Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY DOCUMENT

ASSESSMENT AND MANAGEMENT OF CHOKING (ADULTS)

Policy Number:	**SD52**
Scope of this Document:	**All Staff**
Recommending Committee:	**Physical Health Strategy Working Group**
Approved By:	**Executive Director of Nursing & Operations**
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Lead Executive Director:	**Executive Director of Nursing & Operations**
Lead Author(s):	**Modern Matron (Physical Health) Members of the Trust Choking Group including Speech & Language Therapists Dietitians & Physiotherapists**

TRUST-WIDE CLINICAL POLICY DOCUMENT

2020 – Version 3

Striving for perfect care and a just culture

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ASSESSMENT AND MANAGEMENT OF CHOKING (ADULTS)

Further information about this document:

Document name	**ASSESSMENT AND MANAGEMENT OF CHOKING (ADULTS) SD52**
Document summary	**This policy provides practice gudance for all Mersey Care NHS Foundation Trust staff. This guidance has been developed based on the document: *Reducing the risk of choking for people with a learning disability: a multi-agency review in Hampshire* produced by Hampshire Safeguarding Adults Board Multi-Agency Partnership (2012) abd *Supporting People at Risk of Choking Policy* (2016) by Hampshire County Council. This document provides guidelines for staff to help identify when a person may be at risk of choking as well as practice guidelines regarding the choking risk pathway.**
Author(s) Contact(s) for further information about this document	**Joanne Scoltock** **Modern Matron (Physical Health)** **Telephone: 0151 471 2396** **Email: Joanne.Scoltock@merseycare.nhs**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Resus Policy** **Dysphagia Policy**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Version 1	New document developed and approved	November 2018
Version 2	Approved by Choking Task & Finish Group	December 2019
Version 3	Amendments and Consultation with Divisions	February 2020

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child /adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1. PURPOSE AND RATIONALE

1.1 Choking occurs in all patient groups; more at risk are those with a learning disability, dementia, stroke, progressive neurological conditions, complex mental health difficulties, and head injury.

1.2 This policy is to ensure that patients who experience or are at risk of choking episodes receive the highest possible level of assessment, care and support, while keeping the risks associated with this potentially life threatening condition to a minimum.

1.3 This policy provides practice guidance for all Mersey Care NHS Foundation Trust staff. This guidance has been developed based on the document: *Reducing the risk of choking for people with a learning disability: a multi-agency review in Hampshire* produced by Hampshire Safeguarding Adults Board Multi-Agency Partnership (2012) and *Supporting People at Risk of Choking Policy* (2016) by Hampshire County Council. This document provides guidelines for staff to help identify when a person may be at risk of choking as well as practice guidelines regarding the choking risk pathway.

1.4 This policy is in no way intended to supersede basic life support training and is intended only to help identify those at risk of choking, eg from a preventative point of view.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 To reduce the number of choking incidents for inpatient and community patients.

2.2 Increase staff awareness of the risks associated with choking and management of identified risks in line with perfect Care.

3. SCOPE

3.1 This policy is relevant to all Trust staff who are in contact with people who are or who may be at risk of choking. This policy applies to staff employed by the Trust, including all Bank and Agency staff.

3.2 This policy has considered a number of areas including:

- reporting choking episodes/incidents,
- screening for the increased risk of choking,
- care planning and risk management,
- training and health promotion,
- capacity/best interests issues,
- commissioning and monitoring of food provision, mealtime supervision/support and environments,
- protected meal times Going into hospital (general or MCFT).

4. DEFINITIONS

Glossary of Terms	Definition
Asphyxiation	A lack of oxygen or excess of carbon dioxide in the body that is usually caused by interruption of breathing and that causes unconsciousness or death.
Aspiration	Aspiration refers to the situation where material or residue enters the airway and passes below the level of the vocal cords. It usually results in a reflexive cough, but maybe silent.
Binge Eating Disorder (BED)	The main symptom of binge eating disorder is eating very large amounts of food in a short time, often in an out-of-control way. But symptoms may also include: • eating very fast during a binge • eating until you feel uncomfortably full • eating when you're not hungry • eating alone or secretly • feeling depressed, guilty, ashamed or disgusted after binge eating.
Choking	Choking is the introduction of a foreign object (edible or non-edible) into a person's airway which becomes lodged and reduces or completely obstructs the air flow to the lungs. Most obstructions are cleared by the person coughing but in some cases airflow is completely blocked, there may be no sounds to alert others and a person can die within minutes. Signs of a choking episode may include the person being unable to speak (if they are usually able to), they are unable to breathe, breathing sounds wheezy, attempts at coughing are silent, decreasing levels of consciousness, quiet or silent cough, cyanosis.
Dysphagia	Reduction or loss of oral or pharyngeal skills can impact on risks of choking. The term dysphagia is used to describe swallowing disorders characterised by difficulty in oral preparation for the swallow or in moving the bolus from the mouth to the stomach. Subsumed in this definition are problems in positioning food in the mouth and in the oral movements, including suckling, sucking and mastication. Early identification of the symptoms of dysphagia is essential.
IDDSI	International Dysphagia Dietary Standardisation Initiative
Pica	People eating items compulsively of no nutritional value, such as clothing. People may eat relatively harmless items of potentially dangerous items.
Tachyphagia	Excessively rapid eating or cramming food into the mouth, which is behavioural in nature.

5. DUTIES

5.1 Board of Directors

Health care providers are under obligation to provide safe care to their service users and appropriate training to their staff. This duty encompasses ensuring the physical health care of service users whilst under the care of the organisation and the Trust has an obligation to comply with its statutory observations.

The Board of Directors has overall responsibility for ensuring that all staff are appropriately trained and competent to effectively fulfil their role within the organization and to maintain the safety of service users.

5.2 Executive Director

The lead Executive Director for this policy and procedure is the Executive Director of Nursing and Operations. The Executive Director for Nursing and Operations is responsible for the Quality and Patient Safety across the organization and ensuring that arrangements are in place for the optimum level of assessment, care and support in the management of dysphagia.

