Lancashire Care NHS
NHS Foundation Trust

Calderstones Partnership NHS
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Identifying risk of choking and swallowing difficulties

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Calderstones Partnership Foundation trust & Lancashire Care Foundation Trust

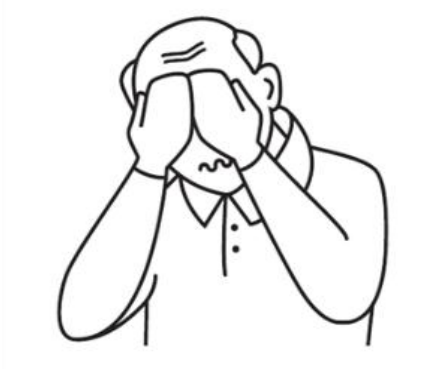
Patient Safety AWARDS 2013
FINALIST

What was the problem?

National perspective…
NPSA 2008, Glover & Ayub 2010, CIPOLD 2013….

Local perspective….
Since 2002: 4 deaths from choking on food, 2 from PICA

- People unsure of significant early warning signs
- People unsure where to turn for advice
- People unsure how to pass on info
- Care staff move away and history is lost



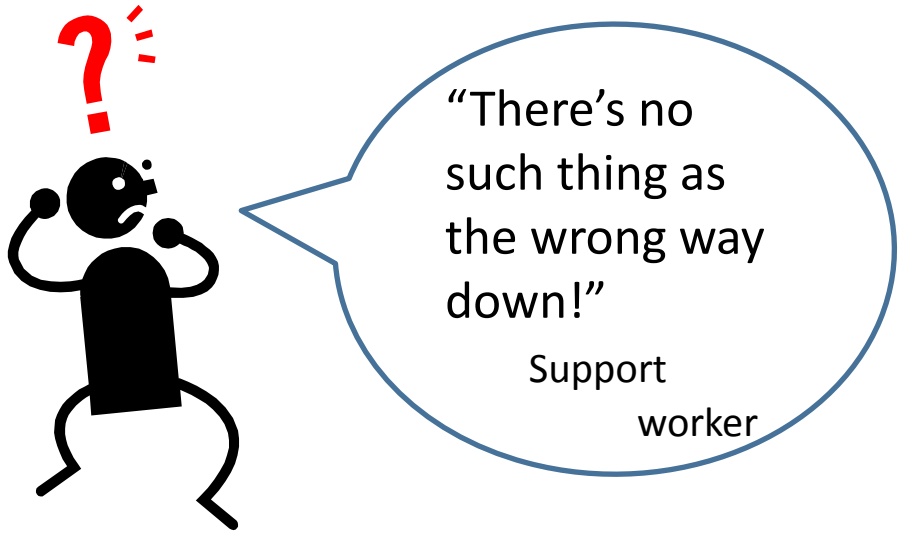
How many near miss?

- Underreporting of swallowing difficulties
- Lack of detail informing learning
- Diagnostic overshadowing

What was the need?

We found people had problems in….

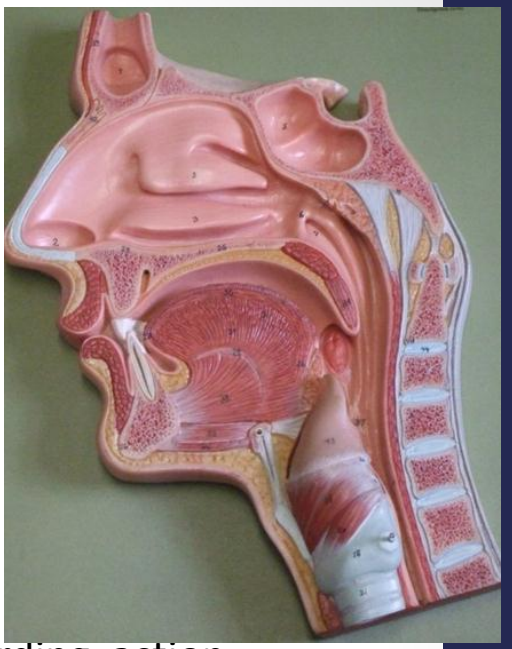
- recognising and understanding mealtime difficulties
- understanding how to make mealtimes safe and enjoyable for everyone.



