



To: Quality Directors, State Psychiatric Centers
Risk Managers, State Psychiatric Centers

From: Marcia L. Fazio, Deputy Commissioner *mf*
Division of Quality Management

Date: August 16, 2012

Subject: **Choking/Aspiration Alert**

The Division of Quality Management has recently reviewed four patient deaths associated with choking.

- A 63 year old gentleman choked while eating an evening snack of cookies and milk. He began coughing and although the Heimlich maneuver was performed, he became unresponsive and later died.
- A 57 year old gentleman, on constant observation, with a history of swallowing inedible objects collapsed and appeared to be choking. Although an obstructing object (newspaper) was felt in his airway and the Heimlich maneuver and lifesaving interventions were initiated, he later died.
- A 63 year old gentleman choked on a piece of meat during dinner, although first responders were able to clear his airway with a laryngoscope and forceps, he remained unresponsive and later died.
- A 51 year old gentleman choked on pancakes at breakfast, although the Heimlich maneuver removed some of the pancakes from his airway, he lost consciousness and became unresponsive and later died.

Similar root causes were identified in each of the deaths. Some of these included: lack of supervision while eating, incomplete assessments, errors during the code, equipment malfunction, and food consistency.

In addition to having the same types of swallowing problems seen in the general public, patients with psychiatric disorders have been identified as having unique risk factors for choking and aspiration. These factors include unsafe eating behaviors (e.g.: food stuffing, talking with food in mouth, failing to chew thoroughly), adverse effects of medications (e.g.: dysphagia, dry mouth, excessive salivation, tardive dyskinesia, sedation), poor dentition and limited awareness and insight regarding swallowing difficulties and eating behaviors. The attached **Alert** highlights the need for facilities and programs to develop policies and procedures to foster a safe eating environment and to encourage safe eating behaviors.

Also attached for your review and consideration are sample policies, forms and safe eating program descriptions from the Buffalo Psychiatric Center. These materials have been used with success as part of this hospital's strategies for reducing the number of choking incidents.



NYSOMH Division of Quality Management—Choking Alert

****Choking and Aspiration Alert**** **Strategies to Reduce Choking and Aspiration Risk**

Common causes of choking and aspiration:

1. **Dysphagia** (swallowing problems) may occur because of:
 - structural problems in the swallowing tract (such as narrowing and poor or absent dentition)
 - neurological conditions that affect muscle tone (such as stroke, Parkinson's disease and tardive dyskinesia)
 - adverse medication effects that increase or decrease salivation, alter muscle tone and affect level of alertness
2. **Cognitive and behavioral problems** include eating or drinking too fast, not chewing food well enough prior to swallowing, inattention to eating, excessive volume per bite, non-compliance with prescribed modified diet and swallowing of inedible objects (PICA).
3. **Diet texture and liquid viscosity issues:** (e.g., patient receiving regular diet when chopped, ground or puree foods, or thickened liquids, are safer to swallow).

Screening, Assessment, Treatment Planning and Intervention:

1. **Screening:** Develop a method to identify patients with significant risk factors for choking and aspiration. These factors include:
 - cognitive or behavioral problems that interfere with safe eating
 - chewing and swallowing difficulty (dysphagia)
 - pre-disposing medical conditions
 - adverse effects of medications
2. **Assessments:** Refer patients identified as having eating or swallowing difficulty or a history of choking or aspiration pneumonia for further evaluation to assist in determining nature and extent of feeding and swallowing problems and recommended treatment interventions. These may include modified barium swallow studies with speech language pathologist present, occupational therapy evaluations, dental exams, etc.
3. **Treatment Plans:** For patients identified as having significant risk for choking or aspiration, develop a treatment plan that clearly identifies the medical and/or behavioral causes, the specific objectives of treatment and the treatment methods (diet modifications, patient education, behavioral interventions) that will be implemented to address specific risk factors.
4. **Interventions:** Interventions may include the following:
 - diet modifications: diet texture and liquid viscosity modifications should be based on biting and chewing ability, swallowing function and eating behaviors. Texture refers to the density (softness or firmness) of food and viscosity refers to the resistance to flow (thickness) of liquids. Soft, uniform textured, moist foods (e.g., mashed potatoes) are easier to swallow than foods that are sticky, dry, slippery, firm or stringy. Thin liquids pose the greatest risk for direct aspiration into the airway.
 - behavioral interventions: redirecting to the task of eating; providing verbal prompts and recognition to encourage safe eating behaviors; intervening in the event that patients attempt to share food or engage in dangerous eating behaviors.