Will ensure that all managers are aware of the policy and are supported in implementing and assuring its use.

5.3 Chief Operating Officers

Are responsible for ensuring that a structure is in place to implement this policy within their Division and that choking risk care plans are in place which meet the specific needs of people who use the service.

5.4 Service Managers, Modern Matrons and Lead Clinicians

Will ensure that:

a) staff have an understanding of how to identify the need to refer on for specialist advice and intervention;

b) staff have the competencies to follow an individualised treatment plan;

c) information relating to choking risk is reviewed on a regular basis to identify learning and action to improve the management of dysphagia. This may include the review of adverse incidents;

d) ensure all staff are up to date with mandatory remaining and what procedures to follow in the event of choking incident.

5.5 Speech and Language Therapist

Will:

a) assess diagnose and provide management strategies for dysphagia;

b) write and review treatment/care plan;

c) liaise with patient, carers, GP and other professionals involved;

d) provide training and education about the Speech and Language Therapist role,

dysphagia awareness, etc;

e) make safeguarding referrals to the Local Authority, as necessary;

f) provide support and advice for palliative care;

g) refer on to other services in relation to choking (eg primary health);

h) organise best interest meetings for patients who do not have capacity to consent to assessment and/or management.

5.6 **Speech and Language Therapy Assistant**

Will:

a) recognise and raise concerns about service user issues related to dysphagia and choking risk. Refer for SALT assessment, as necessary;

b) assess diet, nutrition and hydration. Advise on the nutritional and hydration adequacy of dietary intake;

c) advise on appropriate prescribing of oral nutritional supplements;

d) provide guidance on nutrition and hydration in palliative care;

e) refer for artificial nutritional support and monitor patients who are enterally tube fed;

f) provide staff training on enteral tube feeding;

g) monitor anthropometry and weight;

h) write and review patient centred dietetic treatment/care plan.

5.7 **Dietitian**

Will:

a) recognise and raise concerns about service user issues related to dysphagia and choking risk. Refer for SALT assessment, as necessary;

b) assess diet, nutrition and hydration. Advise on the nutritional and hydration adequacy of dietary intake;

c) advise on appropriate prescribing of oral nutritional supplements;

d) provide guidance on nutrition and hydration in palliative care;

e) refer for artificial nutritional support and monitor patients who are enterally tube fed;

f) provide staff training on enteral tube feeding

g) monitor anthropometry and weight;

h) write and review patient centred dietetic treatment/care plan.

5.8 **Nursing Staff**

Will:

a) recognise and raise concerns about service user issues related to choking risk and make referral for assessment, as needed;

b) follow individualised choking risk care plan;

c) write and review treatment/care plan. This is specific to choking so the plan will not necessarily include a SALT dysphagia plan – the aim was to keep dysphagia and choking separate and for other professionals to take ownership of care plans re choking risk (however, if someone has an existing dysphagia plan, this could be referenced but is not a mandatory part of the choking care plan);

d) support positive behaviour.

5.9 **Occupational Therapist**

Will:

a) recognise and raise concerns about patient issues related to choking risk and make referral for assessment, as necessary;

b) assess feeding equipment and environment;

c) sensory assessment;

d) postural care;

e) write and review treatment/care plan;

f) advise around aids and adaptations to maintain independence, as well as support when eating and drinking.

5.10 **Physiotherapist**

Will:

a) recognise and raise concerns about patient issues related to choking risk and make referral for assessment, as necessary;

b) advise around posture, positioning and seating;

c) write and review treatment/care plan;

d) assess and advise regarding respiratory status, including chest physiotherapy.

5.11 **Medical Staff, eg GP, Consultants**

Will:

a) recognise and raise concerns about patient issues related to choking risk and make referral for assessment, as necessary;

b) write and review treatment/care plan;

c) medication review, eg side effects, liquid vs tablet format;

d) referral on to other services, such as gastroenterology;

e) monitor physical health, including chest health;

f) prescribing/medication review.

5.12 **Pharmacy**

Will:

a) advise around different formulation of medication, medicine information, side effects, etc;

b) covert medication.

5.13 **ENT and Gastroenterology**

Will:

a) diagnose symptoms and causes of reflux;

b) identify medical issues relating to choking;

c) assess, diagnose and manage oesophageal stage dysphagia;

d) undertake structural investigations.

5.14 **Catering Staff**

Will:

a) supply appropriate texture modified diets;

b) supply fortified diet as guided by the dietetic care plan;

c) Catering Managers provide cascade training to catering staff on IDDSI descriptors.

5.15 **Psychology**

Will:

a) recognise and raise concerns about service user issues related to choking risk and make referral for assessment, as necessary;

b) input around deliberate attempts to block airway, PICA, taking food from others, secretive binging on food (BED – Binge Eating Disorder);

c) work with the MDT to assess and manage behaviours around eating, drinking and choking risk.

5.16 **Ward and Team Managers**

Will:

a) ensure that their employees and/or subcontractors who give care are fully aware that choking risks can result in fatal choking incidents;

b) ensure their employees and/or subcontractors have an adequate understanding of the varied conditions and circumstances which can place a person at risk of choking;

c) provide an appropriate screening tool for employees and/or subcontractors to use when they are concerned that a person may be at risk of choking;

d) will identify the choking risk of each patient under their care;

e) ensure that their employees are suitably trained to provide support at mealtimes and to observe and assess eating and drinking skills at each and every meal; as well as consider protected meal times;

f) ensure employees are trained/have access to guidance on what measures to take if a choking incident occurs;

g) ensure their employees and/or subcontractors know when and how to escalate concerns to a specialist service – for example, speech and language therapy, when this has been indicated by the screening tool.

6. PROCESS

6.1 Training

All MCT staff working on complex care wards should undertake the face to face (role specific) mandatory training session. This is on recruitment into the organization and then repeated every two years. Staff may undertake further training which is appropriate to their role.

6.2 Choking Risk Pathway

The choking risk pathway provides a framework for the screening, identification and management of the risk of choking, see Appendix 1, Pg19/20.