Swallowing problems can lead to chest infections or choking

We asked people for their ideas

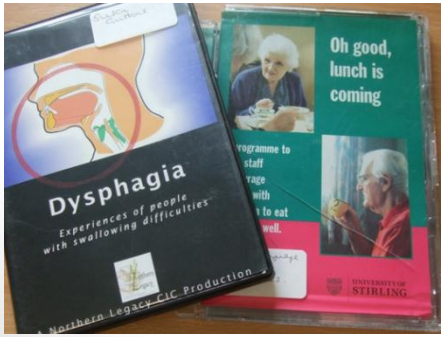
What did we do?



Risk of choking/dysphagia project included:

- Setting up training to increase understanding and awareness, to increase care staff skills
- Setting up annual screening, to improve recognising, recording, action
- Improving reporting for choking incidents

Aim: Improving mealtime safety, improving mealtime quality.



Training : workshops and beyond...

- Managers and nursing staff: coordinate risk assessment
- Support workers, chefs, OTs, carers : wider awareness raising
- House meetings /ward rounds: individual discussions
- Follow-up/revision sessions
- Individual SLT referrals
- Repeat screening and reporting choking

Evaluation: has the training made a difference?

- Questionnaires: has knowledge changed? Has practice changed?
- Quality of Referrals to SLT (on-going)
- Changes in incident reporting (2005 – 2012)
- Audit of screening process
- Talking to witnesses of choking incidents

Evaluation:

Comments before training

I thought there was only one way down for food and drink.

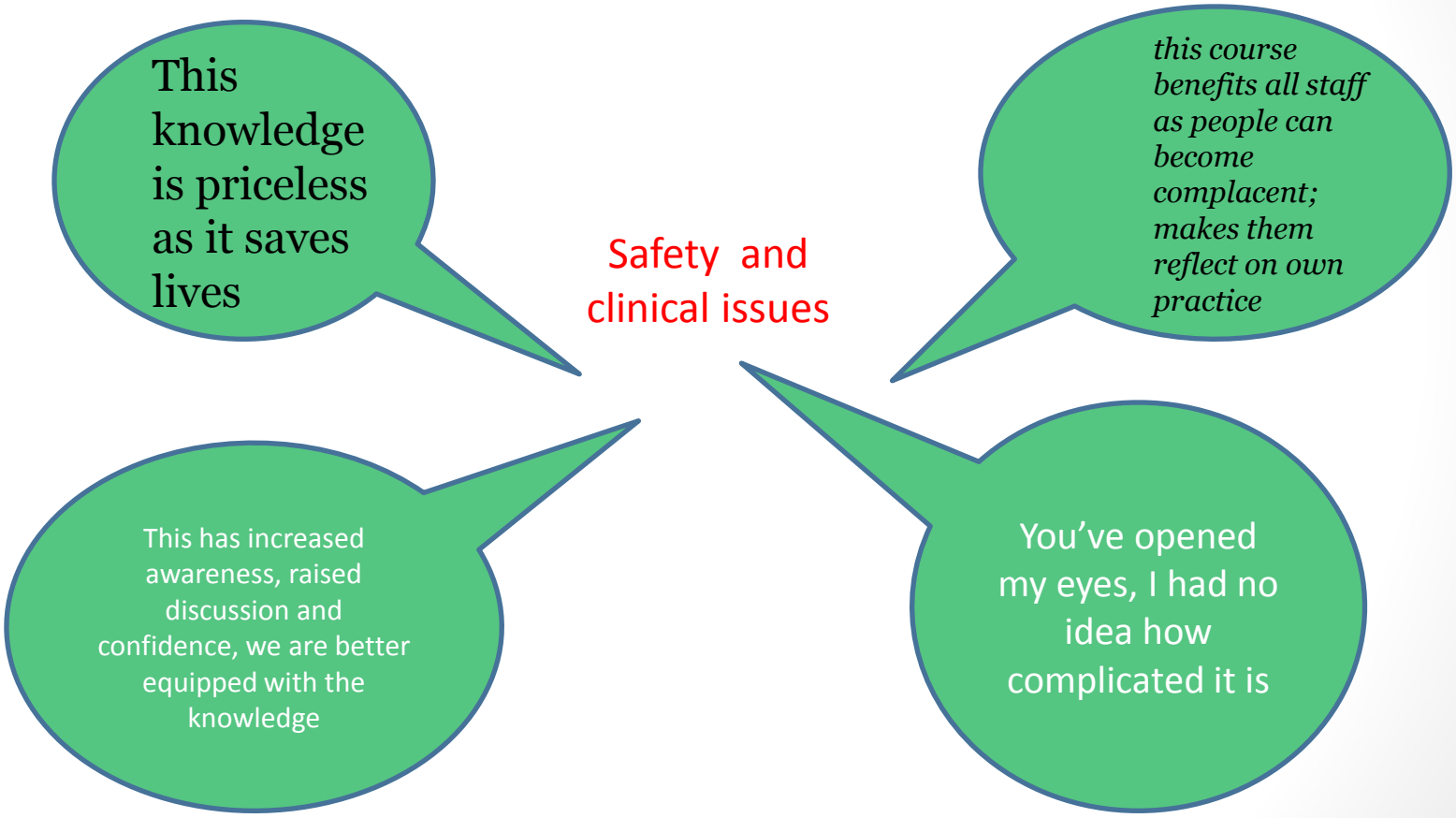
I thought all food went down to your lungs

