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Nottinghamshire Healthcare NHS
NHS Foundation Trust

# Developing Pathways for Managing the Risk of Choking within a High Secure Hospital

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# Why do we need to manage choking risks?

- Research and serious case reviews highlight that the risk of choking within mental health and learning disability patient population is increased in comparison to risk within general population

- **Phw YIM, CSY Chong (2009)-**

19 choking incidents involving 17 patients. Recorded incidents were eight times higher than the general population and were related to medication side effects and poor eating habits.

- **Hwang, Tsai, Chen, Hsu, Li , Kao (2010)-**

Looked at 16 incidents recorded which involved 11 patients. Men were 3 times more likely to choke than women. Among 16 incidents 3 fatal choking incidents occurred. Most (62 %) choking incidents happened at breakfast. The results suggested that patients choking incidence within an MI population was 3.4 times greater than the normal population.

- **Corcoran and Walsh (2003)-**

10% of sudden deaths in those with a Mental illness were related to choking.

**Bryan et al (2012)** conducted a Thematic Review of Choking Incidents at West London Mental Health Trust (includes a high secure hospital) over a 10 year period.

- Highlighted that over the ten year period, there were at least 3 reported cases of unexpected death caused by choking whilst eating within WLMHT.
- Also identified that over the same time period, there were a further 14 incidents of choking reported where the interventions of nursing and medical staff were successful in preventing possible death.

# Why do we need to manage choking risks continued?

Five cases of choking deaths in people with a learning disability in Hampshire led to a multiagency review and report

- Reducing risk of choking for people with a learning disability- A multiagency review in Hampshire

http://documents.hants.gov.uk/adultservices/safeguarding/Reducingtheriskofchokingforpeoplewithalearningdisability.pdf

# Why do we need to manage choking risks continued?

Public Health England report

Making reasonable adjustments to dysphagia services for people with learning disabilities

http://www.ndti.org.uk/uploads/files/Dysphagia_RA_report_FINAL.pdf

# Why do we need to manage choking risks continued?

- Mazars report into the deaths of people with learning disabilities or mental health problem in contact with Southern Health NHS Foundation Trust
- Highlighted concerns around dysphagia assessments and the management of eating and drinking difficulties. Made a number of recommendations, including the need to investigate the quality, timing and follow-up of dysphagia assessments.

http://www.ndti.org.uk/uploads/files/Dysphagia_RA_report_FINAL.pdf

# Possible Risk factors:

- Old age
- Poor dentition
- Alcohol consumption
- Chronic disease
- Sedation
- Eating risky foods
- Neurological Impairment
- Dysphagia
- Medication
- Eating behaviours
- Deliberate self harm

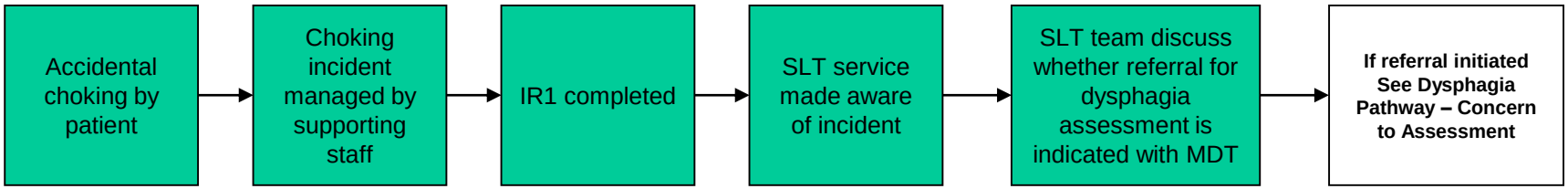
# Why Develop a Pathway?

