Standardised care process (SCP): choking

health

Topic

Response to a choking episode

Objective

To promote evidence-based practice in the response to a choking episode

Rationale

Normal age-related changes place older people at risk of experiencing swallowing problems. The risk is increased by pathological changes such as dementia, stroke, functional decline and the use of medicines. Choking is a medical emergency and can lead to death. Staff initiating appropriate responses to choking can improve outcomes for residents.

Definitions
Choking: complete or partial obstruction of the airway by inhalation of a foreign body
Back thrust: blow to the centre of the back between the shoulder blades using the heel of the hand
Chest thrust: blow to the CPR compression point, similiar to CPR compressions but sharper and delivered at a slower rate. (Australian Resuscitation Council, 2010)
Dysphagia: difficulty with swallowing

Team

Manager, RNs, ENs, PCAs, resident and/or family, GP, speech pathologist, dietician

Evidence base for this SCP

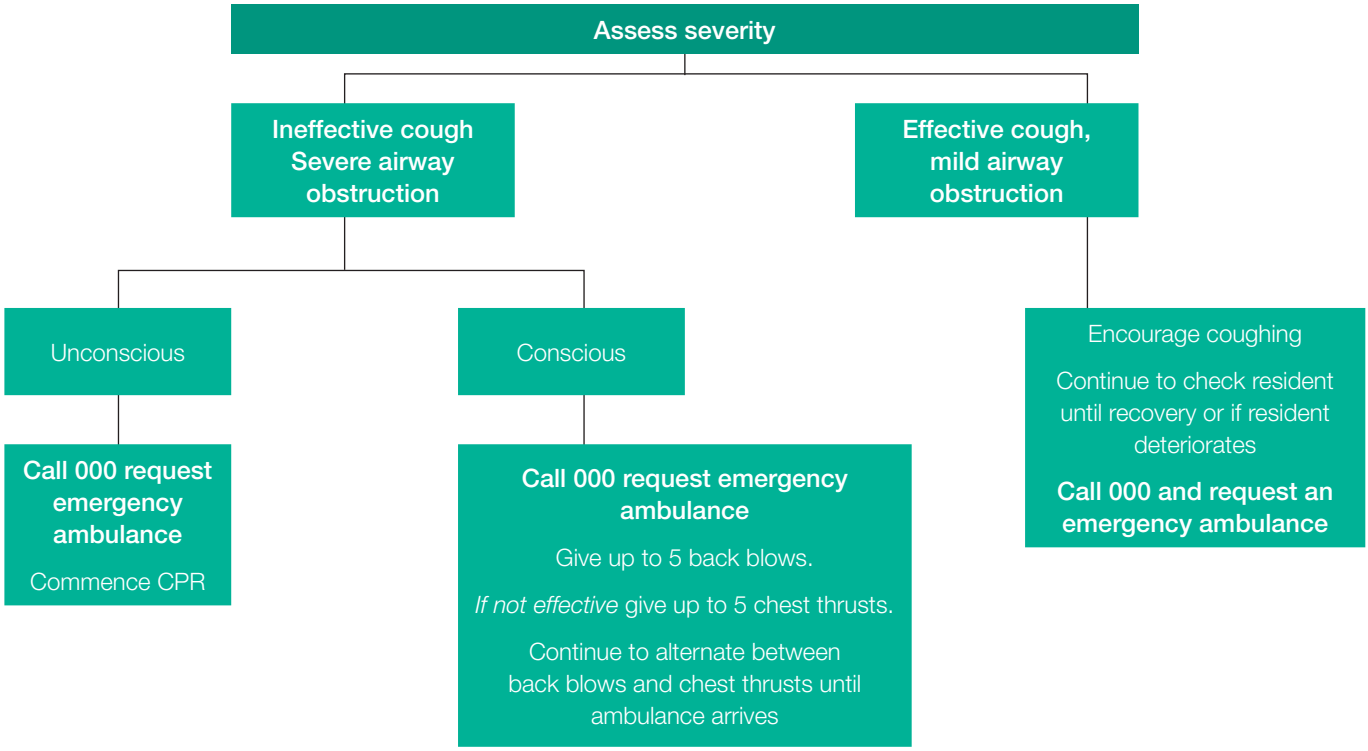
Australian Resuscitation Council 2010, *Guideline for the management of foreign body airway obstruction*, Australian Resuscitation Council, retrieved 24 January 2012, <http://www.resus.org.au/>.

Hines S, Wallace K, Crowe L, Finlayson K, Chang A & Pattie M 2011, 'Identification and nursing management of dysphagia in individuals with acute neurological impairment' (update), *International Journal of Evidence Based Healthcare*, June: 9(2), 148–150.

