to a patient with aphasia. 2. Appropriately adapt session requirements within-session to reflect patient needs. 3. Provide relevant, specific feedback during and post therapy tasks to support a patient to participate effectively within the session.	**Appreciative Inquiry** The assumption of appreciative inquiry is that in every situation, something works. This approach looks for what works in a situation or learning environment and focusses on doing more of this.	**Thinking about that simulation** • Tell me what worked really well in that simulation? • What did you as a person, or you as a group do well? • What made it work well? • Describe a specific time when you felt you/your group performed really well. What were the circumstances during that time? • What do you think contributed to this working so well? • Do you have some ideas about how you could use/do more (*what worked well*) within your clinical practice?	

	OR		
	Advocacy inquiry This approach is based on **advocacy** from the facilitator in the form of objective observation and **inquiry** which explores with the learner what happened in a curious way before thinking about positive ways forward.	**Thinking about that simulation** • How did that feel? • Can you summarise what your simulation was about so we are all on the same page? • I observed you (group or individual) doing….. • I was really comfortable with this because …….. OR • I was concerned about this … because ……… • Tell me why … happened? Help me understand why … happened? • (Ask the group for input) Has this happened to anyone else? • (Brainstorm solutions) How have you dealt with this in the past? Can anyone think of any solutions or strategies? Summary and wrap up In summary, today we learned about…	

Clinical educator self-evaluation at conclusion of simulation
1. What worked well with this simulation? 2. What didn't work well with this simulation? 3. How was the timing for this simulation? 4. What would you do differently next time?

SIMULATION 12: Mr Jim & Mrs Betty Parker

<u>NB:</u> You will now commence the pre-brief for Simulation 12 which includes a review of Jim's recent VFSS. You will guide the students through this assessment and assist with their preparation for Simulation 12 with Jim and his wife Betty on the morning of Day 5.

Overview of the simulation	- Speech pathology have assessed Jim's swallowing and found him to be requiring a modified diet and fluids to manage his suspected aspiration pneumonia. - Speech pathology have also requested a Videofluroscopy Swallow Study (VFSS) to confirm the likelihood that he may be silently aspirating. - The medical team are happy with Jim's current medical status as his UTI has almost resolved and so too has his confusion. - The medical team have advised Jim and Betty that he requires the report of the speech pathology assessment results and then he will be able to be discharged home. - The medical team did advise Jim and Betty that it will be likely that he will require a modified diet and fluids for a short period of time whilst at home but the speech pathologist will need to provide information and education regarding this. - Jim has not had any previous history of dysphagia. Jim's wife Betty is present at the discharge interview. Jim and Betty are waiting to hear from the speech pathologist with regards to the swallowing assessment results. Once this information has been conveyed, Jim will be able to be discharged home. Jim and Betty are meeting with the speech pathology students to discuss: 1. The results of Jim's Videofluroscopy Swallow Study (VFSS). 2. Recommendations for the types of fluids and foods that Jim is safest to eat based on the results of the VFSS. 3. Plans for ongoing monitoring of Jim's swallowing by speech pathology on his return home. Each session will run for **15 minutes**. Each student pair will have an opportunity to conduct the session with Jim and Betty. The session will repeat 3-4 times depending on the number of student pairs.
Setting	Jim and Betty will be waiting in the discharge lounge area or waiting room for the student clinicians.

Learning objectives	- The students will conduct the session in pairs. Other students <u>will not</u> be observing the session. - It is expected they will demonstrate the following skills: - Effectively communicate the results of the assessment using appropriate language. - Make appropriate choice regarding modified foods and fluids in the management of a known patient. - Clearly explain to the patient and carer how to appropriately manage his dysphagia in a community/home environment. - Respond effectively and appropriately to patient and family questions and concerns.
Debriefing model/s	Appreciative Inquiry or Advocacy Inquiry

VFSS notes

For confidentiality reasons, the audio from the VFSS has been deleted. Below is a summary of the clinician's instructions to the patient during the videofluroscopy. Please communicate these instructions to the students during your discussion.

Thin fluids:

Trials 1 and 2:
- Patient instructed to 'have a sip' only.