6.2.1 Screening Risk of Choking

a) all service users must be screened using the Trust Choking Risk Screen which forms part of the MDT admission process, see Appendix 5.

b) the Trust Choking Risk Screen can be completed at several intervention points:

- on admission to inpatient service,
- at intake for community service, intake refers to initial assessment completed by the clinician referred to,
- following chocking incident – witnessed and reported,
- if there has been a significant change in the person's physical/mental health or social situation which might increase their risk of choking.

c) staff must gain the consent of the person wherever possible, before any screening, assessment or medical investigation is undertaken in line with Trust policy and all decisions must be documented.

d) following completion of screen, make a referral on to appropriate service as necessary, eg SALT, Dietitian, OT, Physio, Psychology, GP/Consultant, and Dentist, see Appendix 5, Pg33.

6.2.2 **Reporting of Choking Incident**

When choking episodes occur these should be reported through the Trust Incident Reporting System. Choking episodes should be well documented in care plans and risk assessments in order that frequency and severity can be determined and action (what staff did) reviewed.

6.3 **Care Planning**

6.3.1 Following identification of choking risk, a single choking risk management care plan must be developed with MDT input which captures all professional input for the patient. Different professionals or care givers will often have their own care plans for the people they are supporting. If a person has increased risks around eating and drinking this must be considered and reflected consistently throughout the care planning process. A consistent approach across all care givers is very important for keeping the person safe and reducing the risk of choking. Ensure there is good communication about the care plan between services, for example on admission to or discharge from hospital.

6.3.2 The development of individual care plans must, wherever possible, include the person and those who provide care. The principles and requirements of the Mental Capacity Act 2005 and Best Interests must be considered and implemented when developing an individual care plan.

6.3.3 Where a risk of choking/problems with eating, drinking, medication and pica is identified, the plan must include what the concern is and what needs to be done.

6.3.4 A person's care plan and any decisions outlined in it must be updated following changes identified by the choking screening tool.

6.3.5 While regular reviews are of course necessary, staff must remain vigilant and responsive to the individual's needs on a daily basis, during all oral intake, including meals, drinks, snacks and medications.

6.3.6 If a person lacks capacity to make an informed decision about their own care or where care workers or family members disagree with any decision reached regarding the person's care and the person lacks capacity, a best interest discussion must be held following Trust policy. Where a shared decision has been made this need to be well documented within the care plan.

6.3.7 It may be necessary to restrict access to certain environments, foods or objects for some people due to a risk of choking. In all cases this must be taken as a best interest decision and be documented in the usual way. On occasions it may be appropriate to consider whether this is a Deprivation of Liberty and the appropriate process undertaken to assess this, ie referral as a Deprivation of Liberty Safeguards application to the funding authority if within residential care or an application to the Court of Protection if not within a residential setting.

7. CONSULTATION

7.1 These guidelines were developed by the sub group of the Trust Physical Health Strategy Working Group meeting and wider consultation with AHP/Nursing colleagues across the Divisions.

8. TRAINING AND SUPPORT

8.1 The Trust must ensure that clinical ward based staff and/or subcontractors have sufficient training through its role specific mandatory training on commencement in post (or be able to evidence they have undertaken similar training within another organisation within the last two years) to:

a) be able to safely deliver care to any person at risk of choking;

b) be able to respond to an episode of choking by administering the correct first aid care and then seeking appropriate aftercare.

8.2 All services should have documented a suitable and sufficient first aid risk assessment that identifies a minimum level of trained first aid cover at all times based on the needs of the individual circumstances.

8.3 Staff should be trained in reporting incidents and safeguarding.

8.4 Clinical staff based on complex care wards undertake Basic Dysphagia Awareness training as part of their Role Specific Core Mandatory Training, on commencement in post and then every two years to maintain competence.

8.5 Staff from other areas in the Trust can attend training if issues and risks are highlighted.

9. MONITORING

9.1 The Divisional Chief Operating Officers will have responsibility for ensuring this policy is implemented and supported with the development of a Standard Operating Procedure (SOP) and compliance monitored via an appropriate audit process for their services. Divisional AHP Leads will be responsible for supporting Chief Operating Officers with developing appropriate audit processes and reviewing compliance. Assurance in relation to this process should be presented on an annual basis via Divisional governance compliance checks.

9.2 Role Specific Mandatory Training will be recorded centrally through to the Strategic Workforce Group and these reports will feed into each Division to support a robust monitoring framework for compliance with training requirements particularly for staff working on the complex care wards.

10. EQUALITY AND HUMAN RIGHTS ANALYSIS

Title: SD52 Assessment and Management of Choking
Area covered: Trust-wide Clinical Policy

What are the intended outcomes of this work?
Who will be affected? 10.1 Choking occurs in all patient groups; more at risk are those with a learning disability, dementia, stroke, progressive neurological conditions, complex mental health difficulties and head injury.

Evidence
What evidence have you considered? The policy document and relevant NHS guidance.
Disability (including learning disability) The policy is likely to have a positive impact on people with Learning Disability as our service provides a specialist service for people with LD and we work closely with other disciplines to provide an integrated, holistic approach. People with physical or sensory disabilities are not excluded from our services. Eating and drinking needs are considered within a social model of disability.
Sex No issues identified.
Race No issues identified.
Age Eating, drinking and swallowing difficulties can occur at any age and can affect people with learning disability throughout their lifespan. This policy covers services for people aged 18 and over and not for those undergoing transition from child to adult services. The service does not exclude people on the basis of their age apart from where there are other specialist services more appropriate to their needs (ie paediatric service).
Gender reassignment (including transgender) This policy is unlikely to negatively impact on this group. People who are undergoing/having undergone gender reassignment would not be excluded from our service or treated adversely.
Sexual orientation No issues identified.
Religion or belief This policy is unlikely to negatively impact on someone because of their religion or beliefs. A person would not be excluded from the service due to their religion or beliefs. Staff are mindful of different beliefs for example around health and disability, food and drink

preferences.
Pregnancy and maternity No issues identified.
Carers No issues identified.
Other identified groups No issues identified.
Cross Cutting No issues identified.