- positioning
- environmental modifications: reducing distractions; seating patients on like diets together; ensuring patients have adequate time to consume entire meal.
- compensatory techniques and adaptive equipment for feeding and swallowing problems as prescribed by speech language pathologist and occupational therapist
- health teaching for patient, family and significant others

Additional Measures:

1. Staff education: Educate staff about:

- causes of feeding and swallowing problems, including unique risk factors for psychiatric patients
- signs of swallowing problems
- interventions that can be used to reduce risk of choking and aspiration.
- safe eating policies and procedures

2. Emergency Response:

- Ensure crash carts are readily available and equipment is functioning properly.
- Conduct mock codes and drills to practice emergency response procedures for choking/aspiration events.
- Ensure staff know the universal sign for choking and are trained in performing the Heimlich Maneuver.

3. Communication:

- Ensure staff, care givers and visitors who provide meals and snacks are informed about special dietary needs, restrictions, precautions and interventions.
- Ensure staff who observe difficulties with eating and swallowing report these observations to appropriate medical staff.
- Develop and disseminate a list of patients on choking/aspirations precautions to key staff and update as needed.
- Document choking/aspiration risk and diet orders on medical transfer and home leave forms.
- Complete a NIMRS when the Heimlich Maneuver is performed or when medical intervention is required after a choking event.
- Document self-resolved choking events in the patient's record.

4. Supervision and monitoring: Staff should be assigned to supervise patients at mealtime. This includes the following:

- monitor patient behavior
- ensure patients receive the prescribed diet
- intervene in the event patients attempt to share food
- provide direct supervision in close proximity for patients with choking/aspiration precautions
- ensure adaptive equipment is provided to designated patients
- assist patients with tray set-up and feeding as needed
- interact with patients, encouraging use of safe eating strategies

5. Therapeutic mealtime groups: Mealtimes provide frequent opportunities to educate patients about safe eating and for patients to practice safe eating skills and socially acceptable dining behaviors. These groups facilitate recovery by empowering patients to manage their risk for choking and aspiration by changing eating habits and learning to make safe food choices.

CHOKING / ASPIRATION SCREEN	Name (Last, First, M.I.)	"C" No.
	Sex:	D.O.B.
	Facility Name	Unit / Ward:

- Instructions:**
1. Nurse and MD review assessments and tests such as Physical Exam, Nursing Assessment, Nutrition Evaluation, AIMS, OT and SLP eating and swallowing assessments and video swallow studies.
 2. Within 5 days of admission, at annual update and following significant changes in patient's status, nurse observes patient at mealtime, completes PART 1 and reviews findings with patient's medical physician.
 3. Medical physician completes PART 2 and orders tests, assessments and interventions on Physician's Orders sheet.
 4. Treatment plans are developed for patients with orders for Choking/Aspiration Precautions.

PART 1: NURSING SECTION

- A. Complete checklist below based on direct observation of patient at mealtime and patient's self-report of symptoms. Check all that apply:**

Does the patient have chewing or swallowing problems that may increase the risk for choking or aspiration?

- Poor dentition
- Nasal regurgitation
- Coughing while eating
- Difficulty swallowing medications
- Poor control of food/liquid in mouth
- Throat clearing/gurgly voice while eating

Does the patient have cognitive or behavioral problems that interfere with safe eating?