Trials 3 and beyond (following the slow motion of trials 1 and 2):
- Patient instructed to 'have a few sips in a row, like you're thirsty'
- Patient instructed to 'have a big cough' following the last trial (in response to aspiration – ineffective).

Mildly thick fluids:

- Patient instructed to have 'single swallows' only.

Bread:

- Patient offered mildly thick fluids with first bread trial (due to difficulty with bolus formation).
- Multiple mildly thick fluids wash throughs prompted for subsequent trials.
- Prompted clearing swallow following 2nd mildly thick wash through
- Prompted effortful swallow following fifth mildly thick fluid wash through.
- Patient aware of residue in oral cavity but not pharyngeal residue.

Diced fruit:

- Spontaneous throat clear following first swallow.

Discharge session overview

1. **Introduction and outline of the session:** re-introduction to Jim and introduction to Betty. Provide an outline of the session – VFSS results, diet and fluid recommendations and modifications required, management plan for discharge home. Revise the role of speech pathology with regards to swallowing management.
2. **Clinical bedside swallowing management:** provide a brief overview of bedside management of swallowing whilst Jim has been admitted to hospital.
3. **VFSS results:** students to discuss the VFSS procedure and provide reasons as to why this was required to be conducted with Jim. Briefly outline the results to Jim and Betty.
4. **Recommendations:** Discuss swallowing recommendations – diet and fluid modifications and strategies. Students will need to provide information and education about thickened fluids and how to achieve the desired diet modifications including foods to avoid. Advise Jim and Betty that thickened fluids will be delivered to the home so there will be no need to thicken fluids.
5. **Plan:** Discuss the plan which includes: a referral to a community speech pathologist who will be able to visit Jim at home, reassess his swallow and determine the need for ongoing diet and fluid modifications, repeat VFSS in 2-4 weeks here at the hospital.
6. **Education and support:** provide education regarding speech pathology services and answer any questions regarding swallowing.
7. **Follow-up plan and questions:** Discuss understanding of information provided, opportunity for further questions. Clarification of follow-up plan at home.

NB: Students have been provided with resources to use in the discharge session. These resources have been provided below for your reference. If using an iPad, students may also wish to use the Dysphagia app ©.

THERAPY RESOURCES

James and Betty Parker
Discharge session simulation

Australian Standards for Texture Modified Foods and Fluids

The provision of thickened fluids and texture modified foods is a routine part of the assessment and management of feeding and swallowing difficulties (dysphagia).

If you need assistance with the level of fluid and food texture modification required, contact your Speech Pathologist.

To find a Speech Pathologist, go to **www.speechpathologyaustralia.org.au**

If you require support to determine whether a textured modified diet is meeting nutrition and hydration needs, contact your dietitian.

To find an Accredited Practising Dietitian (APD), go to **www.daa.asn.au**

FLUID

Mildly Thick Level 150

Fluid runs freely off the spoon but leaves a mild coating on the spoon.

Moderately Thick Level 400

Fluid slowly drips in dollops off the end of the spoon.

Extremely Thick Level 900

Fluid sits on the spoon and does not flow off it.

FOOD

Texture A - Soft

Food may be naturally soft or may be cooked or cut to alter its texture.

Texture B - Minced and Moist

Food is soft, moist and easily mashed with a fork; lumps are smooth and rounded.

Texture C - Smooth Pureed

Food is smooth, moist and lump free: may have a grainy quality.

APPENDIX I

Australian standardised definitions and terminology for texture-modified foods and fluids

The following fluid thickness and food texture grading scales provide terms for and descriptions of fluid and food texture modification for individuals with dysphagia (disordered swallowing).

The scales have been developed by a consultation process with dietitians and speech pathologists across Australia. The scales are a consensus standard agreed to by Speech Pathology Australia and the Dietitians Association of Australia and are encouraged for use around Australia. It is hoped that these standards will facilitate the development of the limited evidence base in this area of practice.

This project did not address:
- Nutritional or hydration adequacy of texture-modified diets, for example whether supplementary fluids may be required for individuals on thickened fluids
- Development of guidelines for clinical application or outcomes
- Client acceptability of modified foods/fluids
- Reliability of the consistency of thickened fluids

The scales have been developed to encourage standardisation of definitions and terminology across Australia. The standards are intended to be applied within the policies, procedures and capacities of individual institutions under the direction of dietitians and speech pathologists.