There's no such thing as going down the wrong way is there?

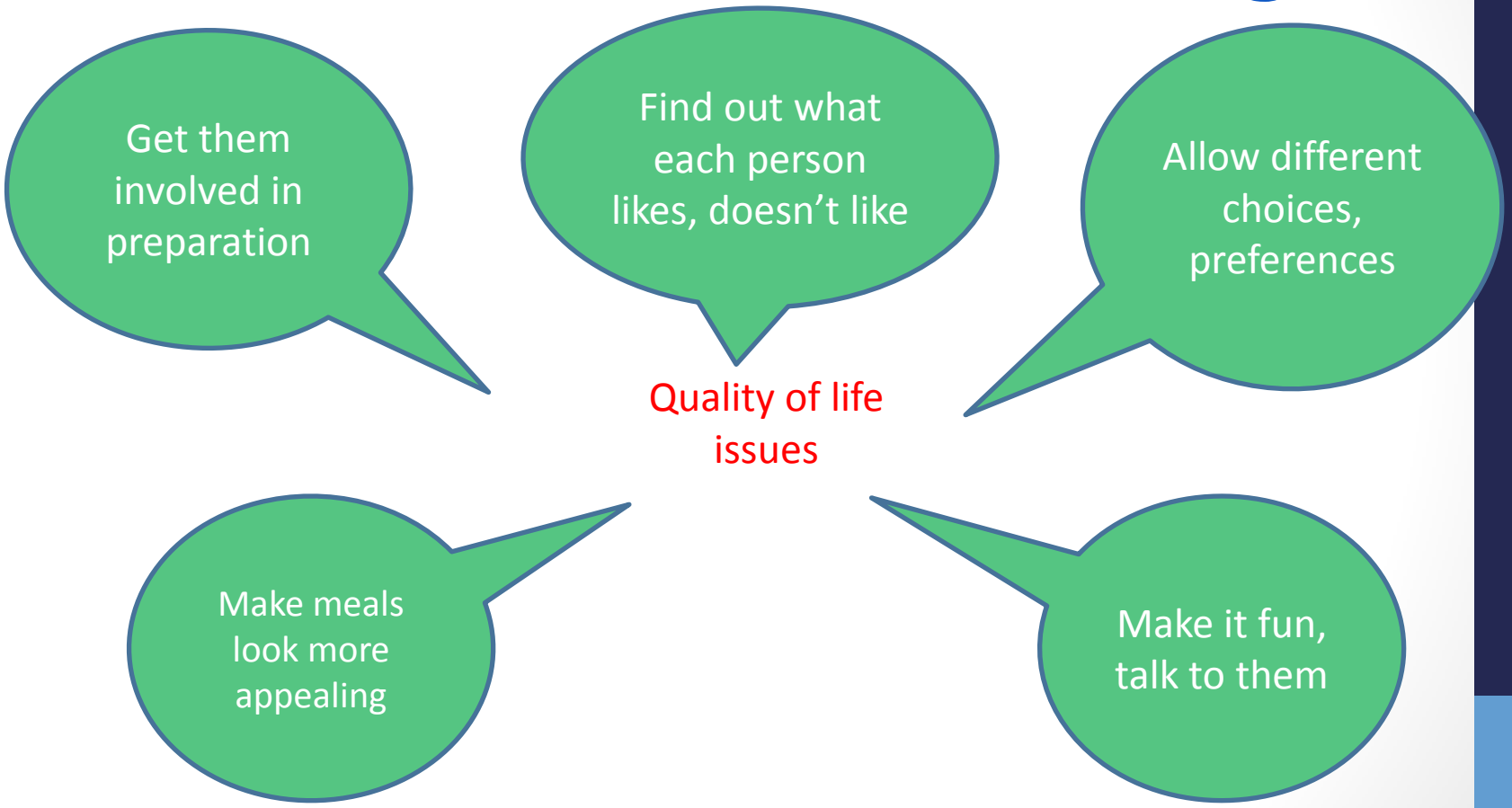
We were told to tip the chin up to open the airway