- Eating at rapid pace
- Stuffing food in mouth
- Talking with food in mouth
- Holding food between cheeks & gums
- Stealing/eating foods not on modified diet
- Pica
- Grossly impaired attention/concentration

- B. When symptoms of dysphagia or problem eating behaviors are identified, review safe eating strategies with patient (cut food into small pieces; take small bites; chew thoroughly; swallow before putting more food in mouth; alternate solids and liquids; refrain from talking with food in mouth).**

Patient response to education: _____

RN Signature _____ **Date** _____ **Time** _____

PART 2: PHYSICIAN SECTION

- A. Assess history and factors that may contribute to increased risk for choking or aspiration. Check all that apply:**

- Previous choking incident
- Neurological factors (stroke, Parkinson's disease, tardive dyskinesia, etc.)
- Medication effects such as xerostomia, sialorrhea, sedation; multiple medications
- Recurrent pneumonia not related to chronic pulmonary disease
- Gastroesophageal disorder (reflux, stricture, achalasia, diverticulum, etc.)

- B. Patient has significant risk factors for aspiration and/or choking:** YES NO

- C. If "YES" to B, order Choking/Aspiration Precautions, and order the following, as indicated, on Physician's Orders sheet:**

- assessments such as Feeding & Swallowing Screen, dental assessment, videofluoroscopy
- diet texture modifications (Regular Cooked Tender / Bite Size with Chopped Meat / Ground / Puree)
- fluid viscosity modifications (Nectar Thick / Honey Thick / Spoon Thick)
- behavioral interventions

If "YES" to B, provide health education:

- Patient informed about significant factors that increase risk for choking or aspiration.
- Patient informed about diet texture and viscosity modifications, if recommended.

- D. Additional Comments:** _____

MD Signature _____ **Date** _____ **Time** _____

Buffalo Psychiatric Center Policy and Procedure	Date Effective: 9/15/00 Revised: 07/2011	Policy # BPC-PC-2123	Page ID BPC-PC-2123.htm
Title:	Prepared by: Director of Nursing		
Mealtime Safety	Responsible Deputy: Director of Nursing		
	Approved by:		
	Thomas Dodson, Executive Director		

A. GENERAL STATEMENT OF POLICY

It is the policy of the Buffalo Psychiatric Center that patients will be provided with a safe and therapeutic dining environment. This will include ongoing assessment of the individual patient's ability to eat and swallow safely, and treatment such as environmental modifications, behavioral interventions, and dietary modifications that are based on the individual needs of each patient.

Psychiatric patients, as a group, have a potential for increased risk for choking and aspiration. In the comprehensive assessment process, patients will be assessed for conditions, behavioral problems and other issues that may increase risk of choking or aspiration while eating. The Choking/Aspiration Screen will identify risk based on patient observation and a review of other discipline's assessments, relevant medical history, medications and other factors that may increase risk for choking or aspiration.

Mealtime Safety Procedures will be followed for all inpatients in order to foster a safe eating environment and to encourage safe eating behaviors. Patients identified as having significant risk factors for choking or aspiration will have an order for Choking/Aspiration Precautions and a treatment plan will be established to address this.

Other related policies include:

[24-hour Nutrition Triggers, BPC-PC-2468](#)

[Inpatient Diet Orders, BPC-PC-2470](#)

[Speech, Language and Hearing Services, BPC-PC-2188](#)

[Tardive Dyskinesia/Clinical Management, BPC-PC-2475](#)

[Policy for the Assignment of Recipient Care, NUR-POL-08/PRO-08](#)

[Incident Reporting, BPC-A-8910](#)

[Behavior Management, BPC-PC-2275](#)

[BPC-PC-2472: Food From Outside Sources](#)

B. SCOPE

This policy and procedure applies to all Inpatient Units at the Buffalo Psychiatric Center.

C. RESPONSIBILITY FOR IMPLEMENTATION

The Clinical Director, Director of Nursing, Director of Operations, Associate Clinical Director (Medical), and Nutrition Services Administrator are responsible for assuring that this policy and related procedures are followed.