In Australia, speech pathologists establish dysphagia severity and determine the level of food and fluid texture modification required. Dietitians ensure that individuals who require texture-modified diets are able to meet their nutrition and hydration needs.

Four levels of texture modification have been identified for fluids and foods—unmodified plus three modified levels. Each modified level has a dual label, for example Texture A—Soft or Level 150—Mildly Thick. It is strongly encouraged that both labels be used.

The Fluid Scale has three different colours to denote the three different modified levels. These colours are a recommendation and may be used at the discretion of individual institutions or commercial companies to help identify more clearly the different levels of fluid thickness.
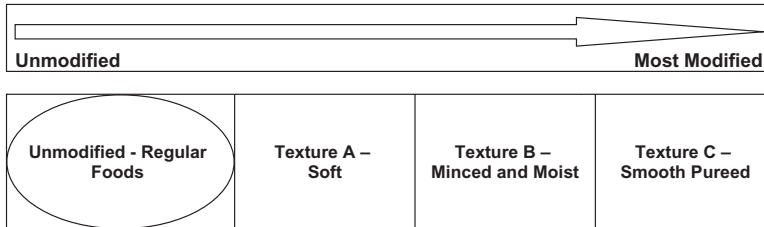
The levels noted in these scales occur on a continuum from unmodified to most modified. The scales do not relate to a scale across which an individual should travel or progress, but rather a scale across which a fluid or food item might travel as it becomes more modified.

It is important to note that speech pathologists and dietitians and the institutions in which they work should only use the levels they deem appropriate for their setting and client demographic. There is no requirement for facilities to use all of the levels and conversely there are some clinicians who will choose to add extra levels to the scales. To ensure consistency, it would be appropriate that any extra levels be referenced against the standard scale presented.
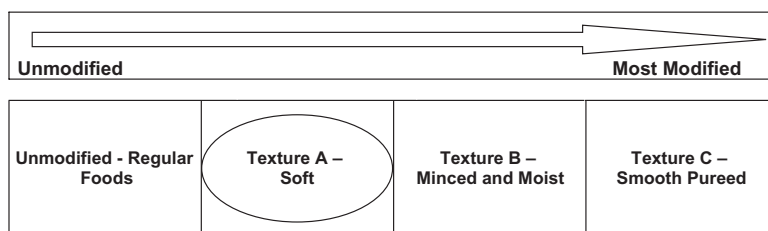
The following scales provide:
- The number of levels of food texture modification and fluid thicknesses
- The names of the levels (and for fluids a corresponding suggested colour to facilitate communication)
- A description of the levels
- Characteristics of the food or fluids that would be appropriate for that level
- Testing information—this is provided as a guide only. It is included for use in food service quality assurance activities
- Examples of *recommended foods* and *foods to avoid* for each food texture level. This list is not exhaustive and simply provides general direction

Food texture modification grading scale for the clinical management of dysphagia

Unmodified - Regular Foods	**Texture A – Soft**	**Texture B – Minced and Moist**	**Texture C – Smooth Pureed**

NAME	UNMODIFIED – REGULAR
Description	• These are everyday foods
Characteristics	• There are various textures of regular foods. Some are hard and crunchy, others are naturally soft
Food inclusions and exclusions	• By definition all food and textures can be included

Unmodified			Most Modified
Unmodified - Regular Foods	Texture A – Soft	Texture B – Minced and Moist	Texture C – Smooth Pureed

NAME	TEXTURE A – SOFT
Description	• Food in this category may be naturally soft (eg ripe banana), or may be cooked or cut to alter its texture
Characteristics	• Soft foods can be chewed but not necessarily bitten • Minimal cutting required – easily broken up with a fork • Food should be moist or served with a sauce or gravy to increase moisture content (NB: Sauces and gravies should be served at the required thickness level) • Refer to *Special Notes (page S72)*
Testing Information	• Targeted particle size for infants and children = less than half that for adults and children over 5 years or equal to 0.8 cm (based on tracheal size)[28] • Targeted particle size for children over 5 years and adults = 1.5 × 1.5 cm[10,27,30]

Texture A—Soft

Recommended foods and those to avoid (examples only)