- Patient death from choking in 2011
- Serious case review
- Request to Speech & Language Therapy manager to develop a protocol for identifying and managing future risk

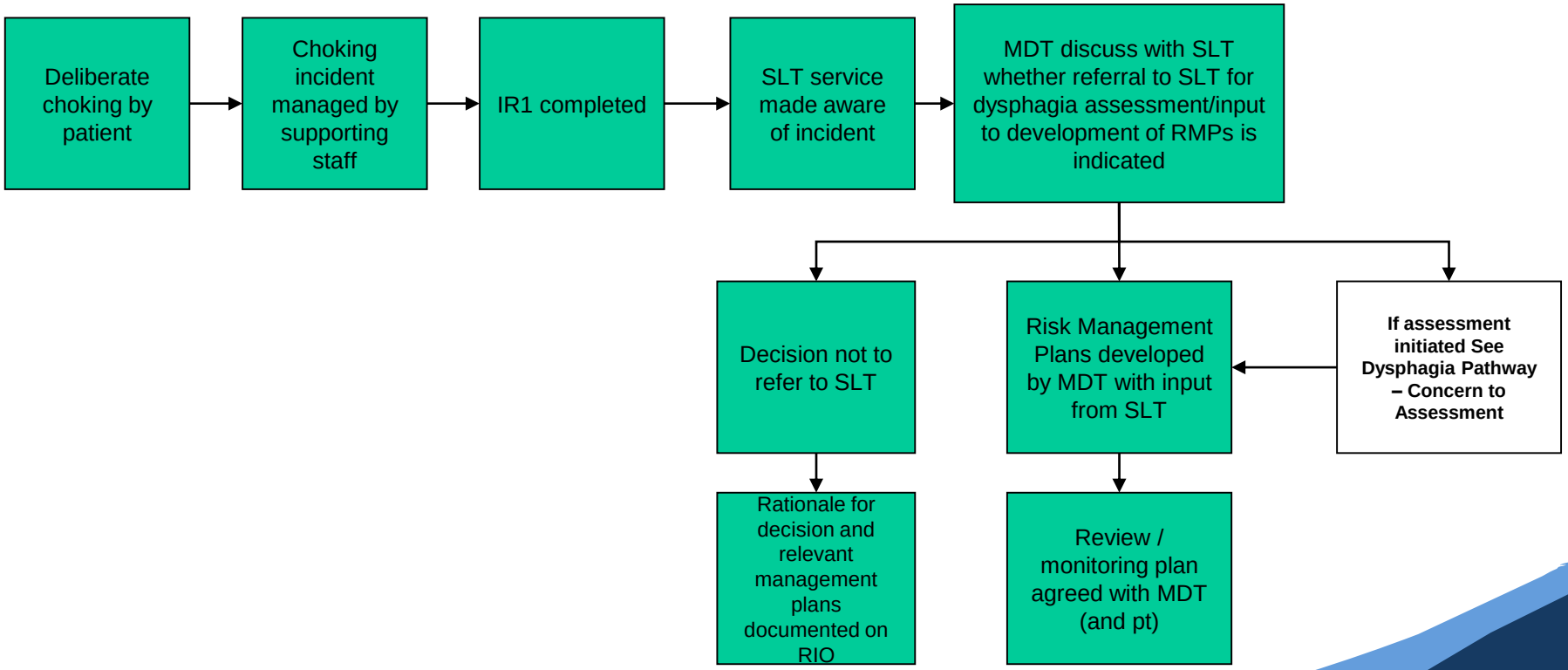
# The Pathways

- 5 pathways produced
- Pathways identify roles and responsibilities of the MDT
- Pathways were ratified by Forensic Senior Management Group in January 2014
- Associated Guidance produced September 2015

