TITLE
CHOKING PREVENTION AND MANAGEMENT

SCOPE
Provincial: Continuing Care

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Not applicable

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this guideline, please contact the Policy & Forms Department at policy@albertahealthservices.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, and practice support documents.

OBJECTIVE(S)

- To reduce the risk of morbidity and mortality from **choking** incidents related to foreign-body airway obstruction.
- To increase **patient** safety by establishing competency/education requirements and processes to manage the risk of choking in a consistent and transparent approach ensuring accurate recording and communication of adverse events.

PRINCIPLES

Choking risk identification and risk mitigation is an essential component of quality care in all Continuing Care settings (home living, supportive living and facility living).

APPLICABILITY

Compliance with this guideline is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary) working in Continuing Care settings.

ELEMENTS

1. Education

1.1 Unregulated **health care providers** who provide assistance with nutrition and hydration and/or medication assistance shall receive training within six (6) months from the date of hire and at minimum every two (2) years thereafter (recommended annually) in:

a) choking prevention; and

b) response to a choking event involving a conscious patient with either partial or complete airway obstruction.

1.2 **Health care professionals** shall be certified in basic life support (BLS) with cardiopulmonary resuscitation (CPR), inclusive of appropriate responses to a choking event involving an unresponsive patient, as required according to their job description and/or terms of employment.

2. Screening/Assessment

2.1 All patients are screened and assessed for choking risk:

a) whenever a RAI-HC© (minimum annually) or RAI-MDS 2.0© (minimum quarterly) assessment is completed routinely, and upon significant change in the patient's health status; and

b) whenever a comprehensive assessment (Acute, Rehabilitation, End-of-Life, and Pediatric) is completed.

Refer to Appendix A: *Choking Prevention in Continuing Care - Care Planning Resources*.

2.2 Practice settings (inclusive of site, unit, program, etc.) may choose to implement additional validated screening/ assessment tool(s) based on the needs of the population served.

3. Care Planning

3.1 When risk of choking has been identified as a current issue, interventions to address the risk shall be documented in the care plan. As much as possible, the patient, and/or their **alternate decision maker(s)**, should be included in the development of the care plan. Refer to Appendix A: *Choking Prevention in Continuing Care - Care Planning Resources* for assessment and care planning support.

a) Patients and/or alternate decision maker(s) may choose to live at risk despite an identified choking risk. In this case health care providers will

negotiate with patients to minimize the risk as much as possible, and document the plan.

4. Interventions

4.1 Should a choking event occur, unregulated health care providers shall, as per level of training, carry out the following choking response interventions:

a) initiate steps to clear the airway of obstruction of a conscious patient;

b) if the airway is cleared immediately, report to a supervisor and/or a health care professional for further instructions;

c) if the airway does not clear immediately and the patient becomes unresponsive, notify a health care professional if available at the point of care, and/or activate the medical emergency response plan (e.g., activate Code Blue or contact Emergency Medical Services [EMS]) appropriate to the site or program;

d) remain with the patient until EMS or a health care professional arrives and assumes care of the patient; and

e) if currently trained in basic life support (BLS), attempt to clear the airway of the unresponsive patient.

4.2 Health care professionals shall:

a) initiate steps to clear the airway of obstruction of a conscious patient;

b) if the airway is cleared immediately, assess the need to transport the patient for further medical treatment, and/or to notify appropriate medical personnel (e.g., physician and/or nurse practitioner);

c) if the airway does not clear immediately and the patient becomes unresponsive, activate the medical emergency response plan (e.g., activate Code Blue or contact EMS) appropriate to the site or program, or based on the patient's plan of care;

d) attempt to clear the airway of the unresponsive patient; and

e) if at any time the patient is assessed to have no pulse and is not breathing, follow **goals of care designation** to determine if CPR should be initiated. Refer to *Advance Care Planning and Goals of Care Designation* Policy and Procedure.

5. Notification, Investigation and Reporting Requirements

5.1 In the event of an adverse event, close call, or hazard, health care providers shall follow the Alberta Health Services *Reporting of Clinical Events, Close Calls, and Hazards* Policy.

5.2 Adverse events shall be disclosed to the patient and their family as appropriate per the Alberta Health Services *Disclosure of Harm* Policy.