	Recommended foods	Avoid
Bread, cereals, rice, pasta, noodles	• Soft sandwiches[a] with very moist fillings, for example egg and mayonnaise, hummus (remove crusts and avoid breads with seeds and grains) • Breakfast cereals well moistened with milk[b] • Soft pasta[a] and noodles • Rice (well cooked) • Soft pastry, for example quiche with a pastry base • Other, soft, cooked grains	• Dry or crusty breads, breads with hard seeds or grains, hard pasty, pizza • Sandwiches that are not thoroughly moist • Course or hard breakfast cereals that do not moisten easily, for example toasted muesli, bran cereals • Cereals with nuts, seeds and dried fruit
Vegetables, legumes	• Well cooked vegetables[a] served in small pieces or soft enough to be mashed or broken up with a fork • Soft canned vegetables, for example peas • Well cooked legumes (the outer skin must be soft), for example baked beans	• All raw vegetables (including chopped and shredded) • Hard, fibrous or stringy vegetables and legumes, for example sweet corn, broccoli stalks
Fruit	• Fresh fruit pieces that are naturally soft, for example banana, well-ripened pawpaw • Stewed and canned fruits in small pieces • Pureed fruit • Fruit juice[b]	• Large/round fruit pieces that pose a choking risk, for example whole grapes, cherries • Dried fruit, seeds and fruit peel • Fibrous fruits, for example pineapple
Milk, yoghurt, cheese	• Milk, milkshakes, smoothies[b] • Yoghurt (may contain soft fruit)[b] • Soft cheeses,[a] for example Camembert, ricotta	• Yoghurt with seeds, nuts, muesli or hard pieces of fruit • Hard cheeses, for example cheddar and hardened/crispy cooked cheese
Meat, fish, poultry, eggs, nuts, legumes	• Casseroles with small pieces of tender meat[a] • Moist fish (easily broken up with the edge of a fork) • Eggs[a] (all types except fried) • Well cooked legumes (the outer skin must be soft), for example baked beans • Soft tofu, for example small pieces, crumbled	• Dry, tough, chewy, or crispy meats • Meat with gristle • Fried eggs • Hard or fibrous legumes • Pizza
Desserts	• Puddings, dairy desserts,[b] custards,[b] yoghurt[b] and ice-cream[b] (may have pieces of soft fruit) • Moist cakes (extra moisture, e.g. custard may be required) • Soft fruit-based desserts without hard bases, crumbly or flaky pastry or coconut, for example apple crumble • Creamed rice, moist bread and butter pudding	• Dry cakes, pastry, nuts, seeds, coconut, dried fruit, pineapple
Miscellaneous	• Soup[b]—(may contain small soft lumps, e.g. pasta) • Soft fruit jellies or non-chewy lollies[a] • Soft, smooth, chocolate • Jams and condiments without seeds or dried fruit	• Soups with large pieces of meats or vegetables, corn, or rice • Sticky or chewy foods, for example toffee • Popcorn, chips, biscuits, crackers, nuts, edible seeds

[a] These foods require case-by-case consideration.
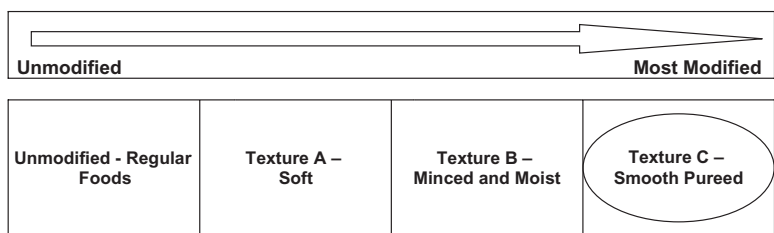[b] These foods may need modification for individuals requiring thickened fluids.

