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Welcome to this Special Edition (issue 18) of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Special Edition Learning Matters: Risk of serious harm or death from choking on foods

Background

Welcome to this Special Edition Learning Matters Newsletter on risk of serious harm or death from choking on foods. This edition will focus on the serious patient safety issue of choking, which unfortunately remains a prevalent public health concern for the Northern Ireland adult population. From 2016 to the present day, there have been **23** choking related Serious Adverse Incidents (SAIs) reported across Health and Social Care (HSC) and the private and independent sector. Of these 23 SAI's, 21 have tragically resulted in death due to choking. Five of these SAIs have occured since February 2021.

In addition, there have been approximately **1383** choking related Adverse incidents (AI's) reported across Northern Ireland HSC Trusts (2016-Feb 2021).

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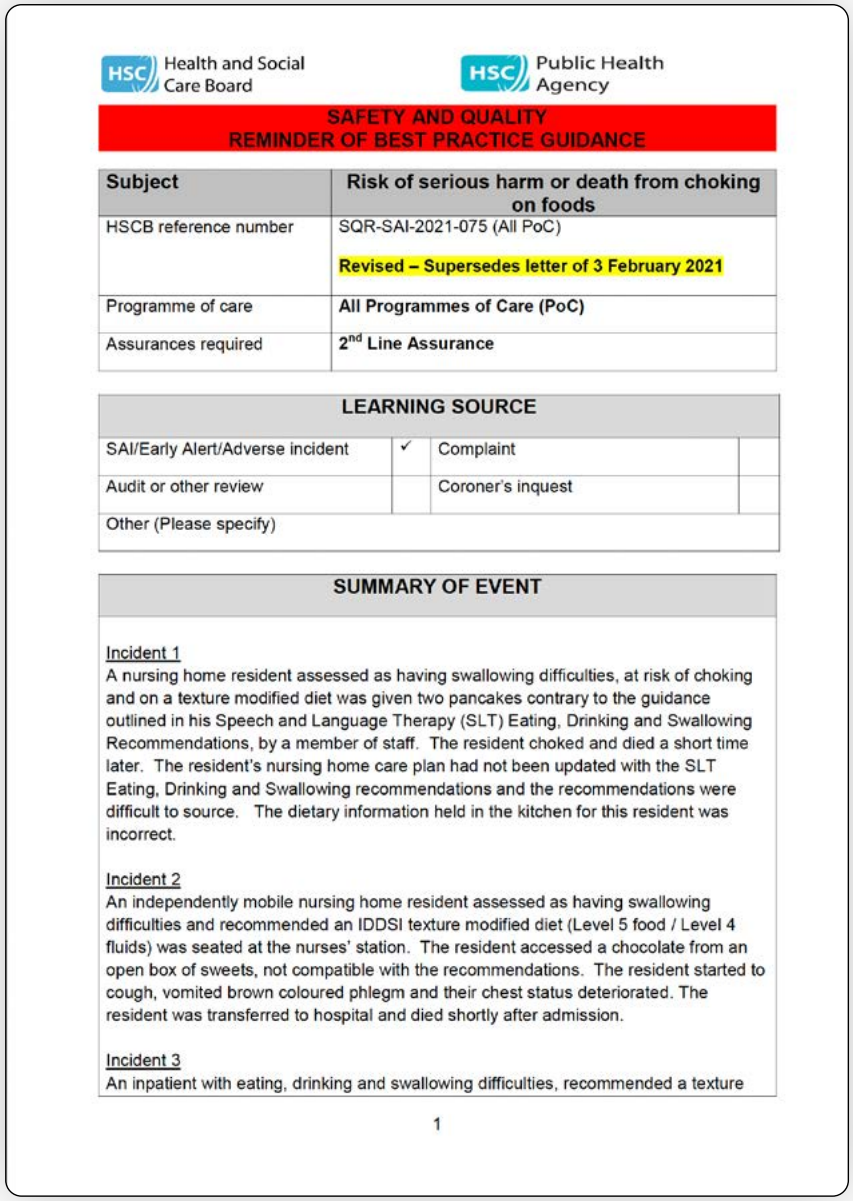
Recent regional learning issued in relation to harm from Choking

On 3rd February 2021, the HSCB / PHA issued a Safety and Quality Reminder of Best Practice Guidance Letter – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)[1]

The letter outlined five choking serious adverse incidents attributed to a failure to recognise and support the needs of people with eating, drinking and swallowing difficulties and at risk of choking. **Six key learning points/recommendations** for all health and social care staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing (EDS) difficulties were highlighted. This letter was reissued in June 2021 to include all Programmes of Care.

