

Thematic Review

 Health and Social
Care Board  Public Health
Agency

THEMATIC REVIEW

Report on the Regional Choking Review Analysis

February 2018

 Health and
Social Care


NIPEC





Context

- Published February 2018
- Aims
 - identify recurring themes
 - consider regional learning
 - highlight areas of good practice
 - determine if regional actions are required to reduce/prevent reoccurrence of these incidents

Background

- An inter professional review team including service users and carers
- Review of all SAIs May 2010 - April 2016 where choking on food was associated with actual or potential harm
- Considered n=17 SAIs; n= 14 (82%) of incidents resulted in death



Themes from SAI's

- Known history of swallowing difficulty;
- Interpretation, understanding and documentation
- Training: food preparation, dysphagia, CPR, first Aid
- Recommendations which were present were not always adhered to
- Behavioural issues
- Posture of patient when eating
- Visitors giving patients food they were not allowed
- The importance of personalised care planning with regards to dietary requirements
- Appropriate supervision in dining rooms.





Key Themes from Review

- Aetiology of individuals who are at higher risk of choking
- Behaviours which increase the risk of choking
- Recognition of signs and symptoms of swallowing difficulties
- Communication and understanding of Speech and Language Therapy (SLT) recommendations
- Implementation of individual care plans
- Physical environment & impact of changes in environment
- Mealtimes and snacks
- Dysphagia training & awareness.



Trust Recommendations

- Posture of individuals when eating
- Visitors, families, friends potentially unaware of SLT recommendations, giving individuals food which were not in keeping with the individuals care plan
- Appropriate supervision when eating & drinking
- Training in food preparation, CPR and first aid

Regional Key Safety Messages & Actions

- Rise public and staff awareness concerning populations at higher risk of choking.
- Regionally agree terminology for food and fluid texture descriptors across all HSC facilities and providers of modified meal contractors.
- A regional approach to agree roles, responsibilities, tailored training & education to the level of competence and skill required by different groups of staff.
- Key safety messages from the Review and the Dysphagia Scoping Exercise should be shared with relevant stakeholders, especially with those caring directly for individuals with swallowing difficulties

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Regional Key Safety Messages & Actions

Care plans relating to individual dietary needs should

Be clear and unambiguous
Include swallowing recommendations,
include requirements for supervision,
include the need for assistance with feeding
detail food and fluid consistency.



Regional Key Safety Messages & Actions

- Clear mechanisms for the communication of the patient's swallowing recommendations should be developed including when transferring individuals between locations.
- Individuals who have experienced a deterioration with their swallowing, dysphagia, or who have difficulty with chest infections or aspiration should be reviewed and their needs reassessed.

Regional Key Safety Messages & Actions

- Effective communication @
 - handovers
 - meal & snack times
 - on moving facilities
 - on attending day centres
 - If in the care of relatives, carers or others.
- The development of a process for a **Safety Pause** based on one question such as;
- “*what patient safety issues for meal and snack times do we need to be aware of today?*”
- Menu planning
 - consider food that can carry a higher risk of choking,
 - requirement for necessary modifications or avoidance.



Key Safety Messages and Actions- Family/Carer

- Families, carers and visitors (if appropriate) should be made aware of any risk of choking and be kept up to date about relevant requirements regarding individual dietary needs.
- Information in an easy to understand format on dysphagia management should be made available for people with swallowing difficulties, their families and carers.



Key Safety Messages and Actions- Staff

- Training and development of staff should be identified and arrangements put in place to meet them.
- Support and counselling be available for staff or witnesses involved directly or indirectly in a choking incident.
- Accurate reporting of patient safety incidents involving all patients with dysphagia.



Actions for Consideration

- Develop a regional plan for
 - Communicating key safety messages arising from the Thematic Review
 - Consideration of promotional materials and media input
- Develop proposal for a regional approach to dysphagia awareness and training for all staff groups & consider the following ;
 - Access to awareness and training
 - Delivery options
 - Theoretical content as required by staff group
 - SLT care plan “language”/terminology including texture descriptors
 - Appropriate supervision of patients whilst eating or drinking
 - Assessment and compliance
 - Roles and responsibilities



Actions for Consideration

- Seek and share outcomes of current improvement initiatives related to choking
- Determine the value of a standardised format for swallow recommendations for use in all care settings.
 - If agreed, engage with relevant stakeholders including professional groups to develop same.
- Determine the value of regional guidance in relation to accurate reporting of patient safety incidents involving all patients with dysphagia.
 - If agreed, engage with relevant stakeholders including professional groups to develop same.



Final Message

- “that simply accessing training is not enough and practice and learning from recent improvement initiatives would indicate that on-going monitoring of practices and support relating to dysphagia management within care facilities is essential to ensure that training is embedded.”

Dysphagia - Swallow and Dysphagia Awareness (Adult)

The screenshot shows a document with the following sections:

- Information** | Dates
- Purpose**
To raise awareness of normal swallow and dysphagia to inform the assessment and ongoing care of adults with dysphagia.
- Learning Outcomes**
By the end of this class participants will have discussed:
 - Normal swallowing/eating/drinking
 - What can go wrong with the swallow
 - International Dysphagia Diet Standardisation Initiative: IDDSI
 - Modification of Liquids and foods Texture and consistency
 - How to help someone with dysphagia
 - Referral process in suspected dysphagia
 - Staff responsibility
- Audience**
Nursing staff (Adult)
- Method**
Before and after quiz. Presentation, discussion, questions and answer, demonstration and practical feeding experience.
- Cost**
£50.00

Please note you will be informed in advance if there is a direct cost to you or your organisation for your