5.3 As appropriate, notify the patient's primary health care practitioner (i.e., patient's physician or nurse practitioner).

5.4 As appropriate, complete and submit a *Reportable Incident* Form to Alberta Health if the event was life threatening or resulted in serious harm.

6. Post Choking Incident

6.1 Following a choking event, the health care professional shall:

a) investigate and report any new complaints of breathing difficulties, pain, new or unusual cough, discomfort or difficulty swallowing, if appropriate;

b) review the patient's care plan to ensure risk mitigation interventions are relevant, appropriate, and based on the individualized need(s) of the patient; and

c) identify if any referrals or consults are required for further assessment or to identify risk mitigation strategies (e.g., Dietitian, Occupational Therapist, Speech Language Pathologist, Respiratory Therapist, Geriatric Consultant, etc.).

7. Documentation

7.1 In addition to the requirements identified in Section 5 of this guideline, the health care provider shall record any choking incidents in the patient's **health record** including but not limited to time of day, location of event, description of food/item ejected, level of intervention required, and impact on the patient.

8. Transfer

8.1 Documented choking risk shall be communicated to the receiving site upon transfer of the patient to another care setting.

DEFINITIONS

Alternate decision maker(s) means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the Mental Health Act or an agent in accordance with a Personal Directive or a person designated in accordance with the Human Tissue and Organ Donation Act.

Choking means, for the purpose of this document only, a partial or complete blockage of the airway resulting in obstruction of the flow of air from the environment into the lungs.

Goals of care designation means one of a set of short-hand instructions by which health care providers describe and communicate general care intentions, specific clinically indicated health interventions, transfer decisions, and locations of care for a patient as established after consultation between the most responsible health practitioner and patient or alternate decision-maker.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta), and who practices within scope and role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, Students, Volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients.

REFERENCES

- Appendix A: *Choking Prevention in Continuing Care - Care Planning Resources*
- Alberta Health Services Governance Documents:
  - *Advance Care Planning and Goals of Care Designation* Policy (#HCS-38)
  - *Advance Care Planning and Goals of Care Designation* Procedure (#HCS-38-01)
  - *Disclosure of Harm* Policy (#PS-01)
  - *Immediate and Ongoing Management of Clinically Serious Adverse Events* Guideline (#PS-11-01)
  - *Reporting of Clinical Adverse Events, Close Calls, and Hazards* Policy (#PS-11)
- Non-Alberta Health Services Documents:
  - *Continuing Care Health Service Standards* (Alberta Health)
  - *Reportable Incident* Form (HCE0001) (Alberta Health)

VERSION HISTORY

Date	Action Taken
May 09, 2016	Initial approval
May 19, 2016	Initial effective
June 1, 2016	Revised
May 13, 2019	Scheduled for review

APPENDIX A

Choking Prevention in Continuing Care - Care Planning Resources

Choking prevention in continuing care involves screening for risk of choking, identifying the level of risk for the individual, and implementing evidence-based risk reduction strategies that promote safe chewing and swallowing.

1. Screening/Assessment

Utilize the RAI-HC, RAI-2.0 or appropriate Comprehensive Assessment based on client group to help identify dysphagia, chewing problems and potential or actual choking risk.

RAI-HC:	**RAI-2.0**	**Acute, Rehabilitation, End-of-Life, and Pediatric**
• Section L: Nutrition/Hydration Status Supporting assessment information: • Section B: Cognitive Patterns • Section H.2(g): ADL Self Performance – Eating • Section J.1(g-l,s,z): Disease Diagnosis – Neurological, Psychiatric/Mood, Emphysema/COPD/Asthma • Section M: Dental Status (Oral Health) • Section Q: Medications	• Section K: Oral/Nutritional Status Supporting assessment information: • Section B: Cognitive Patterns • Section G.1(h): Physical Functioning and Structural Problems – Eating • Section I.1(q-kk): Disease Diagnosis – Neurological, Psychiatric/Mood, Pulmonary • Section L: Oral/Dental Status • Section O: Medication List	• Digestion/Hydration Supporting assessment information: • Oral Health • Respiration • Neuro-muscular-skeletal function • Cognition/consciousness • Medication Regimen • Personal Care (Eating Aids/Ability)
Also consider any history of choking or ingestion of non-food items		
Practice settings may choose to implement an additional screening/assessment tool based on the needs of the population served		

2. Risk Determination

Past history, current assessment and sound clinical judgment guide effective risk determination. The following may be used as a guideline to classify choking risk potential.