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	Human Rights Based Approach supported
Right of freedom from inhuman and degrading treatment (Article 3)	Human Rights Based Approach supported
Right to liberty (Article 5)	Human Rights Based Approach supported
Right to a fair trial (Article 6)	Not engaged
Right to private and family life (Article 8)	Not engaged
Right of freedom of religion or belief (Article 9)	Not engaged
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	Not engaged
Right freedom from discrimination (Article 14)	Not engaged

Engagement and Involvement These guidelines were developed by the sub group of the Trust Physical Health Strategy Working Group meeting and wider consultation with AHP/Nursing colleagues across the Divisions.

Summary of Analysis
Eliminate discrimination, harassment and victimisation This policy should ensure that all patients/service users and in particular those with a learning disability and older people will be treated to promote their physical and mental well being.
Advance equality of opportunity Not applicable.
Promote good relations between groups Not applicable.

What is the overall impact?
The policy does not advance equality of opportunity for any group but ensures a fair approach to undertaking to the management of Assessment and Management of Eating, Drinking and Swallowing Disorders.

Addressing the impact on equalities
There needs to be greater consideration regarding health inequalities and the impact of each individual development/change in relation to the protected characteristics and vulnerable groups.

Action planning for improvement
Not applicable.

For the record **Name of persons who carried out this assessment:** George Sullivan (RMN), Equality and Human Rights Advisor, Secure Division Lynn King, Trust-wide Strategic Recovery & Allied Health Professions Lead Joanne Scoltock, Modern Matron, Executive Nursing Team
Date assessment completed: 19.2.20
Name of responsible Director: Trish Bennett Executive Director of Nursing & Operations
Date assessment was signed: February 2020

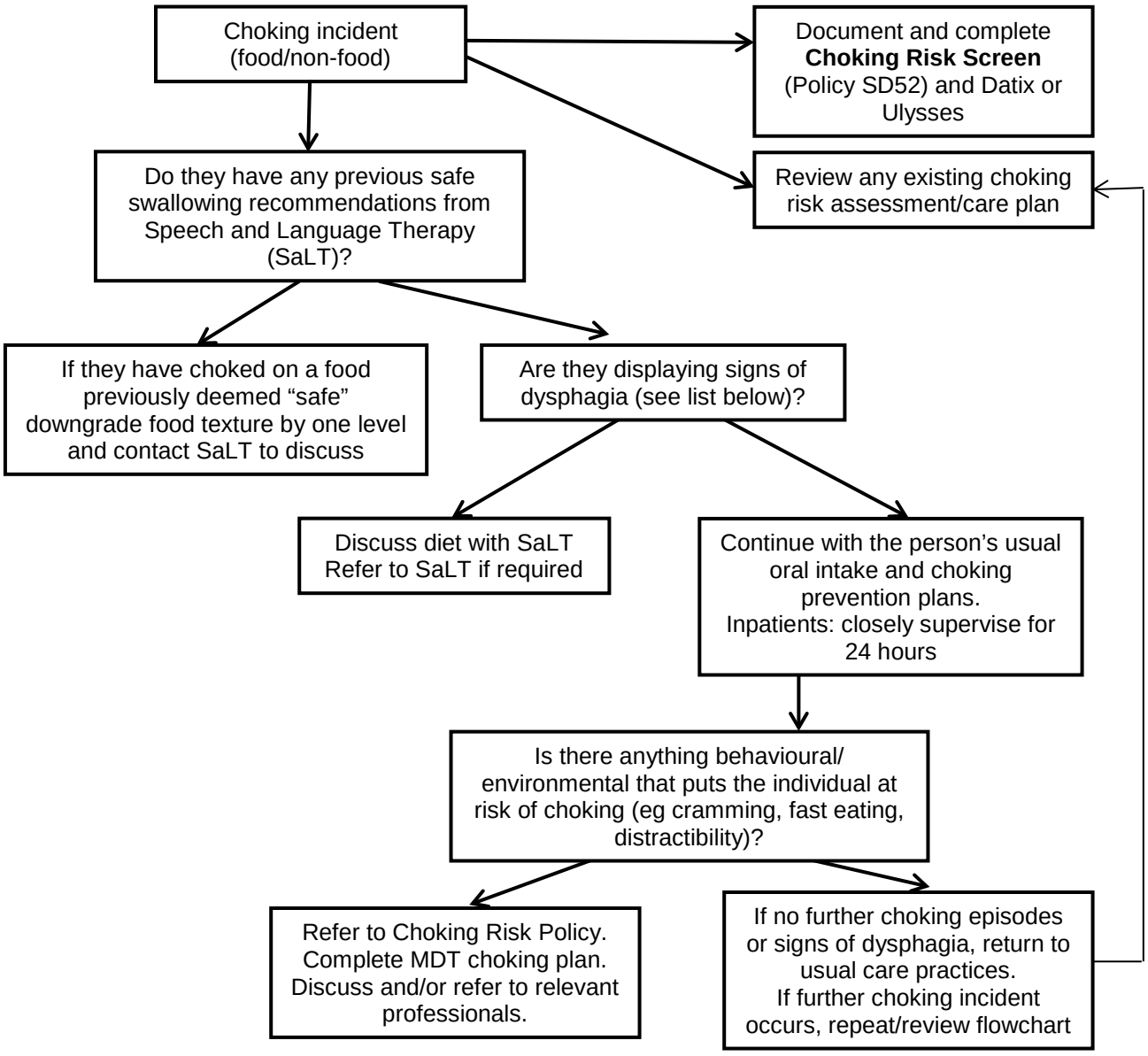
Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring			
Engagement			
Increasing accessibility			

Appendix 1

Flowchart for Secure (excluding Learning Disability Inpatient Wards), Local and Community Divisions (including Learning Disability Community Teams)



Signs of choking include:

- Ineffective cough.
- Attempts at coughing are silent.
- Person cannot speak (if they are usually able to.
- Breathing sounds wheezy.
- Eyes/nose watering.
- Decreasing levels of consciousness.
- Cyanosis.