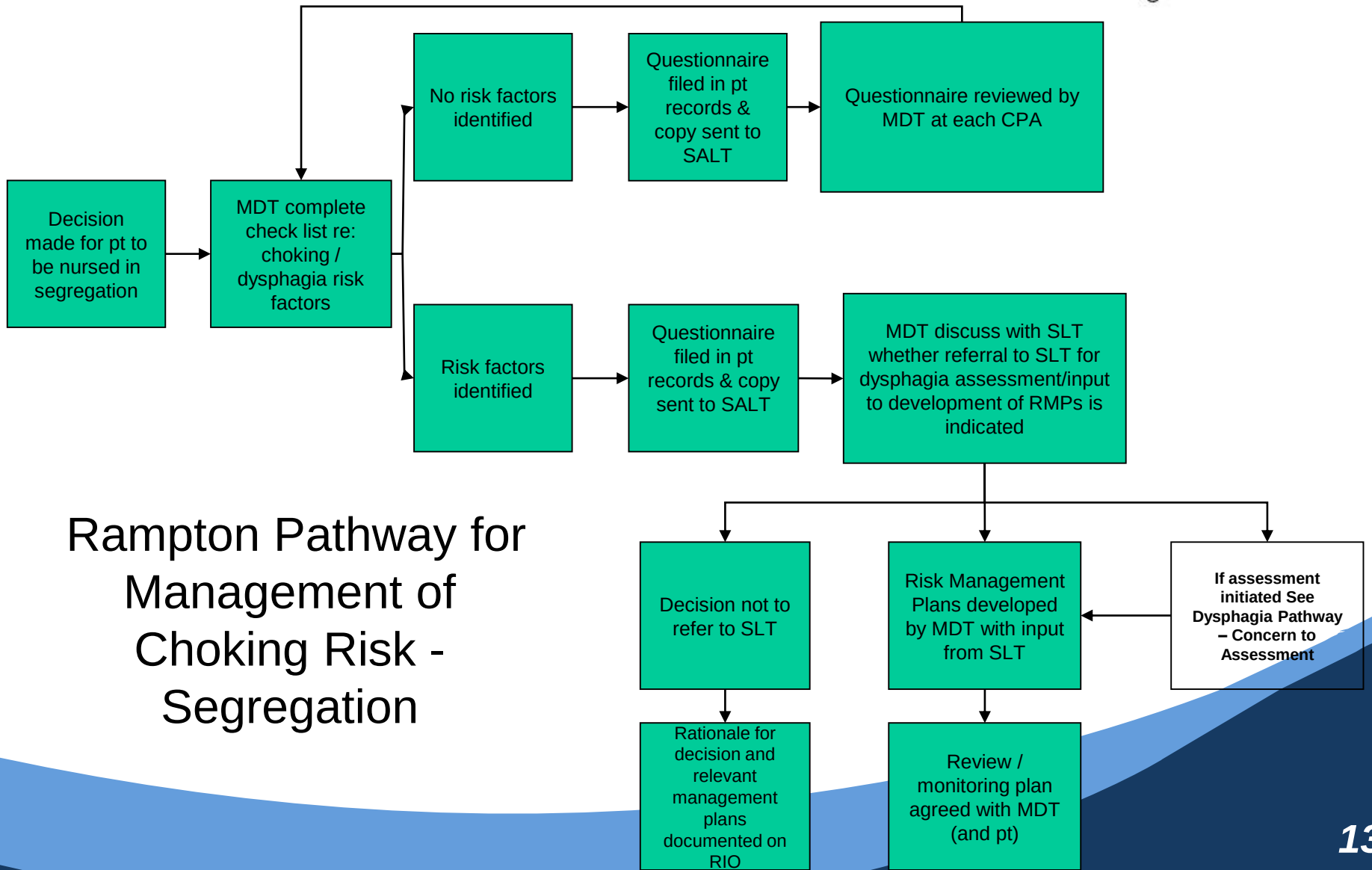
# Rampton Pathway for Management of Choking - Accidental