Whilst much regional work has been undertaken to maximise the safety of people with EDS difficulties, the ongoing deaths as a result of choking remain unacceptably high. In response to the Safety and Quality Reminder of Best Practice Guidance letter, the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which continue, despite previous interventions and guidance issued.

This Special Edition Learning Matters is part of this work and aims to keep the spotlight on this serious patient safety concern. Health and Social Care staff must be aware of the **6 recommendations** for all staff involved with supporting the care of adults and children who present at risk of choking.



HSC Health and Social Care Board | HSC Public Health Agency

SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (All PoC) **Revised – Supersedes letter of 3 February 2021**
Programme of care	**All Programmes of Care (PoC)**
Assurances required	**2nd Line Assurance**

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Incident 1
A nursing home resident assessed as having swallowing difficulties, at risk of choking and on a texture modified diet was given two pancakes contrary to the guidance outlined in his Speech and Language Therapy (SLT) Eating, Drinking and Swallowing Recommendations, by a member of staff. The resident choked and died a short time later. The resident's nursing home care plan had not been updated with the SLT Eating, Drinking and Swallowing recommendations and the recommendations were difficult to source. The dietary information held in the kitchen for this resident was incorrect.

Incident 2
An independently mobile nursing home resident assessed as having swallowing difficulties and recommended an IDDSI texture modified diet (Level 5 food / Level 4 fluids) was seated at the nurses' station. The resident accessed a chocolate from an open box of sweets, not compatible with the recommendations. The resident started to cough, vomited brown coloured phlegm and their chest status deteriorated. The resident was transferred to hospital and died shortly after admission.

Incident 3
An inpatient with eating, drinking and swallowing difficulties, recommended a texture

1

1 Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

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SAFEY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE LETTER: RISK OF SERIOUS HARM OR DEATH FROM CHOKING ON FOODS - KEY LEARNING

The reasons why people choke are complex and often have numerous contributory factors. Recognition of patients' difficulties, implementation of Speech and Language Therapy Eating, Drinking and Swallowing Recommendations into a care plan, alongside coordinated multidisciplinary team efforts, reduces the risk of serious harm or death.

- SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE Letter 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075) outlines **six recommendations** for all staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing difficulties. They are:

1. When a person has identified eating, drinking and swallowing difficulties this should be centered on an **up to date** Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.
2. Clear mechanisms for the **communication** of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.
3. The needs of individuals with swallowing difficulties should be **communicated at pivotal times**; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others.
4. The development of a process for a **safety pause** before any meals and snacks should be considered e.g. "what patient safety issues for meal and snack times do we need to be aware of today?"
5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.
6. The **training** and **development** needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

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Serious Adverse Incidents reported since February 2021

Since issuing the Safety and Quality Reminder of Best Practice Guidance Letter in February 2021, six further SAIs have been reported to the HSCB/PHA. An overview of those with regional learning are provided below:

- A resident in a Private Nursing Home was passing a tea trolley in the corridor which had a plate of buns on it. The resident ate one of the buns. Five minutes later they were found choking by a member of staff in the corridor. An ambulance was called and the resident was transferred to hospital. The resident had a Speech and Language Therapy (SALT) care plan which recommended their food as IDDSI Level 6 (soft, "Food should be cut into small pieces (no bigger than 1.5cm)". The resident required supervision at meal times as they were identified as being at risk of choking. The resident's capacity regarding their dietary needs had not been assessed. Sadly the resident was pronounced dead a short time later.

- A hospital inpatient was not provided IDDSI Level 1 (Slightly Thick Fluids) from admission and 5 days later they experienced a choking episode. They were commenced on antibiotics for pneumonia/aspiration. The patient's family advised that they should have been on IDDSI Level 1 from the outset. The patient deteriorated and sadly passed away.