Unmodified			Most Modified
Unmodified - Regular Foods	Texture A – Soft	Texture B – Minced and Moist	Texture C – Smooth Pureed

NAME	TEXTURE B – MINCED AND MOIST
Description	• Food in this category is soft and moist and should easily form into a ball
Characteristics	• Individual uses tongue rather than teeth to break the small lumps in this texture • Food is soft and moist and should easily form into a ball • Food should be easily mashed with a fork • May be presented as a thick puree with obvious lumps in it • Lumps are soft and rounded (no hard or sharp lumps) • Refer to *Special Notes (page S72)*
Testing Information	• Recommended particle size for infants and children = 0.2–0.5 cm (based on tracheal size)[28] • Recommended particle size for children over 5 years and adults = 0.5 cm[10,29]

Texture B—Minced and moist

Recommended foods and those to avoid (examples only)

	Recommended foods	Avoid (in addition to the Foods to Avoid listed for Texture A—Soft)
Bread, cereals, rice, pasta, noodles	• Breakfast cereal with small moist lumps, for example porridge or wheat flake biscuits soaked in milk • Gelled bread • Small, moist pieces of soft pasta, for example moist macaroni cheese (some pasta dishes may require blending or mashing)	• All breads, sandwiches, pastries, crackers, and dry biscuits • Gelled breads that are not soaked through the entire food portion • Rice that does not hold together, for example parboiled, long-grain, basmati • Crispy or dry pasta, for example edges of a pasta bake or lasagne
Vegetables, legumes	• Tender cooked vegetables that are easily mashed with a fork • Well cooked legumes (partially mashed or blended)	• Vegetable pieces larger than 0.5 cm or too hard to be mashed with a fork • Fibrous vegetables that require chewing, for example peas
Fruit	• Mashed soft fresh fruits, for example banana, mango • Finely diced soft pieces of canned or stewed fruit • Pureed fruit • Fruit juice[a]	• Fruit pieces larger than 0.5 cm • Fruit that is too hard to be mashed with a fork
Milk, yoghurt, cheese	• Milk, milkshakes, smoothies[a] • Yoghurt[a] (may have small soft fruit pieces) • Very soft cheeses with small lumps, for example cottage cheese	• Soft cheese that is sticky or chewy, for example Camembert
Meat, fish, poultry, eggs, nuts, legumes	• Coarsely minced, tender, meats with a sauce. Casseroles dishes may be blended to reduce the particle size • Coarsely blended or mashed fish with a sauce • Very soft and moist egg dishes, for example scrambled eggs, soft quiches • Well cooked legumes (partially mashed or blended) • Soft tofu, for example small soft pieces or crumbled	• Casserole or mince dishes with hard or fibrous particles, for example peas, onion • Dry, tough, chewy, or crispy egg dishes or those that cannot be easily mashed
Desserts	• Smooth puddings, dairy desserts,[a] custards,[a] yoghurt[a] and ice-cream[a] (may have small pieces of soft fruit) • Soft moist sponge cake desserts with lots of custard, cream or ice-cream, for example trifle, tiramisu • Soft fruit-based desserts *without* hard bases, crumbly or flaky pastry or coconut, for example apple crumble with custard • Creamed rice	• Desserts with large, hard or fibrous fruit particles (e.g. sultanas), seeds or coconut • Pastry and hard crumble • Bread-based puddings
Miscellaneous	• Soup[a]—(may contain small soft lumps, e.g. pasta) • Plain biscuits dunked in hot tea or coffee and completely saturated • Salsa's, sauces and dips with small soft lumps • Very soft, smooth, chocolate • Jams and condiments without seeds or dried fruit	• Soups with large pieces of meats or vegetables, corn, or rice • Lollies including fruit jellies and marshmallow

[a] These foods may require modification for individuals requiring thickened fluids.

Unmodified	**Most Modified**

Unmodified - Regular Foods	Texture A – Soft	Texture B – Minced and Moist	Texture C – Smooth Pureed

NAME	**TEXTURE C – SMOOTH PUREED**
Description	• Food in this category is smooth and lump free. It is similar to the consistency of commercial pudding. At times, smooth pureed food may have a grainy quality, but should not contain lumps. • Refer to *Special Notes* (page S72)
Characteristics	• Smooth and lump free but may have a grainy quality • Moist and cohesive enough to hold its shape on a spoon (i.e. when placed side by side on a plate these consistencies would maintain their position without 'bleeding' into one another) • Food could be moulded, layered or piped
Testing information	• Cohesive enough to hold its shape on a spoon (i.e. when placed side by side on a plate these consistencies would maintain their position *without* 'bleeding' into one another)
Special Note	• Some individuals may benefit from the use of a ***runny pureed*** texture. This texture would be prescribed on a case by case basis. (Runny pureed textures do not hold their shape; they bleed into one another when placed side by side on a plate).