D. PROCEDURES

Responsible Staff	Action(s) Taken
Nurse Practitioner, Admitting Physician	<ol style="list-style-type: none"> 1. Reviews AIMS and other admission information and completes Physical Examination and Assessment. Notes history of choking or aspiration and medical conditions that may affect eating or swallowing ability. 2. Refers patients who have difficulty eating or swallowing, or who have a history of choking or aspiration, for further evaluation as clinically indicated (i.e.: speech language pathology; occupational therapy). 3. Orders interventions (i.e.: dietary modifications) to address eating and swallowing problems.
Medical Physician	<ol style="list-style-type: none"> 1. Reviews Physical Examination and Assessment, AIMS, and other admission information. Refers patients who have difficulty eating or swallowing, or who have a history of choking or (aspiration) pneumonia, for further evaluation (i.e.: Feeding and Swallowing Screen, videofluoroscopy, neurology consult) as clinically indicated. 2. Completes Part 2 (Physician Section) of the Choking/Aspiration Screen. 3. Orders Choking/Aspiration Precautions for patients with significant risk factors for choking or aspiration on Physician's Orders sheet. 4. Orders diet texture and/or fluid viscosity modifications and other interventions as indicated. Considers ordering downgrade in diet texture and liquid viscosity following choking or aspiration pneumonia incidents pending further tests and assessments. 5. Participates in development of multi-disciplinary treatment plan when Choking/Aspiration Precautions are ordered. 6. Consults with psychiatrist regarding psychiatric medications that may affect swallowing.
Psychiatrist	<ol style="list-style-type: none"> 1. For patients at risk of violence involving eating utensils, participates in development of a treatment plan that identifies the behavior changes required for discontinuation of utensil or other restrictions. Orders plastic utensils when deemed clinically appropriate. 2. Consults with medical physician and reviews medications that may affect swallowing function.
Treatment Team Leader	<ol style="list-style-type: none"> 1. Provides opportunity during Kardex Review for exchange of information regarding eating and swallowing status and results of related tests and assessments. 2. Ensures that a multi-disciplinary treatment plan is developed for patients with physician's order for Choking/Aspiration Precautions. 3. Ensures development of treatment objectives and methods if utensil or other mealtime restrictions are implemented by the psychiatrist, and that the behavior changes that are required for discontinuation of the restrictions are identified.

RN	<ol style="list-style-type: none"> 1. Follows MHTA and LPN procedures when assisting at mealtime. 2. Assigns staff to supervise dining and ensures that at least two staff are present in dining room during mealtime. 3. Completes Part 1 (Nursing Section) of the Choking/Aspiration Screen. 4. Reviews all relevant assessments and develops a treatment plan when Choking or Aspiration Precautions is ordered. 5. Informs medical physician of new swallowing issues or problem eating behaviors; informs treatment team of changes in eating/swallowing status, new assessment findings, changes in diet and other interventions during Kardex Review/Treatment Plan Review. 6. For problem chewing or swallowing, choking incidents and other issues that prevent normal intake, completes PROGRESS NOTES (Nutrition Triggers) Form 450.4 MED, calls Nutrition Department and sends electronic diet order on Nursing Shift Report. 7. Documents all choking related events in the Progress Notes and notifies the medical physician and dietitian. Ensures that a NIMRS is completed when the Heimlich Maneuver is performed or when medical intervention is required after a choking event. 8. Ensures that patients with seizures or patients receiving ECT will not be given food immediately after the event; holds meal trays for one hour post seizure or ECT as a precaution to prevent choking. 9. Notifies visitors of special dietary needs, restrictions, and/or precautions. Notifies visitors not to bring food to patients without consulting the nurse, dietitian or medical physician. 10. Informs treatment team of any inappropriate use of utensils and documents this behavior in a progress note. Obtains MD order if there is an on-going need for use of plastic ware.
MHTA, LPN	<ol style="list-style-type: none"> 1. Monitors patient behavior and follows the Mealtime Safety Procedures (see "All Staff..." procedures) for all patients while eating. 2. When Choking or Aspiration Precautions are ordered, provides direct supervision, remaining in close proximity to assigned patients to facilitate close observation and intervention during meal and snack times. 3. Ensures that all utensils are returned to the meal cart at the end of the meal. 4. Intervenes in the event that patients attempt to share food from their meal trays. 5. Encourages patients to eat what is served, but respects the right to refuse. Advises dietitian of patient food preferences. 6. Remains with patients until all have completed their meals and exited the dining room. 7. Advises visitors to consult with nurse, dietitian or medical physician prior to providing food to patients. 8. Informs RN of changes in eating or swallowing status and documents these changes in the progress notes of the patient's medical record. 9. Informs RN when an intervention is necessary to address inappropriate use of utensils or other high risk behavior/violence. Provides plastic ware to patients who require a staff intervention related to inappropriate use of eating utensils. 10. Documents patient's response to treatment methods in the Progress Note section of the medical record.