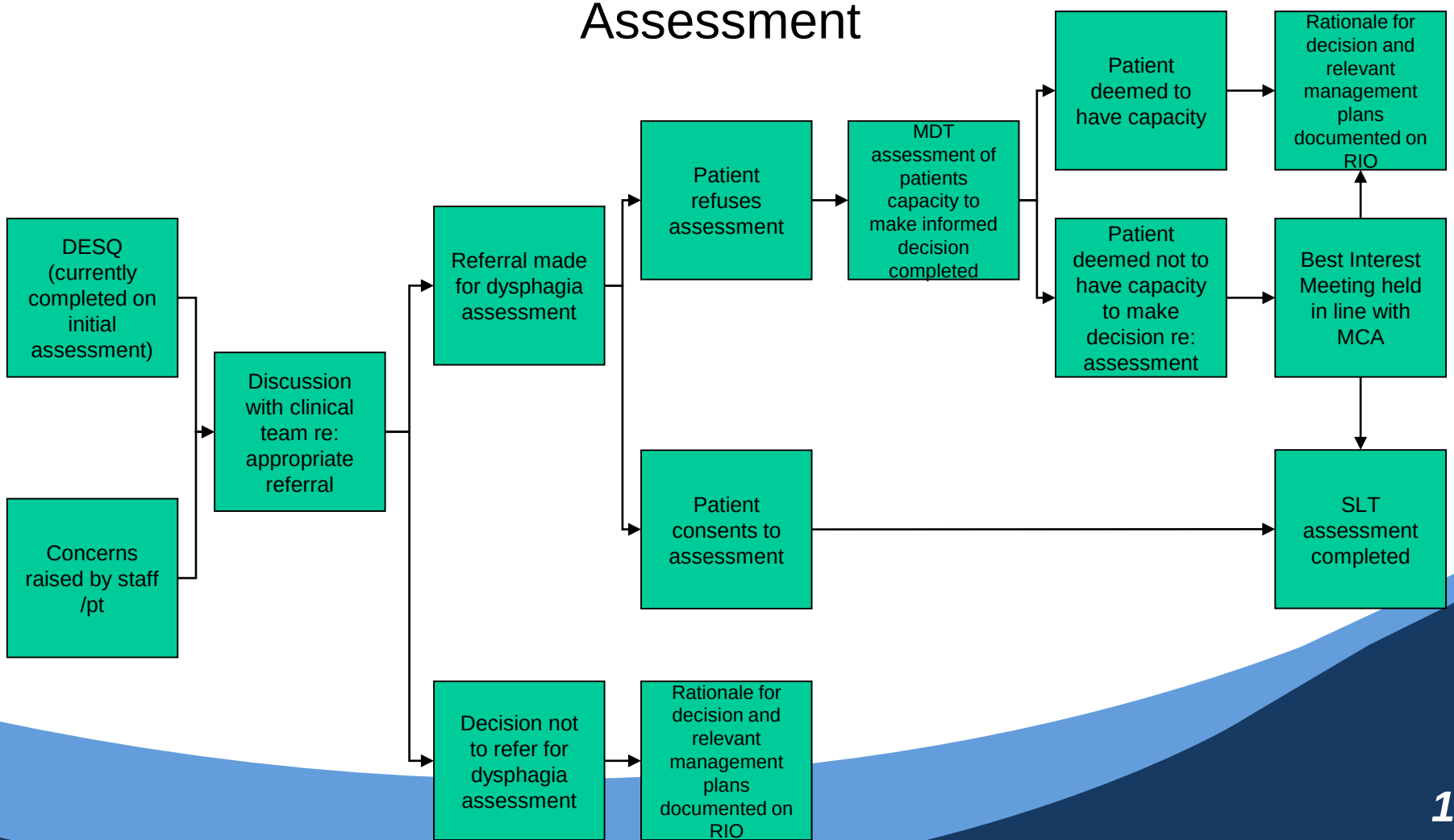
# Rampton Pathway for Management of Choking - Deliberate