Texture C—Smooth pureed

Recommended foods and those to avoid (examples only)

	Recommended foods	Avoid (in addition to the Foods to Avoid listed for Texture B—Minced and Moist)
Bread, cereals, rice, pasta, noodles	• Smooth lump-free breakfast cereals, for example semolina, pureed porridge • Gelled bread • Pureed pasta or noodles • Pureed rice	• Cereals with course lumps or fibrous particles, for example all dry cereals, porridge • Gelled breads that are not soaked through the entire food portion
Vegetables, legumes	• Pureed vegetables • Mashed potato • Pureed legumes, for example baked beans (ensuring no husks in final puree) • Vegetable soups that have been blended or strained to remove lumps[a]	• Coarsely mashed vegetables • Particles of vegetable fibre or hard skin
Fruit	• Pureed fruits, for example commercial pureed fruits, vitamised fresh fruits • Well mashed banana • Fruit Juice[a] without pulp	• Pureed fruit with visible lumps
Milk, yoghurt, cheese	• Milk, milkshakes, smoothies[a] • Yoghurt[a] (lump-free), for example plain or vanilla • Smooth cheese pastes, for example smooth ricotta • Cheese and milk-based sauces[a]	• All solid and semi-solid cheese including cottage cheese
Meat, fish, poultry, eggs, nuts, legumes	• Pureed meat/fish (pureed with sauce/gravy to achieve a thick moist texture) • Soufflés and mousses, for example salmon mousse • Pureed legumes, hummus • Soft silken tofu • Pureed scrambled eggs	• Minced or partially pureed meats • Scrambled eggs that have not been pureed • Sticky or very cohesive foods, for example peanut butter
Desserts	• Smooth puddings, dairy desserts,[a] custards,[a] yoghurt[a] and ice-cream[a] • Gelled cakes or cake slurry, for example fine sponge cake saturated with jelly • Soft meringue • Cream[a], syrup dessert toppings[a]	• Desserts with fruit pieces, seeds, nuts, crumble, pastry or non-pureed garnishes • Gelled cakes or cake slurries that are not soaked through the entire food portion
Miscellaneous	• Soup[a]—vitamised or strained to remove lumps • Smooth jams, condiments and sauces	• Soup with lumps • Jams and condiments with seeds, pulps or lumps

[a] These foods may require modification for individuals requiring thickened fluids.

SPECIAL NOTES

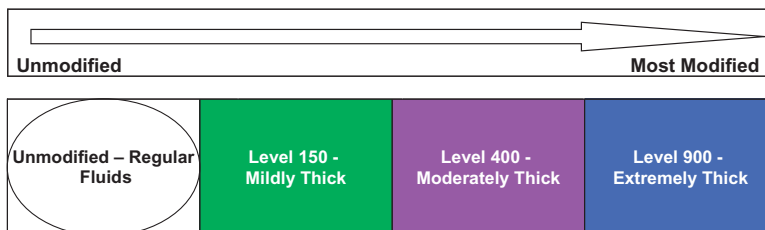## Foods and other items requiring special consideration for individuals with dysphagia

The following foods were identified as requiring emphasis.

