

sistency is difficult to control and easily runs out of the mouth or into the pharynx and airway. In initial therapy sessions, present small spoonfuls of water in the same manner as described in the section on swallowing. If liquids drool from the mouth when in the recommended position, the head may be returned to a level posture, although extension of the head should be avoided. When attempting to use a glass or cup, begin with a full glass so that the patient does not have to tilt his or her head backward. Place the rim of the glass on the person's lower lip. Avoid pouring liquids into the mouth, instead encourage the patient to take small sips.

Use of a straw requires a considerable amount of function in oral musculature. Shorter straws with larger diameters are somewhat easier as the creation of a pressure differential within the mouth is required to successfully suck fluids. Strength of muscles should be considered and a program of facilitation may be necessary before this is a practical means of maintaining fluid input.

The initial goal of swallowing, chewing, and drinking programs is to assess and establish a functional and adequate means of nutritional support.

## ADAPTIVE FEEDING EQUIPMENT

Once feeding has been identified as a problem, the rehabilitation professional has a spectrum of therapeutic modalities available for enhanced intervention. Based upon the evaluation of the patient's status, the plan of action may include diet, physical conditioning and strengthening exercises, swallowing exercises, behavioral modification, use of an assistive device, or the combination of these modalities.

Selection, provision, and training in the use of assistive or adapted feeding devices should only be performed by the registered therapist. Although problems may be common to persons with similar conditions, solutions are unique and need to be tailored to the individual.

The equipment and various solutions to eating presented in this chapter are for the most common symptoms found in a variety of disease conditions. These symptoms and the equipment often prescribed are classified as one-handedness, limitation in joint motion, muscle weakness, poor coordination, and visual problems.

### One-Handed Assistive Devices

One-handedness is most common among older persons who have hemiplegia following a cerebrovascular accident. Other neuromuscular conditions may

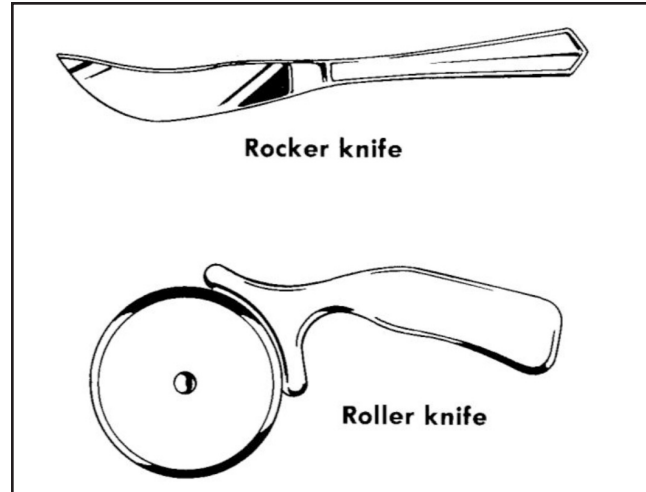


Figure 6-3. Adapted knives.

include: amputation or traumatic injury to an upper extremity such as fracture of the wrist, arm, or shoulder or neurological involvement from orthopedic problems in the cervical or thoracic spine. The most difficult eating problem is cutting meat with one hand. Figure 6-3 is an example of a *rocker knife* and a *roller knife*. The rocking motion helps to cut through meat, however, for those who have difficulty mastering the rocking motion, a rolling device may be used (with a sufficient guard over the cutting wheel).

Another problem is buttering bread. Provision of a suctioned board with a low rim around the edge to prevent sliding of the bread may be helpful as shown in Figure 6-4.

Individuals who have suffered a stroke may have hemianopsia, a visual problem that prevents them from seeing objects on one side of their visual field. They cannot see food in dishes placed to their hemianopsic side, so items should be placed in their field of vision. Patients should also be taught to “scan”

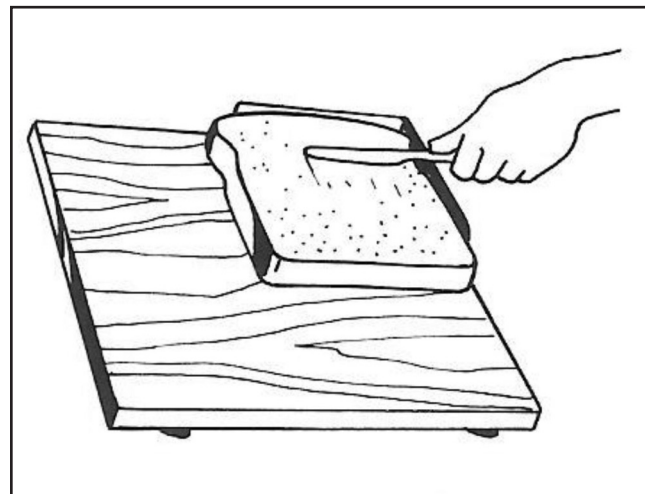


Figure 6-4. Buttering board. Corner keeps bread from sliding.