Signs of dysphagia include:

- Coughing when eating/drinking.
- Prolonged or slow chewing.
- Wet gurgly voice during eating/ drinking.
- Losing fluid/food out of mouth.
- Holding food/drink in mouth.
- Recurrent chest infections.
- Choking episodes.

What to do:

In the event of a choking incident follow Basic Life Support procedures for choking and after care.

Unseen or witnessed choking incidents must be reported via the appropriate Divisional incident report system.

Appendix 2

Flowchart for All Learning Disability Inpatient Units (To be used in conjunction with Appendix 4)

All service users must be screened using the **Risk of Choking Screening Checklist** by Registered Nurses who have received training from Speech and Language Therapy (SaLT) in use of the tool to assess the level of choking risk:

- On admission.
- Annual review (prompted by Electronic Patient Records), or sooner if there has been cause for concern, such as:
  1. An incident of choking and/or;
  2. Signs of deterioration, and/or;
  3. Changes to their physical/mental health, or social situation which may increase choking risk.

No Risk Identified:

- No immediate further action required.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

Low/Medium Risk Identified:

- MDT identify need for referral to SaLT or other Specialists depending on risks identified.
- Choking risk management care plan developed with service user and MDT.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

High Risk Identified:

- Make referral to SaLT or other Specialists depending on risks identified.
- Interim/emergency choking risk management care plan developed with service user and MDT.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

High Risk – Dysphagia:

- No immediate further action required.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

High Risk – Medical/Mental Health Issues:

- MDT identify need for referral to SaLT or other Specialists depending on risks identified.
- Choking risk management care plan developed with service user and MDT.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

High Risk – Behavioural Issues:

- Make referral to SaLT or other Specialists depending on risks identified.
- Interim/emergency choking risk management care plan developed with service user and MDT.
- Registered Nurses trained in using the **Risk of Choking Screening Checklist** screen annually, or sooner if there is cause for concern.

Signs of choking include:

- Ineffective cough.
- Attempts at coughing are silent.
- Person cannot speak (if they are usually able to.
- Breathing sounds wheezy.
- Eyes/nose watering.
- Decreasing levels of consciousness.
- Cyanosis.

Signs of dysphagia include:

- Coughing when eating/drinking.
- Prolonged or slow chewing.
- Wet gurgly voice during eating/ drinking.
- Losing fluid/food out of mouth.
- Holding food/drink in mouth.
- Recurrent chest infections.
- Choking episodes.

What to do:

In the event of a choking incident follow Basic Life Support procedures for choking and after care.

Unseen or witnessed choking incidents must be reported via the appropriate Divisional incident report system.

Appendix 3

Choking Risk Screen Secure (excluding Learning Disability Inpatient Wards), Local and Community Division (including Learning Disability Community Teams)

Name of Service User:	
NHS Number:	
D.O.B:	
Name/role of person carrying out the Screen:	
Date of the Screen:	

This Choking Risk Screen forms part of Mersey Care NHS FT Choking Pathway and Policy.

Does the Service User have any of the following Physical/Mental Health conditions that are associated with an increased risk of choking? Tick those that are relevant:

- ☐ Learning Disability
- ☐ Physical Disability
- ☐ Schizophrenia
- ☐ Epilepsy
- ☐ Dementia
- ☐ COPD
- ☐ Huntington's
- ☐ Self Harm
- ☐ Parkinsonism
- ☐ Chest infection due to suspected aspiration
- ☐ Other degenerative condition
- ☐ Stroke
- ☐ Head/neck cancer

Please circle Yes/No in the appropriate column in response to the following questions:			**Action**
1. Has there been a choking incident in the past 12 months?	Yes	No	If yes refer to flowchart (appendix _)
2. Are there chewing or swallowing problems? Tick all that apply: ☐ Coughing during or after eating ☐ Effortful or repeated attempts to swallow mouthful ☐ Changes to breathing during or immediately after food/drink ☐ Voice sounds gargly or wet after swallowing ☐ Poor dentition and impaired chewing impacting eating ☐ Poor control of food/drink in the mouth e.g. food pocketing, food remaining in mouth after swallow ☐ Service User or Caregiver reports choking or problems swallowing ☐ Repeated or prolonged chest infections/recent	Yes Yes	No No	If yes to any of these discuss with SaLT to establish if referral is required. If yes to any of these discuss with SaLT to

aspiration pneumonia □ Reports of food or drink “going down the wrong way” or into the nose			establish if referral is required.
□ The Service User needs 1:1 support to eat/drink	Yes	No	If yes ensure care plan reflects support needs.
□ Service user shows or describes distress or pain when eating, drinking or swallowing □ Physical changes or abnormalities of mouth/throat □ Acute change in medical condition such as CVA/ neurological condition □ Reduced or varying levels of alertness	Yes	No	If yes consider advice from medical team.
3. Is there anything about the person’s behaviour that puts them at risk of choking? This may include □ PICA – a compulsive eating of non food items or materials □ Rushing or cramming food □ Grabbing from others plates □ Overfilling the mouth □ Leaving the table during the meal/moving around when eating □ Trying to lie down or recline immediately or soon after eating □ Not chewing their food □ Holding food in their mouth □ Talking with food in the mouth □ Poor attention/concentration □ Self harm or other physical damage to face and/or neck e.g. ligature □ Reluctance to eat or refusal of certain foods (e.g. tougher/chewy items or liquids)	Yes	No	If yes discuss with psychology and/or SaLT.
4. Is the person currently experiencing any side effects of medication that impact eating and drinking? Examples may include: relaxed muscle tone, sedation/drowsiness, dry mouth, increased/decreased saliva, extra pyramidal symptoms e.g. tremor, tension or rigidity in face/neck/jaw, or reduced sensation around mouth/throat.	Yes	No	If yes, contact GP/medical team to review medication. Consider advice from Pharmacy.
Please ensure all sections 1-4 have been completed. Risk screen must be included in the service user’s care plan and appropriate actions are taken. See Appendix 3 for information on other professionals’ roles in the management of risk of choking. If No to all sections there is no immediate action required, however the service user should be monitored for any changes in line with the Reducing the Risk of Choking Policy.			