Evaluation

Comments after training



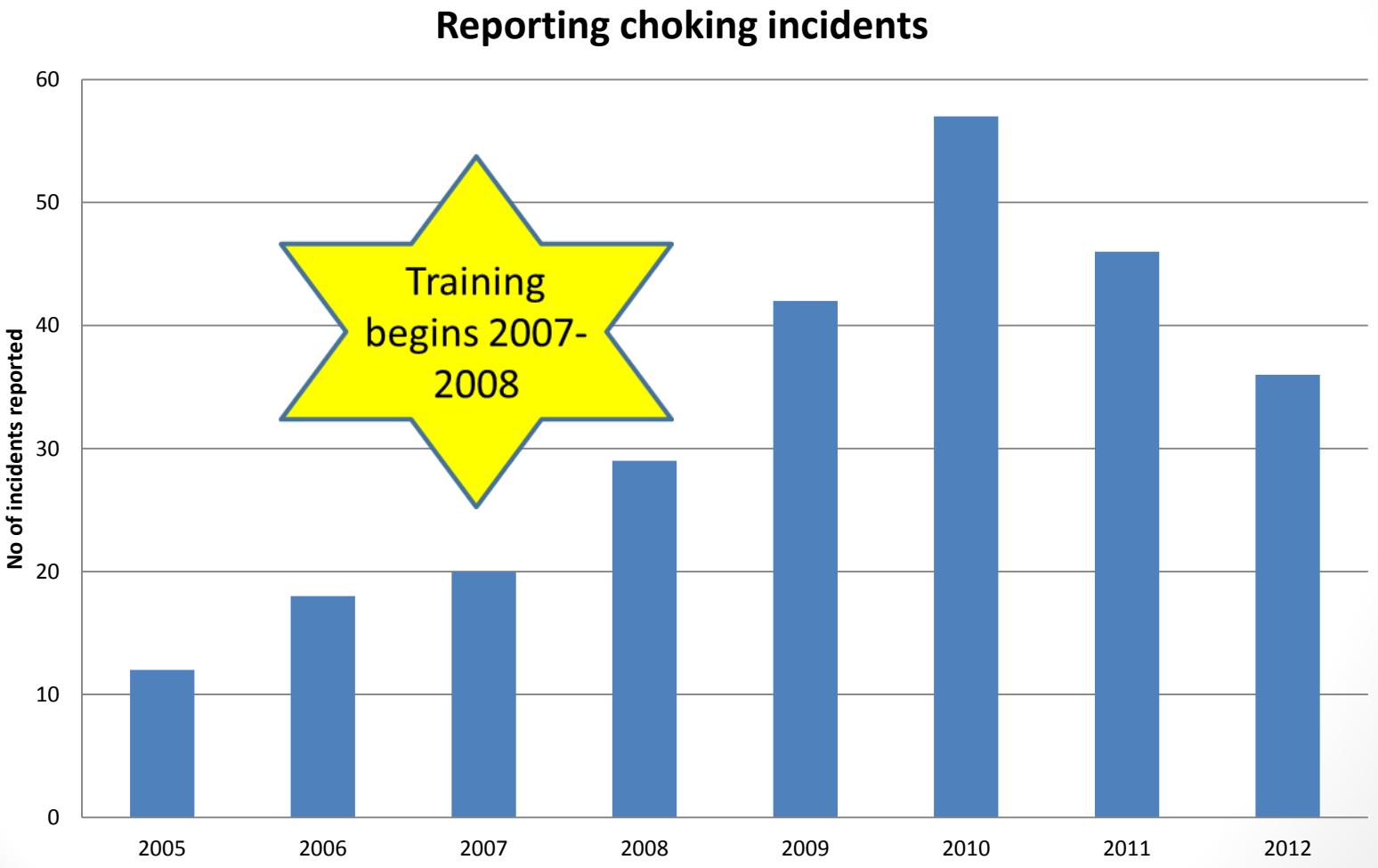
Evaluation:
Comments after training



