

GUIDELINES FOR IDENTIFICATION AND MANAGEMENT OF CLIENTS AT RISK FOR CHOKING

CSH-1006

- PURPOSE:** To provide staff with a guideline for the identification and management of clients at risk for choking.
- GOALS:** To assist the individual client at risk for choking in learning how to eat with the highest degree of independence, safety, and the least restrictive diet possible while maintaining good health, nutrition, and hydration in order to reduce the risk of and ultimately prevent choking. Interventions may include proper positioning techniques, food consistency changes, use of adaptive equipment and individualized feeding programs.
- APPLICABILITY:** This policy applies to the clients residing in the long-term care areas of this facility. These include clients who reside in the Freeman building, Powell 3E, Binion 2N, Binion 1N and 1S (long-term clients only), Craig Nursing Center, Riverside Nursing Center, and all of the DDD. This policy also applies to any client residing in an acute psychiatric area, acute forensics area, or acute medical setting if the medical evaluation indicates a need to assess choking risk. This policy does not apply to clients who are fed via gastrostomy tubes.
- FREQUENCY:** The Choking Risk Assessment will be performed and the form completed by the attending physician or APRN annually for the clients designated above and with a change in the clients clinical condition as determined by the attending physician or APRN.
- PROCEDURE:**

I. IDENTIFICATION OF RISK FACTORS FOR CHOKING

Any member of the Treatment Team will identify clients as having a potential for choking through observation of risk factors.

- A. Risk factors for choking:
1. Eating too fast (packing mouth full of food)
 2. Difficulty chewing
 - a. Absence of chewing
 - b. Missing or absent teeth
 - c. Ill-fitting dentures
 - d. Dental caries
 3. Difficulty swallowing
 - a. Coughing during or after eating
 - b. Choking

- c. Gagging on food and/or liquids
 - d. Medical diagnosis of difficulty swallowing
 - e. Diagnosis of reflux, cerebral palsy, narrowing of the throat, tongue placement/tongue thrust
- 4. Environmental factors
 - a. Distractions during eating
 - b. Rushing while eating
 - c. Improper positioning
- 5. Food residual
 - a. Food in cheek
 - b. Residual food in mouth following swallowing and/or eating
 - c. Food and/or liquid through nose or mouth
- 6. Behavior Issues
 - a. Stealing food
 - b. Pica
 - c. Packing too much food in mouth
- B. Signs and Symptoms:
 - 1. Unplanned weight loss
 - 2. Unusual drooling
 - 3. Pica behavior and/or stealing
 - 4. Prolonged mastication
 - 5. Throat clearing frequently
 - 6. Coughing during or after the meal
 - 7. Swallowing several times on one bite
 - 8. Food or liquid falling out of the mouth
 - 9. Voice that sounds wet or “gurgly”
 - 10. Changes in voice
 - 11. Congestion
 - 12. Wheezing
 - 13. Complaints of throat or chest discomfort
 - 14. Awakens at night coughing or gagging
 - 15. Refusal to eat
 - 16. Upper respiratory infection
 - 17. Persistent low-grade fever
 - 18. History of Aspiration Pneumonia
- C. Common choking hazards:
 - 1. Foods
 - a. Popcorn
 - b. Potato chips
 - c. Hot-dogs and sausages
 - d. Peanuts and nuts
 - e. Chunks of meat
 - f. Hard candies
 - g. Grapes
 - h. Raw carrots

- i. Apple chunks
- j. Fruit seeds
- k. Raisins
- 2. Household items
 - a. Toys with small parts
 - b. Coins
 - c. Small balls and marbles
 - d. Balloons
 - e. Jewelry
 - f. Arts and crafts

II. OBSERVATION AND REPORTING OF RISK FACTORS:

If any of these risk factors are observed the person making the observation should document the episodes and notify:

- A. Nurse
- B. Physicians
 - 1. Upon notification, the RN/Physician/Dietitian should complete and document a risk assessment for the client.
 - 2. Risk assessment should be done based on the client's needs/occurrences.
 - 3. Documentation of assessments should be maintained in the client health record.

III. REFERRAL PROCESS:

If, during the clinical assessment process, the client is determined to be at a significant risk (aspiration, dysphagia, dehydration or a nutritional problem), the physician should be notified immediately to ensure that the client's safety is maintained and appropriate action is taken.

- A. Recommendations should be sent to the Treatment Team from the physician, dietitian, and appropriate action taken based on these findings.
- B. The RN/physician/dietitian/Treatment Team members will send a referral to the appropriate clinical staff for further assessment.

IV. EVALUATION:

Based on the Treatment Team/physician/dietitian, the following may be scheduled:

- A. Modification of diet: The dietitian will evaluate for appropriate changes in food consistency.

- B. Occupation and Physical Therapy: The therapists will evaluate for adaptive feeding equipment and wheelchair positioning during mealtime.
- C. Clinical swallowing evaluation: The speech/language therapist will complete a detailed report.
- D. Modified Barium Swallowing: This is especially important if aspiration or difficulty swallowing is suspected.

V. MONITORING/FOLLOW UP:

- A. Annual choke risk screening assessment by physician
- B. Documentation of mealtime observation by dietician
- C. Choke episode report
- D. Periodic re-assessment/monitoring PRN

VI. ENSURE IMPLEMENTATION OF RECOMMENDATION FROM TREATMENT TEAM

- A. The RN will review the choke risk assessment completed by the physician. A positive score indicates risk of choking.
- B. The nurse will incorporate the Choke Risk Prevention Intervention into the care plan based on the individual client's needs.
- C. The nurse will ensure the Choke Risk Prevention Interventions are implemented and carried out by the assigned staff.

VII. RECOMMENDED ASSESSMENTS AND FOLLOW-UP BASED ON RESULTS OF THE ASSESSMENT

- A. **Minimal Risk**
 - 1. Annual and prn reassessment
- B. **Moderate Risk**
 - 1. Annual and prn reassessment
 - 2. Dietary Evaluation to determine if dietary modification is required
 - 3. OT assessment regarding the need for adaptive feeding equipment
 - 4. Treatment Team assessment of environmental or behavioral issues related to eating and choking risk
 - 5. Bedside swallowing study
 - 6. During evaluation, provide one-to-one staffing during eating
- C. **Severe Risk**
 - 1. All of the above, plus a modified barium swallow