- A patient with a history of aspiration and diagnosis of dysphagia was transferred between sites within a hospital. Nursing handover noted a requirement for modified diet and fluids. Speech and Language Therapy Eating Drinking and Swallowing Recommendations could not be located. The patient aspirated on food which did not meet the Speech and Language Therapy recommendations. The patient's condition deteriorated and they were transferred for medical management.

- An inpatient in an acute mental health care setting was discovered unresponsive and sitting on the bed in a lent over position by nursing staff. Food was observed on the person's shoulder. CPR was commenced and the patient was transferred to the Intensive Care Unit. The patient died eight days later and the cause of death was recorded as cerebral hypoxia secondary to cardiac arrest which resulted following choking on food. The patient had been recommended an IDDSI Level 7 diet at the time of the incident and food intake was to be supervised.

In summary, these SAIs relate to adults with eating, drinking and swallowing difficulties and the failure to recognise and support their needs. On each occasion, there was a failure to confirm the eating, drinking and swallowing needs of the person, and a failure to communicate their needs to the wider team and ensure safe communication and meal time processes were in place.

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Current Guidance

Current guidance relevant to these Serious Adverse Incidents which all Health and Social Care workers must be aware of is:

1. **International Dysphagia Diet Standardization Initiative**
2. In 2018 NHS Improvement issued Patient Safety Alert NHS/PSA/RE/2018/004 “Resources to support safer modification of food and drink” detailed at
   HSC (SQSD) 16 18 - Resources to support safer modification of food and drink (hscni.net)

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Fundamentals of Care – Identifying and supporting the needs of people with Eating Drinking and Swallowing (EDS) difficulties

The following measures will support identification of EDS difficulties and the complex needs of people at risk of choking. In adult inpatient care settings all registered nursing staff must ensure that every patient has a robust Person-centred Nursing Assessment and Plan of Care completed on admission. The section on Eating and Drinking (see below) must be accurately completed to ensure early identification of any eating, drinking and swallowing difficulties, support referral to Speech and Language Therapy for further assessment and /or support identification of any existing SLT recommendations.

Eating and drinking

Person – All About Me	Assessment
Able to eat and drink:	Nil by mouth ☐ Yes ☐ No
☐ Independently ☐ Help required ☐ Full assistance	Last ate: _____
Difficulty swallowing: ☐ Yes ☐ No	Last drank: _____
Appetite: ☐ Good ☐ Fair ☐ Poor	Enteral feeding: ☐ Yes ☐ No
Appetite change: ☐ Yes ☐ No	Type of feed:
Dietary Requirements/Modifications including preferences:	Regime:
	Route/ Device type:
Food intolerances:	Size:
	Frequency of change:
Do you wear dentures: ☐ Yes ☐ No	Date next change due:
Top present: ☐ Yes ☐ No	Are you taking oral steroids: ☐ Yes ☐ No
Bottom present: ☐ Yes ☐ No	Do you wish to be involved in your insulin administration: ☐ Yes ☐ No ☐ NA
Secure fitting: ☐ Yes ☐ No	If Yes, Person able and agrees to administer insulin under supervision: ☐ Yes
Diabetes: ☐ Type1 ☐ Type 2 ☐ None	
Controlled by: ☐ Diet ☐ Tablet ☐ Hormone ☐ Insulin	
Other: _____	

Figure one: Person-centred Nursing Assessment and Plan of Care

All other healthcare settings

For all other health care settings that do not use the inpatient Person-centred Nursing Assessment and Plan of Care document, such as nursing and residential settings, the same principles must apply and the regional Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet (REDS) must be central to safe management of the person's needs.

Interface between primary and secondary care

All relevant healthcare staff must ensure effective communication between the primary and secondary care interface, regarding any patients/clients who have identified eating, drinking and swallowing difficulties. An up to date Speech and Language Therapy Eating, Drinking and Swallowing Care Plan specific to their needs, must be in place.

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The Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

FOR ALL STAFF: When a person has identified eating, drinking and swallowing difficulties this MUST be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet. This document is central to supporting the needs of people with dysphagia. Robust communication and meal time systems must be in place to support its implementation and communicated widely with all staff.

For adults, the Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet (REDS) was launched in October 2021, to help maximize the safety of people with EDS difficulties.