Getting everyone involved…..

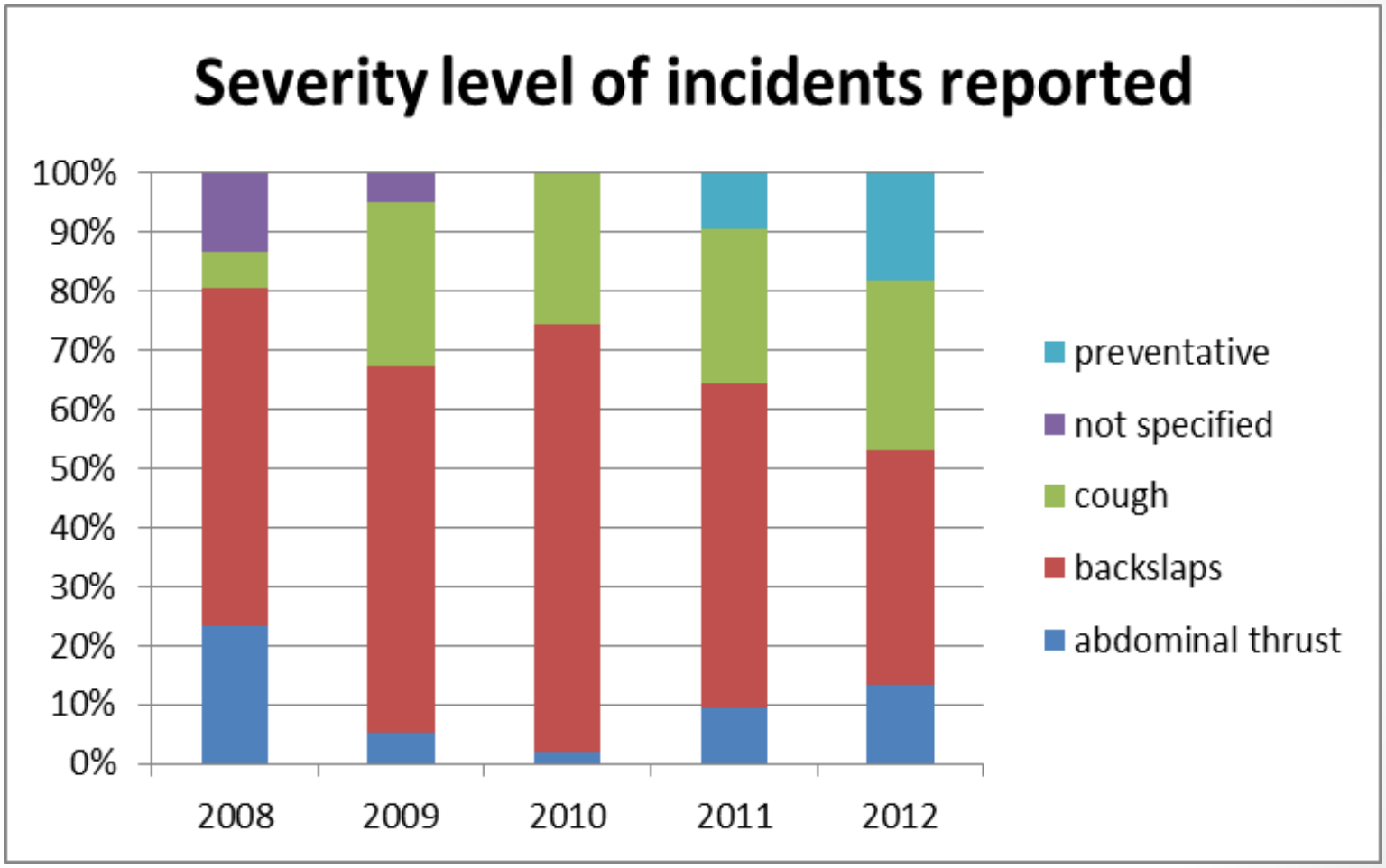
Evaluation:
Referrals to SLT service improved