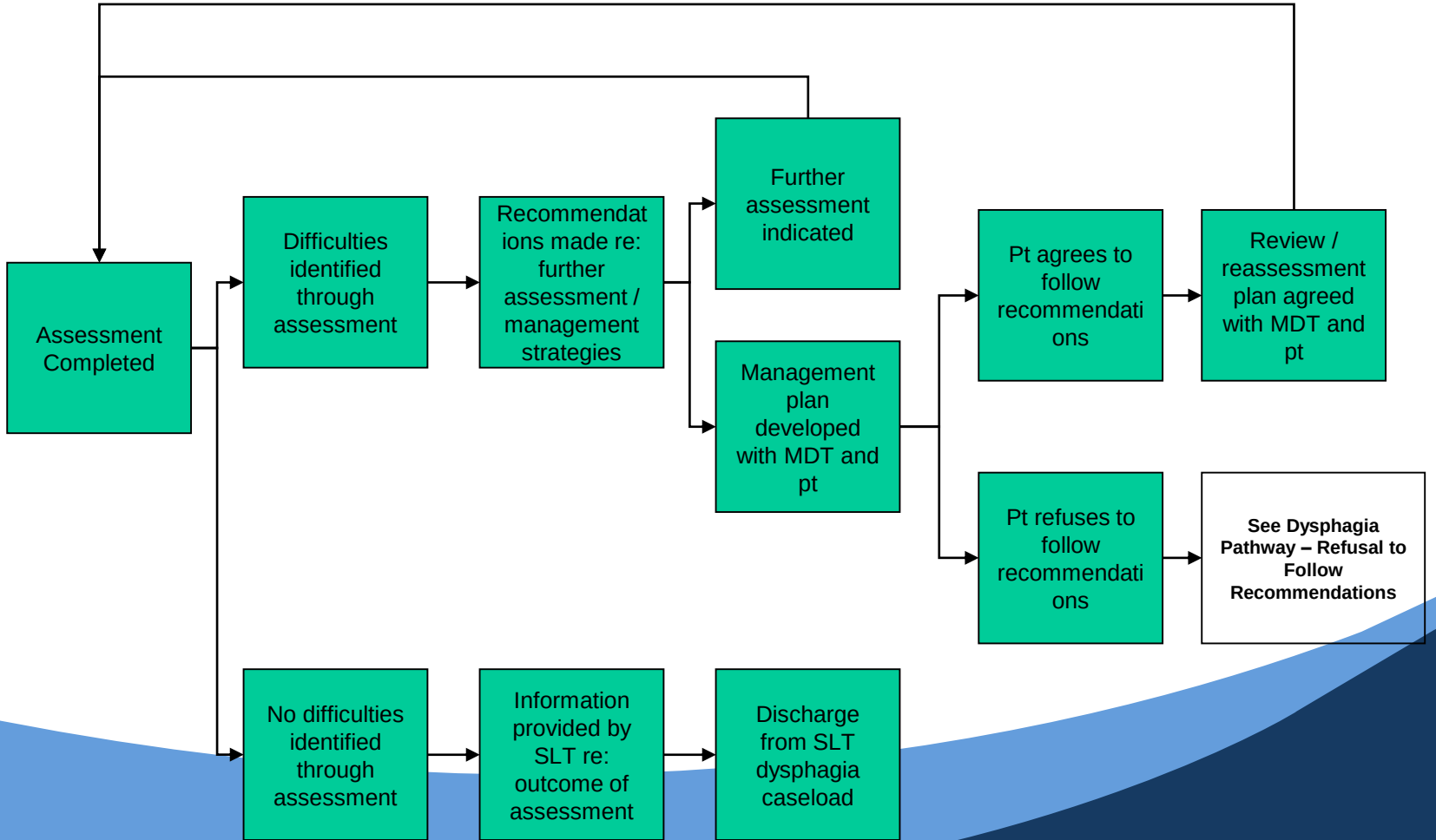
# Rampton Pathway for Management of Choking Risk - Segregation