This document must be kept in its **original format** and **not translated or modified!**

Speech and Language Therapy
Eating, drinking and swallowing recommendations

Swallow Aware

HSC Health and Social Care

Patient name:	Health and Care number:	Date of plan:

Important information to help when eating, drinking and swallowing

Food	
Drinks	
Bread	
Supervision	
Additional considerations	

Contact your Speech and Language Therapist if you experience:

- Coughing and or choking when eating and drinking.
- Frequent chest infections (always contact your GP if chesty).
- Difficulty managing the food or liquid consistencies you have been advised to follow.
- Your voice sounds gurgly after meals or drinks.

Ask your doctor or pharmacist about prescribed medications or supplements.

Supplementary information given:			
Speech and Language Therapist	Signature	Print name	Contact no.
Discussed with:			

Figure two: Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

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Staff roles and responsibilities in supporting people with EDS difficulties.

Dysphagia NI has developed guidance on the roles and responsibilities of Health and Social Care staff in supporting the safety of people with eating, drinking and swallowing difficulties. The regional document can be accessed at the following link: 'Are you caring for someone with Eating, Drinking and Swallowing difficulties?'

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Other Key Patient Safety Alerts

1. Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

In 2015, NHS England issued a Patient Safety Alert on Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder (health-ni.gov.uk). This alert was issued following an incident where a care home resident died following the **accidental ingestion** of the thickening powder that had been left within their reach. Thickening powder formed a solid mass which caused fatal airway obstruction.

Whilst it is important that thickening products remain accessible, all relevant staff must be aware of **potential risks to patient safety**. **Appropriate storage and administration** of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia.

2. Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

In April 2021 the Medicines and Healthcare Products Regulatory Agency (MHRA) issued their Drug Safety Update volume 14, issue 9: April 2021: 1. Of note:

- There have been reports of a possible **potential harmful interaction** between **polyethylene glycol (PEG) laxatives and starch-based thickeners** when they are mixed together.
- Combining the two compounds can counteract the thickening action and result in a thin watery liquid — patients with swallowing difficulties (dysphagia) are potentially at **greater risk of aspiration** of the thinner liquid.
- **Avoid directly mixing together PEG laxatives and starch-based thickeners**, especially in patients with dysphagia who are considered at risk of aspiration, such as elderly people and people with disabilities that affect swallowing.
- Report suspected adverse drug reactions (ADRs) to the Yellow Card Scheme

3. Risk to patient safety: prescribing and dispensing thickeners and thickened oral nutrition supplements

HSCB has received reports of adverse incidents where people with dysphagia received thickeners or thickened oral nutritional supplements that were not suitable for them. Reasons for this include:

1. Parallel imported products were dispensed from community pharmacies that could cause confusion and increased risk to patient safety; these include thickening products that are not IDDSI compliant and thickened oral nutritional supplements in packs using older “Stage” terminology rather than the new “Level” description.

2. GPs prescribe these products on the recommendation of a SLT or dietitian. Non-specific product descriptions e.g. “Thickening product” may result in an inappropriate product being prescribed. Product details should be clearly described in letters of recommendation to avoid any confusion.

People with dysphagia must receive IDDSI compliant food and fluid consistencies and IDDSI compliant products to reduce the risk of complications such as choking and aspiration. See letter issued from HSCB ‘Risk to patient safety: Parallel imports of thickeners and thickened oral nutritional supplements’