Evaluation:
Reporting incidents improved



Evaluation:

Severity of choking incidents decreased

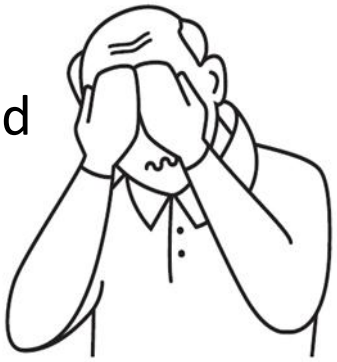


Evaluation: screening

- Shows impact of training in descriptive detail on screens and in quality of referrals
- Now have mealtime skills record over time
- Inclusive screening process triggers conversations about mealtime skills, prompting MDT review
- Increasing data > increasing understanding of risk factors/influences

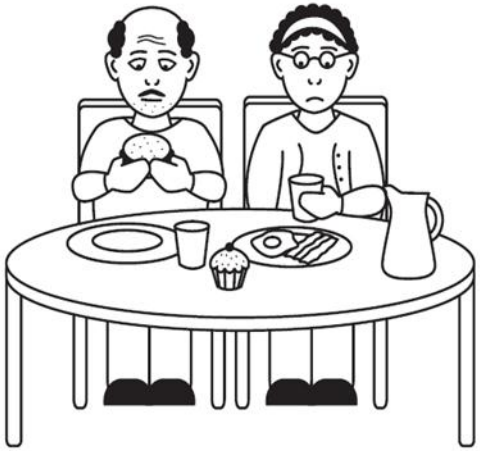
Evaluation: understanding of choking incidents

- Teatime (evening meal) is most common time of day to choke
- Mental illness is important factor
- Pressures and distractions at end of day affect staff and service user
- Dining rooms can be noisy, crowded and upsetting
- Choking can be quiet and easy to miss



What helps?