Joanna Briggs Institute (JBI) 2008, *Best practice information sheet: identification and management of dysphagia in adults with neurological impairment*, JBI, Adelaide.

Royal Australian College of General Practitioners (RACGP) 2006, *Medical care of older persons in residential aged care facilities* (4th ed.), RACGP, Melbourne.

Flow chart: Immediate response to a choking episode



(Australian Resuscitation Council, 2010)

Brief SCP: Choking

Recognition and assessment	• Recognise presence of airway obstruction • Assess severity of airway obstruction. This may be partial or complete and the resident may be conscious or unconscious. Severity is assessed readily by determining whether the resident is able to cough effectively or if the cough is not effective • Assessment post-episode
Interventions	• Inform RN • Immediate response to choking episode as per flow chart • Referral to GP and speech pathologist for assessment • Implement risk minimisation strategies as above
Referral	Refer to: • RN • ambulance services: emergency assistance • GP: assessment and recommendations post episode • speech pathologist: swallowing assessment and recommendations post episode.
Evaluation and reassessment	Monitor: • swallowing status • adequacy of food and fluid intake • chest for signs of chest infection.

Resident involvement	• Education regarding risk factors • Discussion regarding modified diets • Advance care planning
Staff knowledge and education	• Immediate response to a choking episode • Identification of swallowing difficulties • Interventions to reduce risk of choking once swallowing difficulties have been identified

Full SCP: choking

Recognition and assessment	Recognise presence of airway obstruction. • Symptoms in the conscious resident include: – extreme anxiety – agitation – gasping sounds – coughing – loss of voice – resident may clutch neck. • Partial obstruction is indicated if: – breathing is laboured – breathing is noisy – air can be felt from the mouth. • Complete obstruction is indicated if: – resident is attempting to breathe – there is no sound of breathing – no air can be felt coming from the mouth. Assess severity of airway obstruction. This may be partial or complete and the resident may be conscious or unconscious. Severity is assessed readily by determining whether the resident is able to cough effectively or if the cough is not effective. Following an episode of choking: • conduct a swallowing assessment • refer to GP and/or speech pathologist for assessment and recommendations • refer to dietician • monitor resident for signs of chest infection • monitor food and fluid intake to ascertain whether these are adequate • refer to dietician if intake is not adequate.
Interventions	**Inform RN** Immediate response to choking episode as per flow chart: *Immediate response to a choking episode.* • If the resident is coughing (effective cough): – encourage the resident to keep coughing to force out the foreign body – inform GP – inform family.

Interventions	• If the resident is not coughing and is conscious: – call 000 and request emergency ambulance – give up to five blows in the centre of the back, between the shoulder blades using the heel of the hand – after each blow check whether the obstruction has been relieved as the aim is to relieve the obstruction with each blow rather than give all five blows – if back blows are not effective identify the CPR cardiac compression point and give up to five chest thrusts. Chest thrusts are similar to cardiac compressions but sharper and delivered at a slower rate – after each thrust check whether the obstruction has been relieved as the aim is to relieve the obstruction with each thrust rather than give all five thrusts. – if obstruction is not relieved continue to alternate back blows and chest blows until the ambulance arrives – inform GP – inform family. • If the resident is unconscious: – call 000 and request an emergency ambulance – open the resident's mouth and tilt slightly downwards to let any obvious foreign body drain out – remove loose dentures - well fitting dentures may be left in place – examine the mouth for any visible foreign objects – if present remove any visible foreign objects with gloved fingers – if object is not visible or the resident does not start breathing commence CPR. After an episode of choking: • identify possible causes • refer to GP • refer to speech pathologist if available for swallowing assessment and recommendations. Implement risk minimisation strategies such as: • modified diet and fluid textures • avoidance of mixed texture foods (for example, solid and liquid foods together such as vegetable soups, food with seeds, sticky foods, dry crumbly foods) • modify the way in which assistance with meals is provided (for example, encourage coughing after swallowing, allowing adequate time for chewing and swallowing, check mouth for residual food after each meal, provide oral hygiene after each meal) • ensure resident is sitting upright and encourage slow swallowing.
Referral	• RN • Ambulance services: emergency assistance • GP for assessment and recommendations post episode • Speech pathologist: swallowing assessment and recommendations post episode • Dietician

Evaluation and reassessment	Monitor: • swallowing status • adequacy of food and fluid intake • chest for signs of chest infection.
Resident involvement	• Education regarding risk factors • Discussion regarding modified diets and safe swallowing methods • Advance care planning
Staff knowledge and education	• Immediate response to a choking episode • Identification of swallowing difficulties • Interventions to reduce risk of choking once swallowing difficulties have been identified • Education regarding swallowing strategies (head tilt etc.)

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