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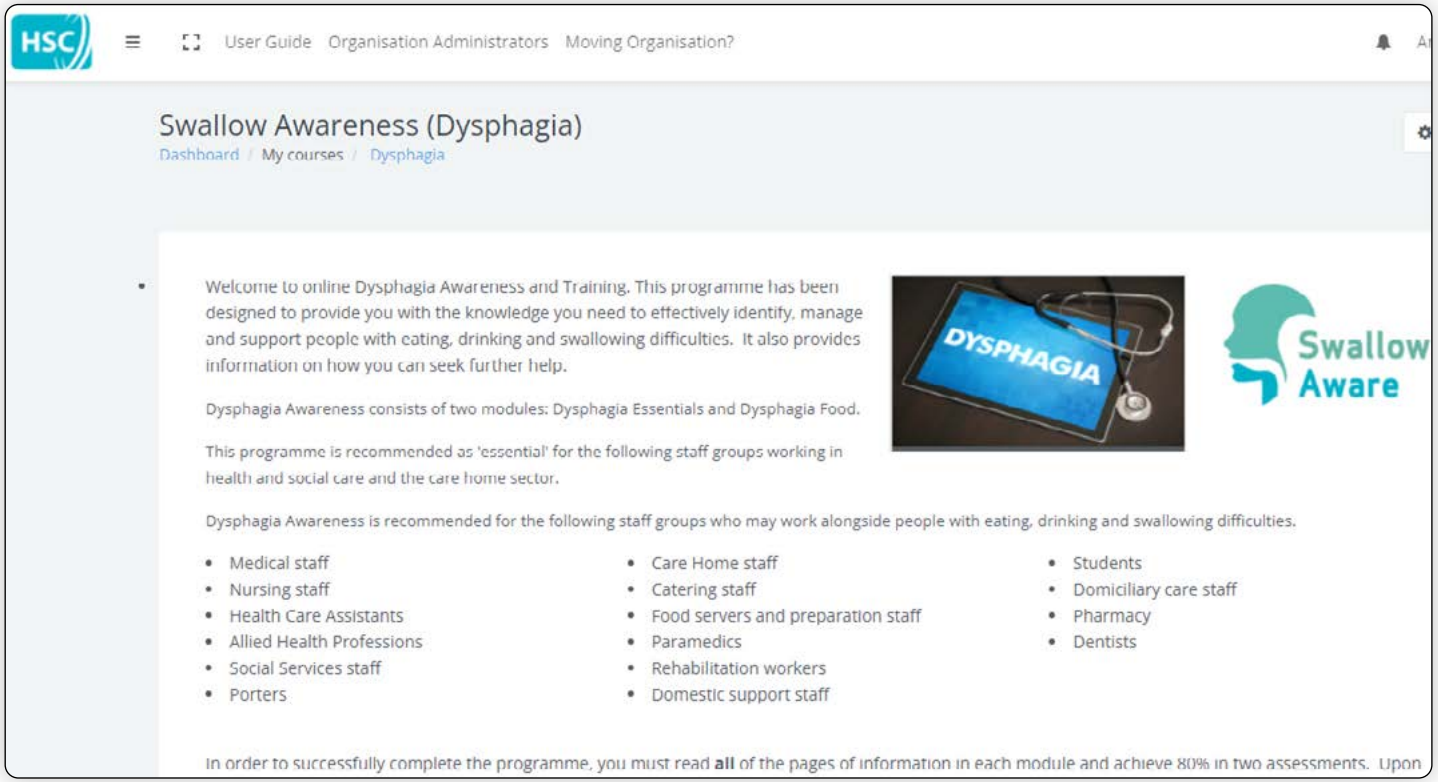
REGIONALLY ENDORSED E-DYSPHAGIA AWARENESS TRAINING TO SUPPORT STAFF:

One of the 6 recommendations of the Safety and Quality Reminder of Best Practice Guidance letter is to ensure the training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties are identified and arrangements put in place to meet them. To support this recommendation, it is advised that staff access regionally endorsed e-Dysphagia Awareness training via the HSC Learning Centre. This training has been designed to help all staff identify, support and manage the needs of people at risk of choking and / or eating, drinking and swallowing difficulties. This e-learning programme is available at: Dysphagia (hsclearning.com)