Appendix 4

Risk of Choking Screening Checklist –
All Learning Disability wards

Service User Name:	Enter service user name
Completed By:	Enter trained nurse name (must have completed the risk of choking screen training)
Co-signed By:	Enter staff name
Date Completed:	Click here to enter date

Notes: Before completing this screening checklist, please discuss mealtimes with the service user using the 'Me at Mealtimes' booklet and support him / her to complete the self-rating score card. You should add comments at the end of this checklist.

1. Staff completing and co-signing this document must…
   - have completed the risk of choking screen training.
   - be familiar with the service user, e.g. have had regular contact at mealtimes over the last 2 months.

2. For new admissions, this screening checklist should be completed within 2 weeks making every effort to source information from previous caregivers, MDT and / or family.

3. Ensure any new concerns are fully reported at Ward Round.

Please contact the Speech and Language Therapy Department for any advice or guidance.

Referral to:	Enter name	**Date referral submitted:**	Click here to enter a date.
Speech and Language Therapy:	Enter information		
Psychology:	Enter information		
GP:	Enter information		
Physiotherapy	Enter information		
Dietician:	Enter information		
Other – Please state:	Enter information		

This document needs to be stored on the clinical notes system.

Part A – Non-dysphagia

1. Is there anything about the person's behaviour at mealtimes that puts them at risk of choking?

Guidance Notes

- Do they rush their food?
- Do they eat non-food items?
- Do they grab food from other people's plates?
- Do they overfill their mouth?
- Do they leave the table during the meal?
- Do they try to lie down or recline during or soon after the meal?
- Do they become agitated or deteriorate in crowded or noisy dining rooms?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to PTS on:	Click here to enter a date.
High risk identified	☐
Referral made to PTS on:	Click here to enter a date.

2. Is there anything about the person's behaviour outside of mealtimes that put them at risk of choking?

Guidance Notes

- Do they eat non-food items?
- Do they have PICA or copy this behaviour from others?
- Do they put non-food items in their mouths for any reason?
- Do they chew their own clothing, buttons etc.

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to PTS on:	Click here to enter a date.
High risk identified	☐
Referral made to PTS on:	Click here to enter a date. Click here to enter a date.

3. Is the person ever left alone to eat or drink, and does this make you feel concerned for their safety?

Guidance Notes

- Do they attend a day placement where they may have no support at mealtimes?
- Do they take food from fridges / cupboards or elsewhere and eat unsupervised?
- Do they visit relatives and friends and eat unsupervised?
- Is the eating environment overly noisy / busy or have other distractions that could leave to the person being unsupported when eating (even for a short amount of time)?
- Do visitors being food / treats which the person then eats on their own?

- Does the person have the table during / after the meal with food still in their mouth?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to PTS on: — Click here to enter a date.

High risk identified ☐
Referral made to PTS on: — Click here to enter a date.

4. Do you think the person's behaviour has changed at all, in any way over the last 12 months?

Guidance Notes
- Is there any disturbed or agitated behaviour?
- Does he / she ever refuse food or drink?
- Is there any short term or temporary changes?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to PTS on: — Click here to enter a date.

High risk identified ☐
Referral made to PTS on: — Click here to enter a date.

5. Has the person's mental well-being changed over the last 12 months?

Guidance Notes
- Does he / she seem as alert as they used to be?
- Has there been a change in mood?
- Any change in level of cooperation or participation in activities?
- Do you ever think they seem depressed?
- Are there any short term or temporary changed which need different management?
- Has the person got a formal diagnosis of schizophrenia, depression, affective disorder, dementia or any other mental health; or are there any concerns about their mental health?
- Do they become unsettled or deteriorate in crowded or noisy dining rooms?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to PTS on: — Click here to enter a date.

High risk identified ☐
Referral made to PTS on: — Click here to enter a date.

6. Are there any issues or changes in the person's physical health over the last 12 months?

Guidance Notes

- Is the position or posture at mealtimes a problem?
- Can you see any physical change (deterioration) in the person?
- Is there a progressive condition? e.g. Motor Neurone Disease, Parkinson's Disease etc.
- Do they seem to be getting more 'elderly' physically, compared to 12 months ago?
- Has there been any weight loss?
- Is reflux a problem for the person?
- Does the person suffer from any other neurological condition?
- Does the person have epilepsy?
- Any short-term or temporary changes?
- Is seating or positioning before a meal a problem?
- Can the person detect / sense hot temperatures? Do they understand the need to avoid foods / drinks that are too hot?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to PTS on:	Click here to enter a date.
High risk identified	☐
Referral made to PTS on:	Click here to enter a date.

7. Does the person take medication that may affect their movement, physical abilities, levels of consciousness, mood or concentration?

Guidance Notes

- Movement? Physical capability?
- Level of consciousness? Concentration? Mood?
- Has there been a change in the person's condition since their last medication review?
- Dry mouth? Too much saliva?
- Are there any temporary or short-term effects that require different management, e.g. as required medications, sedation, rapid tranquillisation etc.?
- Are there any signs of tremor or increased tension in the face, jaw, neck or tongue movement?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to Consultant Psychiatrist on:	Click here to enter a date.
Referral made to GP on:	Click here to enter a date.
Referral made to prescribing professional on:	Click here to enter a date. Enter prescribing professional's title
High risk identified	☐
Referral made to Consultant Psychiatrist on:	Click here to enter a date.
Referral made to GP on:	Click here to enter a date.

Referral made to prescribing professional on:	Enter prescribing professional's title

8. Does the person appear to stimulate him / herself by <u>regurgitating or vomiting</u>?

Guidance Notes

- Can they be distracted from this behaviour?
- Has this behaviour changed in any way?
- Has this behaviour become more frequent or more intense?
- Does the regurgitated food appear un-chewed?
- Are there any long-term digestive problems such as reflux?
- Has there been any gastroenterology involvement?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to PTS on:	Click here to enter a date.
High risk identified	☐
Referral made to PTS on:	Click here to enter a date.