Low Risk	Moderate/High Risk
• No history of choking • Eats independently • No clearly identified risk factors Concerns that may require further investigation: • Need for repeated swallowing • Recurrent chest infections/pyrexia • Weak voluntary cough • Food residue in mouth • Inability to maintain optimal eating posture • Poor oral/dental health • Reduced appetite • Poor fitting dentures	• History of: choking; aspiration; swallowing disorder; chewing problems; mouth pain; dry mouth; prolonged swallow; changes in approach to food: avoidance of eating alone (fear), avoidance of eating with others (embarrassment), depression/frustration (r/t restricted food choices); • Complaints of: difficulty initiating a swallow; sensation of obstruction in throat or chest; regurgitation of food or acid; inability to handle secretions; impaired breathing during meals or immediately after eating; pain on swallowing. • Dependent for eating/oral care • Frail elderly • Psychiatric (medication related), neurological (paralysis), cognitive (impaired insight), or respiratory disease (micro-coordination of breathing swallowing) • Polypharmacy; sedating medications • Edentulous/poor dentition • History of ingesting non-food items

3. Risk Reduction Care Planning Interventions

The following interventions may be considered based on identified risk and individual assessed needs/preferences.
This is not an exhaustive list.
Please consider individualized needs and supports available.

Low Risk	Moderate/High Risk

General Interventions:
• Ensure dentures (if used) fit properly
• Provide oral care before and after meals
• Ensure the client is seated in an upright position
• Sit facing the client while assisting
• Adjust rate of feeding and size of bites to the person's tolerance
• Avoid rushed or forced feeding
• Ensure enough time to chew between bites
• Consider using a spoon instead of a fork when assisting
• Alternate solid and liquid boluses
• Observe for and report signs of choking, regurgitating, drooling, pocketing food, etc.
• Provide a pleasant mealtime atmosphere
• Increase concentration by reducing distractions (TV off; limit conversation during swallowing phase)
• Encourage participation
	All general interventions plus consider:
	• Evaluate swallowing specific quality of life using validated assessment tools (e.g., SWAL-QOL; SWAL-CARE; MD Anderson Dysphagia Inventory; EAT-10)[1]
	• Medication Review (r/t dry mouth; cause motor fluctuations; reduce alertness; depress reflexes; increase reflux; cause nausea; require alteration to administer)
	• Ongoing observation for aspiration pneumonia in high-risk persons
	• Effective mouth care is performed frequently to decrease oral bacterial load decreasing chance of aspiration pneumonia
	• Consider placement of food in the person's mouth according to the type of deficit (e.g. stroke) and appropriate head positions
	• Assess diet modifications to ensure they do not contribute to malnutrition/dehydration (e.g., unappealing texture/ presentation (use food molds); decreased food choices r/t modification needs (increase choices)
	• Re: inappropriate ingestion of non-food items
	  o Environmental scan for and removal of high risk non-edible / non-food items (e.g., paper napkins, condiment packages/lids, pill cups, latex gloves, etc.)
	  o Consider cloth napkins/placemats, bulk condiment packages (jars), keeping appropriate snacks readily accessible/ available
	• Involve a registered dietitian (RD) in care planning and assessment of appropriate diet texture and fluid consistency and comprehensive swallowing assessment
	• Referral to a speech language pathologist (SLP) for comprehensive swallowing assessment and appropriate interventions
	• Involve Physiotherapy (PT) to improve trunk/head control strength and arm/hand co-ordination
	• Referral to an occupational therapist (OT) to assist with functional challenges and equipment needs and comprehensive swallowing assessment
	• Referral to a respiratory therapist (RT) for comprehensive respiratory assessment and appropriate interventions
	• Referral to a geriatrician for cognitive/medical needs
	• Consult with a dental hygienist for oral care needs

[1] Miller, N., & Patterson, J. (2014). Dysphagia: implications for older people. Reviews in Clinical Gerontology, 24(01), 41-57.