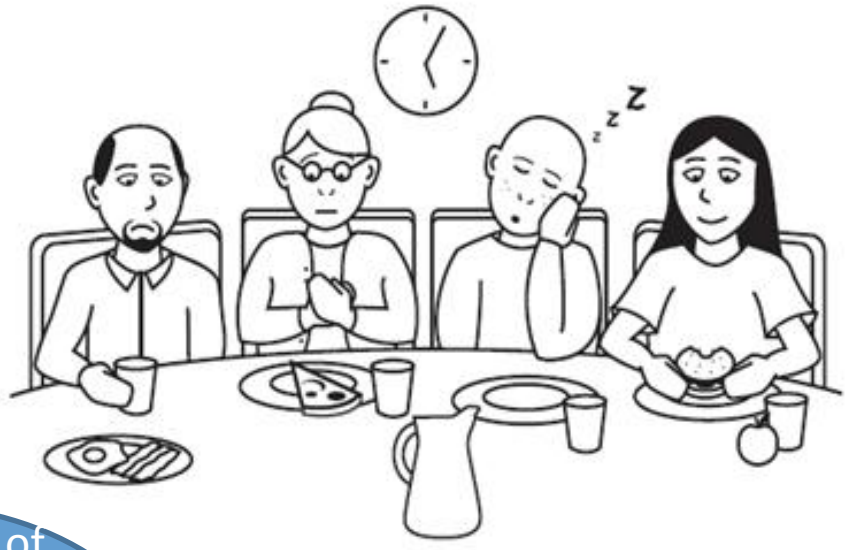
- Familiar staff are more aware of signs of change
- Flexibility to respond to personal preferences at mealtimes
- SLT training leading to earlier identification of mealtime difficulties



Evaluation: understanding of choking incidents

What is it about teatimes?

It's the only time of day we all sit close together (service user)



There's a lot of pressure to finish the meal quickly at this time of day (support worker)

Conclusion: Where are we now?

- Now working on improving service user involvement: developing accessible resources eg 'Me at mealtimes' book, video & i-pad use
- Dissemination continuing (exploring wider interest): individual, local, regional, international
- Potential benefit for other populations, long term care etc
- Seeking funding for further research: validation study of screening with easy access resources

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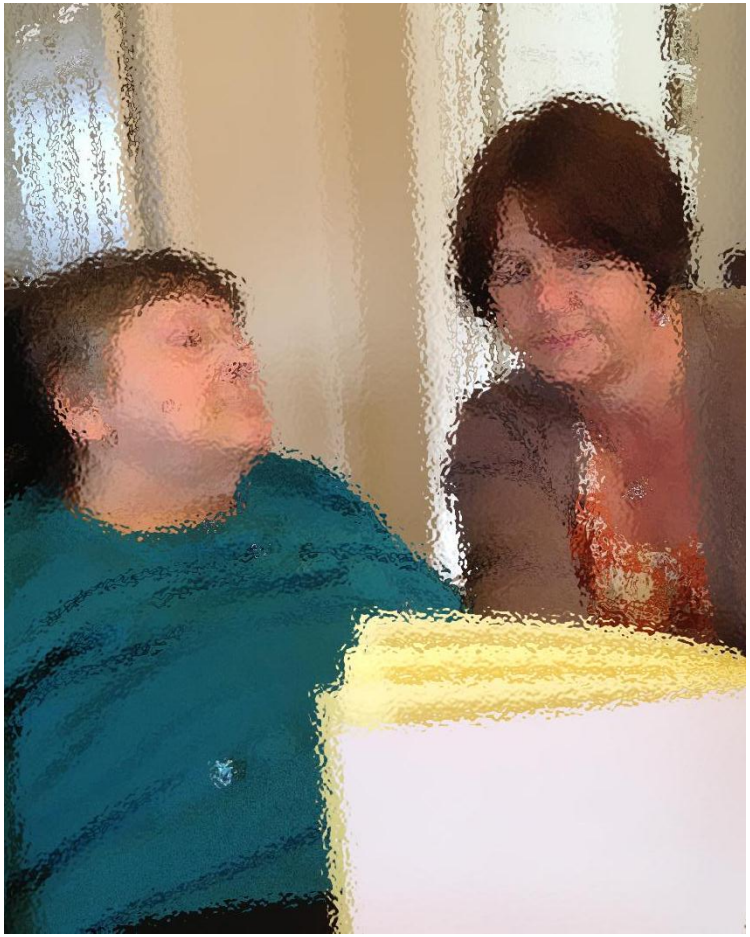

Identifying risk of mealtime difficulties – getting everyone involved

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