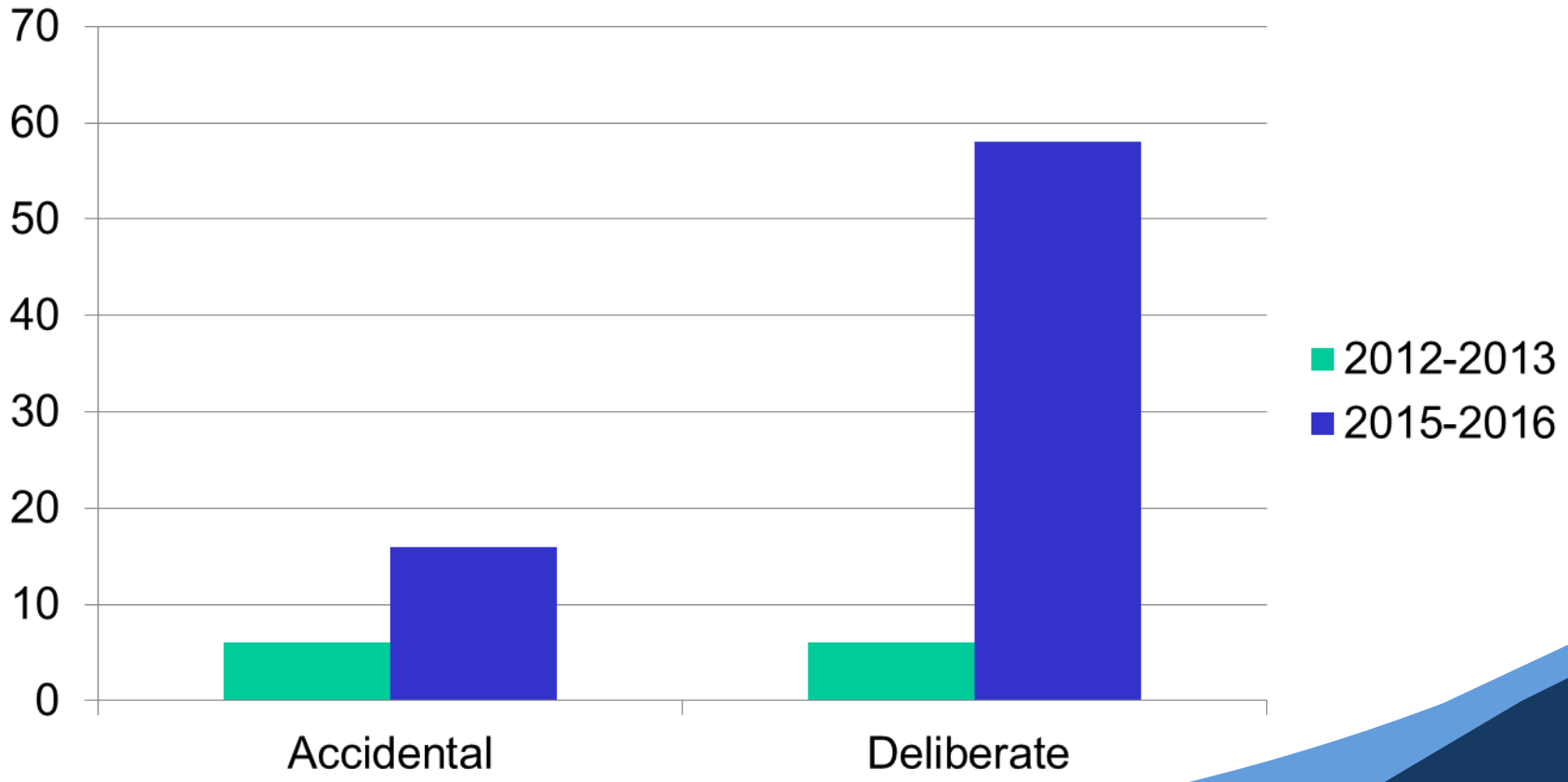
# Rampton Dysphagia Pathway – Concern Identified to Assessment



# Rampton Dysphagia Pathway – Assessment to Management



# Choking Incidents within the Hospital



# Dysphagia

- All new admissions offered a dysphagia screening questionnaire by SLT
- Currently 7% of the population under dysphagia management
- MDT approach to management of dysphagia

# Accidental Choking

- Choking events often occur at mealtimes
- Some patients have poor dentition which increases risk
- Nursing staff present at mealtimes in the dining room and can respond
- Patients can eat in their rooms and this increases the risk for some
- Under reporting of events

# Deliberate Choking

- Increasing number of reported incidents
- Predominately female patients but male patients also engage in these behaviours
- Use a variety of items to occlude airway-

Food

Clothing

Hair

Paper/Tissue

Bodily fluids

# Role of Speech & Language Therapist in Deliberate Choking

3 clearly identified agreed areas-

1. Where patient uses food items to deliberately choke
2. When items swallowed or subsequent interventions have potential to cause harm to swallowing structures
3. Where nursing staff are feeding patient due to procedures to minimise risk e.g. mechanical restraint

Some of our patients with dysphagia also engage in deliberate choking behaviours

# Discussion points

- Are these risks present in other settings?
- How are these risks managed?
- Is there anything else we should be doing?

# Thank you for listening

Any questions or queries please contact:

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