9. Does the person have any <u>sensory impairment</u>?

Guidance Notes

- Does the person have any visual impairment?
- Does the person have a hearing impairment?
- Does the person have any impairment that affects their ability to taste or smell?
- Does the person notice when any food is left on the tongue or lips after a mouthful has been swallowed?
- Can the person detect / sense hot temperatures? Do they avoid food or drinks that are too hot?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to PTS on:	Click here to enter a date.
High risk identified	☐
Referral made to PTS on:	Click here to enter a date.

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Part B – Dysphagia

10. Do you think that the person has any difficulty when eating or drinking?

Guidance Notes

- Do they ever complain verbally or show non-verbally any pain or discomfort when eating and drinking?
- Do they ever have repeated coughing or throat clearing after food and drink?
- Have you ever seen the person appearing to 'choke' on anything?
- Does their voice sound wet or gargley after food or drink?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.
High risk identified	☐
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.

11. Is the person receiving non-oral / tube / PEG feeds? If yes, do they also have food or drink by mouth?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.
High risk identified	☐
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.

12. Has he / she had any repeated or prolonged chest infections over the last 12 months?

Guidance Notes

- Can the infections be easily explained by an existing medical condition?
- Do you have any reason to suspect there is aspiration?

No concerns	☐
No action needed	Enter comments.
Low / medium risk identified	☐
Strategies in place within document	Enter strategies.
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.
High risk identified	☐
Referral made to Speech Therapy on:	Click here to enter a date.
Referral made to Physiotherapy on:	Click here to enter a date.

13. Is the person ever fed food by someone else instead of feeding themselves?

Guidance Notes

- Are there any concerns regarding the feeder's approach or methods?
- Does the person react differently to unfamiliar people helping or feeding at mealtimes?
- Does the person indicate clearly and consistently when they would like the feeder to pause or to stop feeding?

No concerns ☐
No action needed Enter comments.

Low / medium risk identified ☐
Strategies in place within document Enter strategies.
Referral made to Speech Therapy on: Click here to enter a date.

High risk identified ☐
Referral made to Speech Therapy on: Click here to enter a date.

14. Does the person seem to need several swallows to clear each mouthful?

Guidance Notes

- Does this depend on what he / she is eating or drinking, e.g. the consistency or texture of the food or drink?
- Does this person have difficulty with particular foods or drinks?
- Do they seem to eat very slowly?
- Have you observed a tendency to cramming (overfilling the mouth) or bolting food (eating too fast)?

No concerns ☐
No action needed Enter comments.

Low / medium risk identified ☐
Strategies in place within document Enter strategies.
Referral made to Speech Therapy on: Click here to enter a date.

High risk identified ☐
Referral made to Speech Therapy on: Click here to enter a date.

15. Does the person have thickener in his / her drink or meals?

Guidance Notes

- Has this been specified by the Speech and Language Therapist?
- Has this been reviewed in the last 12 months?
- Do you feel the guidelines are still appropriate?

No concerns ☐
No action needed Enter comments.

Low / medium risk identified ☐
Strategies in place within document Enter strategies.
Referral made to Speech Therapy on: Click here to enter a date.

High risk identified ☐
Referral made to Speech Therapy on: Click here to enter a date.

16. Is there food left in the person's mouth at the end of the meal?

Guidance Notes

- Is the food visible inside the person's cheeks?
- Are there lumps of food visible on the lips / tongue (but the service user is not aware)?
- Is there cramming behaviour leading to food being packed into the cheeks?
- Is there food stuck to the roof of the mouth?
- Ask the person to swallow again, does this clear the mouth?
- Do you think the person is relying on a drink to get the swallow going / clear the mouthful?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to Speech Therapy on: — Click here to enter a date.

High risk identified ☐
Referral made to Speech Therapy on: — Click here to enter a date.

17. Does the person have <u>problems</u> with their <u>teeth</u>?

Guidance Notes

- Do they have sore or infected teeth?
- Problem with dentures?
- Poor oral hygiene?
- Does the person suffer from infections or have halitosis (bad breath)?
- Is the person missing some or all of their teeth?
- Do you suspect the person is avoiding food that needs chewing?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to the Dentist on: — Click here to enter a date.

High risk identified ☐
Referral made to the Dentist on: — Click here to enter a date.

18. Does the person have any <u>unexplained weight loss</u>?

Guidance Notes

- Do you have concerns about the person's nutrition?
- Has the weight / BMI been accurately and consistently measured?

No concerns ☐
No action needed — Enter comments.

Low / medium risk identified ☐
Strategies in place within document — Enter strategies.
Referral made to the Dietician on: — Click here to enter a date.

High risk identified ☐

Referral made to the Dietician on: Click here to enter a date.

19. Do you think the person may be <u>dehydrated</u>?

Guidance Notes

- Do they appear to have difficulty with drinking?
- Do you have any concerns about the person's nutrition?
- Has the weight / BMI been accurately and consistently measured?
- Do they cough or splutter during or after drinking?
- Does the sound of breath or voice change during or soon after the drink?

No concerns ☐
No action needed Enter comments.

Low / medium risk identified ☐
Strategies in place within document Enter strategies.
Referral made to the Dietician on: Click here to enter a date.

High risk identified ☐
Referral made to the Dietician on: Click here to enter a date.

20. Insight and understanding of choking difficulties and risk

- Has this service user had a conversation about eating, drinking and swallowing difficulties using the 'Me at Mealtimes' booklet?
- Do the answers that they gave match with staff opinions about mealtime skills?
- Do the answers that they gave conflict with staff opinions about mealtime skills?
- Is the service user's account likely to have been influence by suggestion?
- Does the service user show resistance to advice around mealtime safety and risk mitigation?

No concerns ☐
No action needed Enter comments.

Low / medium risk identified ☐
Strategies in place within document Enter strategies.
Referral made to Speech Therapy on: Click here to enter a date.

High risk identified ☐
Referral made to Speech Therapy on: Click here to enter a date.