<p>All Staff Who Monitor On and Off Unit Dining</p>	<ol style="list-style-type: none"> 1. Know and implement Mealtime Safety Procedures during meal and snack times as follows: <ul style="list-style-type: none"> • Confirm the identity of each patient before passing meal trays using two patient identifiers. Will ask each patient their name and date of birth and verify each patient's identity using photographs in the Patient Identifier Book from the EMR closet. • Check front of the tray ticket for a notation "Choking/Aspiration Precautions" and for special mealtime instructions such as use of adapted equipment. • Check "CBORD Census Report: Choking Aspiration List" to identify patients who have swallowing problems or aspiration risk. • Provide assistance as needed to help patients open cartons, containers and pouch kits and cut food into bite-size pieces. • Encourage patients to sit with proper posture (upright, feet on floor, close to table, chin tucked) and reposition patients who need assistance to attain upright seated position. • Ensure that adapted equipment is provided to designated patients at each meal and collected at the end of every meal. • Move about the dining room to fully observe and interact with patients. • Encourage safe eating behaviors at meal and snack time by prompting patients (i.e.: verbally or with cue cards) to use a knife and fork to cut foods, take small bites and sips, chew thoroughly, swallow before taking another bite/sip, refrain from talking with food in mouth, and avoid sharing food with other patients. • Ensure that adequate time is provided for patients to finish their entire meal without rushing. • Ensure that staff trained to perform the Heimlich maneuver are in close proximity to patients during every meal. • Report to the RN in charge any changes in eating or swallowing behaviors. 2. Provide direct supervision to patient when Choking or Aspiration Precautions are ordered to facilitate close observation and intervention during meal and snack times. 3. Identify patients with special dietary requirements and methods required for eating or assisting with feeding before providing food or beverages during programs, off unit activities and community trips. 4. Have menus pre-approved by the dietitian for all special events where meals are not provided by the meal tray system to ensure that dietary modifications can be provided so all patients may participate. Low calorie, low cholesterol, no concentrated sweets and/or low sodium diet modifications will be waived for special events; however, staff will encourage patients to limit servings to one standard portion of each menu item. Patients on texture/viscosity modified diets and Choking/Aspiration Precautions must have the proper texture, fluid viscosity and mealtime safety procedures followed at all times; no waivers apply to texture/viscosity modified diets without a written MD order. 5. Inform unit RN of any observed changes or problems related to eating or drinking and document them in patient's medical record. 6. Reinforce with patients the necessity of using safe eating practices outlined in the Mealtime Safety Procedures prior to leaving for special events.
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Occupational Therapist, Speech Language Pathologist	<ol style="list-style-type: none"> 1. Provides assessment and recommendations relative to feeding and swallowing. 2. Recommends tests or assessments when indicated and reviews reports from videofluoroscopic studies, other staff and consultants. 3. Collaborates with RN, M.D., psychiatrist and dietitian and recommends treatment objectives and methods as part of treatment planning process. 4. SLP recommends diet texture and liquid viscosity modifications to MD based on assessment of eating and swallowing function. 5. OT recommends and provides orthotics, adapted eating and positioning equipment and modified feeding techniques to foster independent feeding skills. 6. Provides direct treatment for feeding and swallowing problems as indicated, based on assessment findings and as ordered by M.D. 7. Provides training to nursing and other direct care staff regarding causes of feeding and swallowing problems and treatment methods that can be utilized to reduce risk for choking and aspiration.
Dietitian	<ol style="list-style-type: none"> 1. Completes a Nutrition Assessment for each patient addressing chewing, swallowing, or choking problems and recommends appropriate food textures to the M.D. 2. Observes the eating habits of assigned patients, encouraging patients to consume all of the food served as per specified diet. 3. Collaborates with RN, M.D., occupational therapist and speech language pathologist in developing a plan of treatment, identifying discipline specific objectives and methods. 4. Reviews menus for Special Events and advises staff on menu modifications to ensure that special dietary needs are met. 5. Completes "CBORD Census Report: Choking Aspiration List" for staff reference.
Clinical Staff Conducting Cooking Classes	<ol style="list-style-type: none"> 1. Clinical staff must successfully complete and maintain certification on lifesaver first aid, and complete training on textured and viscosity modified diets prior to conducting cooking class. 2. Will follow procedures 1 through 5 listed in "All Clinical Staff Who Monitor Off-Unit Dining" procedures above.