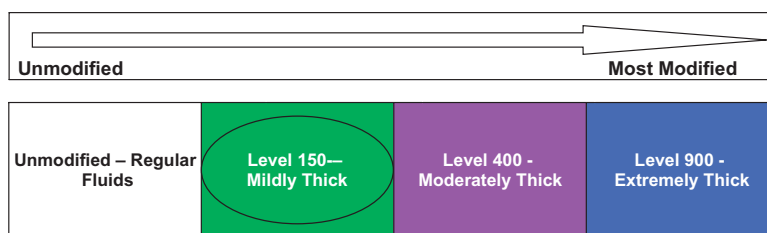|	
Bread	• Bread requires an ability to both bite and chew. Chewing stress required for bread is similar to that of raw apple. The muscle activity required for each chew of bread is similar to that required to chew peanuts.[35] For this reason, individuals who fatigue easily may find bread difficult to chew • Bread requires moistening with saliva for effective mastication. Bread does not dissolve when wet; it clumps. It poses a choking risk if it adheres to the roof of the mouth, pockets in the cheeks or if swallowed in a large clump. This is similar to the noted choking effect of 'chunks' of peanut butter[36]
Ice-cream	• Ice-cream is often excluded on diets for individuals who require thickened fluids. This is because ice-cream melts and becomes like a thin liquid at room temperature or within the oral cavity
Jelly	• Jelly may be excluded from diets for individuals who require thickened fluids. This is because jelly particulates in the mouth if not swallowed promptly
Soup	• Individuals who require thickened fluids will require their soups thickened to the same consistency as their fluids unless otherwise advised by a speech pathologist
'Mixed' or 'dual' consistencies	• These textures are difficult for people with poor oral control to safely contain and manipulate within the mouth • These are consistencies where there is a solid as well as a liquid present in the same mouthful • Examples include individual cereal pieces in milk (e.g. cornflakes in milk), fruit punch, minestrone soup, commercial diced fruit in juice, watermelon
Special occasion foods or fluids	• Special occasion foods (e.g. chocolates, birthday cake) should be well planned to ensure that they are appropriate for individuals requiring texture-modified foods and/or thickened fluids
Nutritional supplements	• For individuals who also required thickened fluids, nutritional supplements may require thickening to the same level of thickness
Medication	• Individuals on Texture C—Smooth Pureed are unsuitable for oral administration of whole tablets or capsules. Consult with medical and pharmaceutical staff • Individuals requiring any form of texture-modified food or fluids may have difficulty swallowing medications. Seek advice if in doubt

Characteristics of foods that pose a choking risk

Stringy	Rhubarb, beans Celery is considered a choking risk until three years of age[37,38]
Crunchy	Popcorn, toast, dry biscuits, chips/crisps[39]
Crumbly	Dry cakes or biscuits[39]
Hard or dry foods	Nuts, raw broccoli, raw cauliflower, apple, crackling, hard crusted rolls/breads, seeds Raw carrots are considered a choking risk until three years of age[37–41]
Floppy textures	Lettuce, cucumber, uncooked baby spinach leaves (adheres to mucosa when moist—conforming material)[42]
Fibrous or 'tough' foods	Steak, pineapple[39]
Skins and outer shells	Corn, peas, apple with peel, grapes[38,40,41]
Round or long shaped	Whole grapes, whole cherries, raisins, hot dogs, sausages[40,41]
Chewy or sticky	Lollies (adhere to mucosa); cheese chunks, fruit roll-ups, gummy lollies, marshmallows, chewing gum, sticky mashed potato, dried fruits[36,41–43]
Husks	Corn, bread with grains, shredded wheat, bran[38,41]
'Mixed' or 'dual' consistencies	Foods that retain solids within a liquid base (e.g. minestrone soup, breakfast cereal, e.g. cornflakes with milk); watermelon[44]

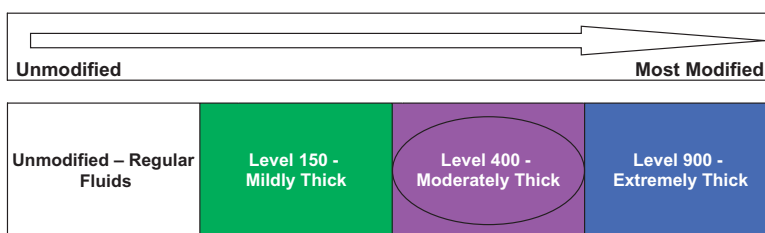## Fluid thickness grading scale for the clinical management of dysphagia

| Unmodified – Regular Fluids | Level 150 - Mildly Thick | Level 400 - Moderately Thick | Level 900 - Extremely Thick |

NAME	UNMODIFIED – REGULAR FLUIDS
	• There are various thickness levels in unmodified fluids. Some are thinner (eg water, and breast milk) and some are thicker (eg fruit nectar) • Unmodified - Regular fluids do not have thickening agents added to them
Flow rate	• 'Very fast - fast flow'
Characteristics	• Drink through any type of teat, cup or straw as appropriate for age and skills
Testing information	• N/A