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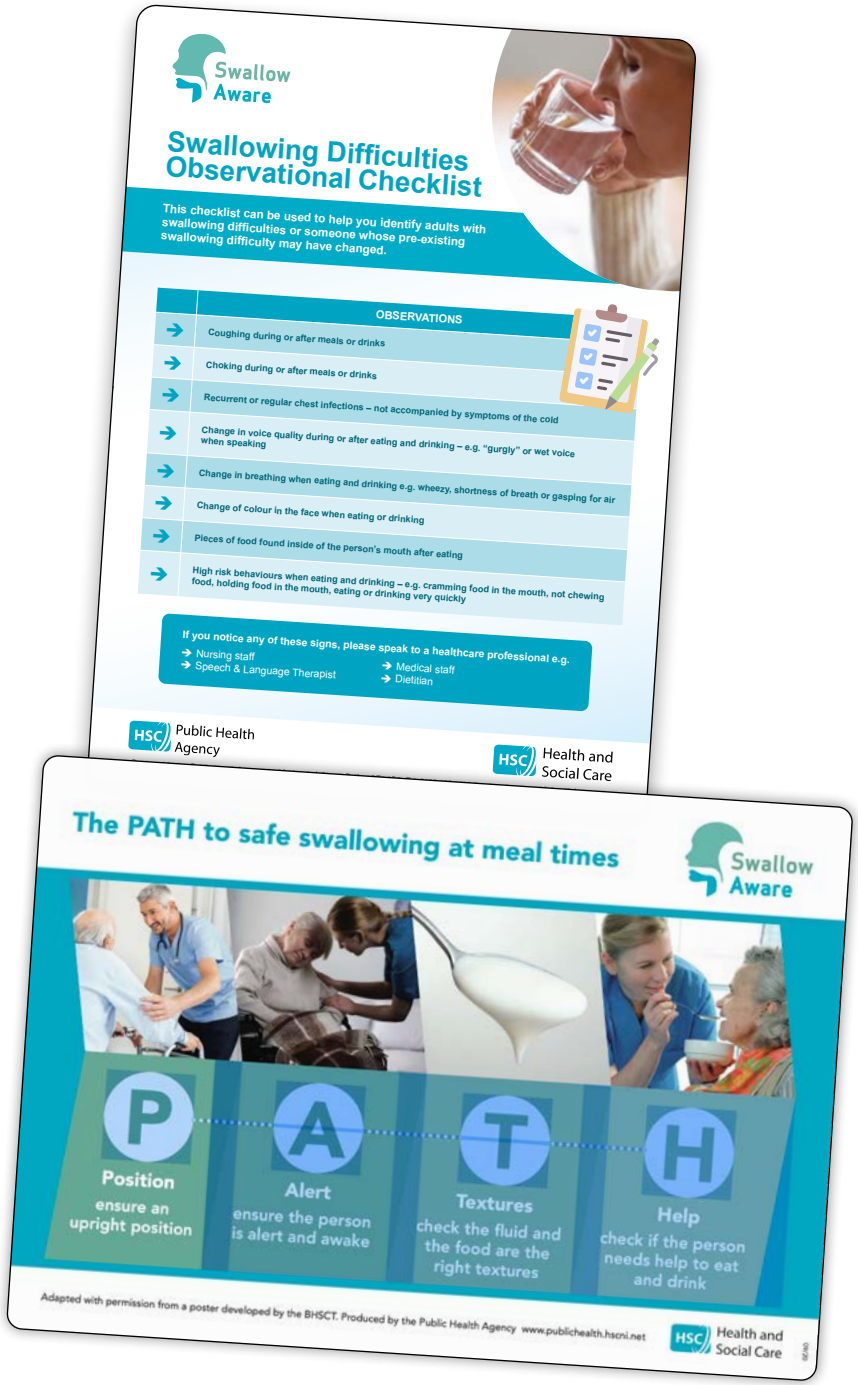
Practical resources to support staff:

- International Dysphagia Diet Standardization Initiative IDDSI - Home
- Resuscitation Council UK (2021), Choking Guidance; available at: Adult Choking Algorithm 2021.pdf (resus.org.uk)
- Resuscitation Council UK (2021), Paediatric Choking Guidance; available at: Paediatric Choking Algorithm 2021.pdf (resus.org.uk)
- Dysphagia Northern Ireland, Public Health Agency, practical resources to support staff available here: Dysphagia | HSC Public Health Agency (hscni.net)
- Staff Roles and Responsibilities supporting people with EDS
- **Swallowing Difficulties Observational Checklist** – a checklist to help staff identify adults with swallowing difficulties or someone whose pre-existing swallowing difficulty may have changed
- **PATH Resource** – Position, Alert, Textures, Help – feeding support for carers and staff to support safe swallowing at mealtimes



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Practical resources to support staff:

- How to Help People with Swallowing Difficulties Keep Their Mouths Clean – guidance for carers and staff to support oral hygiene for people with swallowing difficulties
- Dysphagia Adverse Incident Trigger List – Information for staff on reporting swallowing related incidents or "near misses" using local risk management systems
- NI Formulary Website Poster – Medication information for adults with swallowing difficulties – everything at just one click for healthcare professionals, patients and carers

If you have any comments or questions related to this Special Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

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