E. DISTRIBUTION

This policy will be posted on the BPC intranet. Hard copies will be provided to BPC program sites without intranet access and the Director's Office.

F. REVISION

This policy will remain in effect until it is determined that revisions/updates are required.

Therapeutic Mealtime Groups for Patients with Psychiatric Disorders

Purpose: Educate all patients on the unit about risk factors for choking and aspiration pneumonia associated with unsafe eating behaviors, poor dentition, medication side-effects and dysphagia (swallowing problems). Also, teach patients strategies they can use at meal and snack time to reduce their risk such as complying with their prescribed diet and using safe eating behaviors.

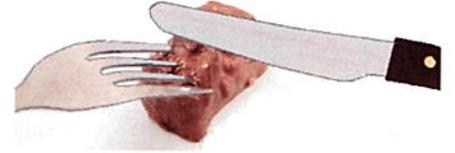
Mealtime groups will also focus on the individual needs of patients having significant risk for choking/aspiration by implementing the specific treatment recommendations for that patient.

Procedures: Before meal begins, staff will:

1. Briefly discuss safe eating information with all patients in dining room. *Key points:*
 - some patients may not realize they have a swallowing problem.
 - swallowing problems can start suddenly or develop slowly over time.
 - swallowing problems are very serious - can cause people to choke (*food gets stuck in throat and blocks windpipe so person can't breathe*) or to develop aspiration pneumonia (*lung infection when food goes into windpipe*).
 - unsafe eating behaviors are a frequent cause of choking for patients with mental health issues: *Ask patients to name unsafe eating behaviors:*
 - not using knife and fork to cut food into small pieces
 - taking large bites and sips
 - not chewing food thoroughly before swallowing it
 - eating too fast
 - putting several bites into mouth before swallowing first bite
 - talking with food in mouth
 - missing teeth (*for biting and chewing*), medication side-effects (*dry mouth, changes in tone/tension of swallowing muscles*) and medical conditions (*head injury, stroke, Parkinson's disease*) can also cause swallowing problems.
 - people who do not eat safely may have their diet changed to soft, moist food that is pre-cut or ground up.
 - there are things people can do to keep safe when they eat and drink: *Ask patients to name safe eating tips:*
 - ✓ change their eating habits:
 - sit upright while eating
 - use knife and fork to cut food into small bites
 - eat slowly
 - take small bites
 - chew thoroughly
 - swallow each bite before putting more food into mouth
 - drink liquids throughout meal
 - do not talk with food in mouth
 - if they begin to cough, stop eating/drinking until coughing stops
 - ✓ learn about their diet and how to make safer food choices
 - soft, moist foods (*mashed potatoes*) are easier to swallow than foods that are sticky (*peanut butter*), dry (*toast*), slippery (*grapes*), firm (*meat*) or stringy (*celery*). Thick liquids (*apricot nectar*) are less likely to go into the airway than thin liquids (*water*).
2. Encourage patients identified as having significant risk for choking or aspiration to identify the specific safe eating behaviors, and/or compensatory strategies recommended by occupational therapist or speech language pathologist, they will use during the meal. Refer to individualized cue cards placed on patient's meal tray as a reminder.
3. Give prompts during meal to high risk and other patients as needed and recognize patients efforts to implement desired safe eating behaviors.
4. At the end of the meal, ask each high-risk patient about their progress toward desired behaviors (*self-assessment*) and give feedback about actual performance.

Be safe when you eat. Please:

✓ cut food into small pieces



✓ take small bites



✓ chew food thoroughly

✓ swallow before putting more food in your mouth

✓ avoid talking with food in your mouth