Unmodified	Most Modified

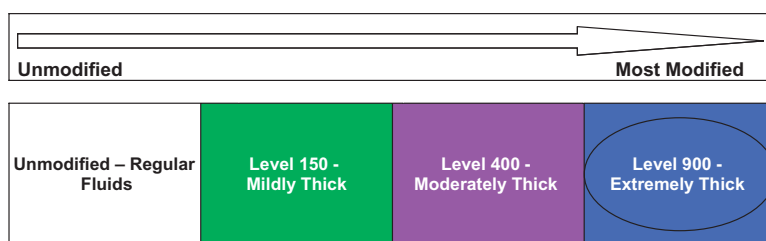| Unmodified – Regular Fluids	Level 150— Mildly Thick	Level 400 - Moderately Thick	Level 900 - Extremely Thick

NAME	**LEVEL 150 – MILDLY THICK** **Level 150 – Mildly Thick** is *thicker than* naturally thick fluids such as fruit nectars, but for example, not as thick as a thickshake
Flow rate	• Steady, fast flow
Characteristics	• Pours quickly from a cup but slower than regular, unmodified fluids • May leave a coating film of residue in the cup after being poured • Drink this fluid thickness from a cup • Effort required to take this thickness via a standard bore straw
Testing information	• Subjectively, fluids at this thickness run fast through the prongs of a fork, but leave a mild coating on the prongs • Testing scales for viscosity exist but are not formalised or standardised, and therefore are not included
Special Note	• Breast milk or infant formula may be thickened for the therapeutic treatment of dysphagia in infants. This fluid thickness is *thinner* than **Level 150 – Mildly Thick**. However, it is thicker than unmodified breast milk or infant formula. It is the same thickness as commercially available 'Anti-regurgitation' (AR) formula. • Consideration should be given to flow through a teat as determined on a case-by-case basis

Unmodified		Most Modified

Unmodified – Regular Fluids	Level 150 - Mildly Thick	Level 400 - Moderately Thick	Level 900 - Extremely Thick

NAME	**LEVEL 400 – MODERATELY THICK** **Level 400 – Moderately Thick** is similar to the thickness of room temperature honey or a thickshake
Flow rate	• 'Slow flow'
Characteristics	• Cohesive and pours slowly • Possible to drink directly from a cup although fluid flows very slowly • Difficult to drink using a straw, even if using a wide bore straw • Spooning this fluid into the mouth may be the best way of taking this fluid
Testing information	• Subjectively, fluids at this thickness slowly drip in dollops through the prongs of a fork • Testing scales for viscosity exist but are not formalised or standardised, and therefore are not included

Unmodified			Most Modified

Unmodified – Regular Fluids	Level 150 - Mildly Thick	Level 400 - Moderately Thick	Level 900 - Extremely Thick

NAME	LEVEL 900 – EXTREMELY THICK **Level 900 – Extremely Thick** is similar to the thickness of pudding or mousse
Flow rate	• 'No flow'
Characteristics	• Cohesive and holds its shape on a spoon • It is *not* possible to pour this type of fluid from a cup into the mouth • It is *not* possible to drink this thickness using a straw. • Spoon is the optimal method for taking this type of fluid. • This fluid is *too thick* if the spoon is able to stand upright in it unsupported
Testing information	• Subjectively, fluids at this thickness sit on and do not flow through the prongs of a fork • Testing scales for viscosity exist but are not formalised or standardised, and therefore are not included

Reference numbers throughout the Appendix refer to references contained in The Australian Standardized Terminology and Definitions for Texture Modified Foods and Fluids. *Nutrition & Dietetics* 2007; 64 (Suppl. 2): S53–S76.

References/recommended reading:

1. Website: https://daa.asn.au. (2007). Australian standardised definitions and terminology for texture-modified foods and fluids. Retrieved 20 June 2018 from https://daa.asn.au/wp-content/uploads/2015/04/Texture_Mod_Appendix.pdf.
2. Website: https://daa.asn.au. (2015). Australian standards for texture modified foods and fluids poster. Retried 20 June 2018 from https://daa.asn.au/wp-content/uploads/2015/04/A3_Aus-Standards-Food-and-Fluids-Poster-Check-2.pdf.