Me at Mealtimes

Answer the questions below and select the picture that shows how you feel when eating and drinking at mealtimes…

1.	How is it going?	☐	☐	☐
2.	How does it feel to eat, drink and swallow?	☐	☐	☐
3.	Do you put too much food in your mouth?	☐	☐	☐
4.	How does your mouth, throat and chest feel?	☐	☐	☐
5.	What help do you need from staff?	☐	☐	☐
6.	What is the meal like?	☐	☐	☐
7.	What is the dining room like?	☐	☐	☐
8.	How do you feel about others at mealtimes?	☐	☐	☐
9.	Does your health affect you at mealtimes?	☐	☐	☐
10.	Do you get a sore mouth sometimes?	☐	☐	☐
11.	How do you feel about others at mealtimes?	☐	☐	☐
12.	Do you ever eat on your own?	☐	☐	☐
13.	Have you ever choked on anything?	☐	☐	☐
14.	Do you ever self-harm?	☐	☐	☐

Appendix 5

Who to refer on to

GP or consultant if one of the following factors is present:

- Deterioration of health suspected in relation to one of the choking risk factors e.g. ageing, dementia or other health condition, seizure activity, gagging or vomiting, psychotropic or multiple medication, level of alertness or fatigue, excessive rocking during or after meals (may indicate reflux), reflux, regurgitating food, drug and alcohol abuse, allergies, expressing distress, pain or discomfort when eating or taking tablets.

Dentist if one of the following is present:

- Ill fitting dentures, dental carries or poor oral hygiene

Physiotherapist if one of the following is present:

- Deterioration or change in positioning at mealtimes, physical ability, muscle tone, movement, control and coordination or sensation.

Occupational therapist if one of the following is present:

- Foods inadequately prepared by the individual
- PICA
- Cramming food or storing food in the mouth
- Inappropriate food choices for level of ability
- Pushing fingers, food items or utensils to the back of the mouth
- Change in physical level of sensation

Psychologist if one of the following is present:

- Deliberate attempts to block airway
- PICA
- Taking food from others
- Secretive binging on food (BED – Binge Eating Disorder)

Speech and Language Therapist (SLT) if one of the following is present:

- Deterioration or change in physical ability, eating very fast or slowly, cramming food, excessive coughing or complete lack of a cough, difficulty or absence of chewing, food stored in the mouth, food textures have had to be changed due to inability to manage hard, dry, chewy foods etc.
- Also if swallowing problems have not previously been assessed, the individual takes sudden intakes of breath, talks or laughs when eating, eats despite having poor levels of alertness or being distracted or continuing to eat high risk foods despite being advised not to, where food is found in mouth or cheeks after swallowing, food or liquids come out of the nose or mouth, history of choking.

Dietitian if one of the following is present:

- Reduced dietary intake
- Dehydration
- Unplanned weight loss,
- Indicated at nutritional risk from MUST score

Safeguarding if one of the following is present:

- Inadequate staffing or support levels, risk management plan not being adhered to, professional recommendations received but not included in risk management plan or not being adhered to, history of choking not risk assessed or managed
- Visitors or families not complying with risk management plan
- SUI (Severe untoward incident)

Resus Lead if one of the following is present:

Choking procedure training is identified as a need

Specialist training is required (ie service user is a wheelchair user)

Appendix 6

Common Choking Hazards

Food is the most common cause of choking

Foods:

- Toast
- Bread crusts
- White bread (when mixed with saliva can form a glue-like ball)
- Raw vegetables
- Pieces of meat, gristle, rind or cooked fat eg bacon rind
- Nuts, whole grains and seeds
- Grapes and other small round food especially with skins or husks like peas and beans
- Sweets
- Chewing or bubble gum
- Raisins and sultanas
- Oranges and satsumas, especially whole segments with pith
- Crisps
- Biscuits
- Very thick sticky spreads
- Chunks of hard cheese or chocolate
- Pizza
- Salad items e.g. lettuce (flat large pieces), celery, tomatoes, cucumber and any items with stringy or fibrous parts and the skins and seeds
- Mixed texture foods where the liquid is runny and separates out from hard food e.g. some breakfast cereals and milk.

Household items:

- Coins
- Pen and bottle lids
- Marbles or small balls
- Jewellery
- Arts and craft materials
- Material
- Padding
- Balloons
- Tissues
- Clothing
- Buttons
- Hair
- Cigarette butts
- Stones

Tablets and capsule medication:

Advice must be sought from a doctor or pharmacist and recorded when considering altering the form of medication.

NB Anything that can get lodged in the mouth or throat and block the airway is a potential hazard and access to choking hazards needs to be strictly managed for those at risk.

Positioning:

Poor positioning and bad positioning can cause choking.

Feeding/eating in supine lying can cause choking.

Choking can be caused by poor positioning of the head and trunk.

It is very difficult to eat or drink with the head tilted back.

Supporting the seated posture is important at all times.

Keeping the head in the middle and facing forward can help the tongue to fall more naturally.

Appendix 7

Sequence for Steps for Managing ADULT Choking (Resuscitation Council UK)

Suspect choking	**Be alert to choking particularly if patient is eating**
Encourage to cough	**Instruct patient to cough**
Give back blows	**If cough becomes ineffective give up to 5 back blows:** • Stand to the side and slightly behind the patient • Support the chest with one hand and lean the patient well forward so that the when the obstructing object is dislodged it comes out of the mouth rather than goes further down the airway • Give 5 sharp blows between the shoulder blades with the heel of your other hand
Give abdominal thrusts	**If back blows are ineffective give up to 5 abdominal thrusts:** • Stand behind the patient and put both arms round the upper part of the abdomen • Lean patient forward • Clench your fist and place it between the umbilicus (navel) and rib cage • Grasp this hand with your other hand and pull sharply inwards and upwards • Repeat 5 times • If the obstruction is still not relieved, continue alternating 5 back blows with 5 abdominal thrusts
Start CPR	**Start CPR if the patient becomes unresponsive:** • Support the patient carefully to the ground • Immediately activate the ambulance service (call 999) • Begin CPR with chest compressions