Safety Information 001/17

Choking Risk in Mental Health Consumers

6 February 2017

Distributed to:

- Chief Executives
- Directors of Clinical Governance

We recommend you also inform:

- Directors of Clinical Operations
- Directors of Medical Services
- Directors of Nursing and Midwifery
- Directors of Mental Health
- Directors of Allied Health

Expert Reference Group

Content reviewed by:

- Mental Health Branch
- Chief Psychiatrist, NSW
- Clinical Excellence Commission
- ACI Speech Pathology Advisory Network

Clinical Excellence Commission

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Review date

February 2020

Background

People with mental illness experience a higher incidence of dysphagia (swallowing difficulty) and choking. These difficulties can lead to death, with a number of deaths reported as occurring while these patients are in hospital. Choking usually occurs as a result of food or other solid items becoming lodged in the airway. [1]

Causes of choking risk in mental health consumers

Sedation/drowsiness, poor attention, dry mouth, abnormal swallowing reflexes, dystonic reactions, tardive dyskinesia, impulsive behaviours and excessively rapid eating food (tachyphagia/fast eating syndrome)[1] all contribute to an increased risk of choking.

This risk results from:

1. An impaired gag reflex arising from antipsychotic medications (e.g. Clozapine, Droperidol, Haloperidol and Risperidone)[2]
2. Serotonin-specific reuptake inhibitors (SSRI) antidepressants – dysphagia /dryness etc.
3. Eating and/or food-related behaviours associated with psychiatric disorder and/or comorbid neurological disorders[2]
4. The ageing process which causes a general decline in health, cognitive impairment and increased vulnerability to the side effects of antipsychotic medications

Signs and symptoms of dysphagia:

- Difficulties initiating swallow
- Coughing, spluttering or throat clearing during or immediately after oral intake of food/drink
- Wet or 'gurgly' sounding voice during/post oral intake
- Difficulty chewing, containing food or clearing residue from the mouth
- Drooling or the inability to swallow saliva
- Difficulties or descriptions of '*something stuck'* in the throat
- Nasal, oral or pharyngeal regurgitation
- Shortness of breath during/after oral intake of food or drink
- Recurring chest infections
- Increased eating / drinking time

Minimising the Risk

- As part of the consumer assessment, ask them and/or their carers/family members about the presence of any difficulty with chewing or swallowing, cough or splutter due to eating or drinking and whether food or drink gets stuck in the consumer's throat
- Ensure timely access to speech pathology services for further assessment and care when indicated
- Implement an appropriate diet and level of supervision during eating/meal times for at-risk consumers, ensuring he or she is in the upright position before oral intake
- Educate consumers/ carers/families about safe swallowing/eating habits and oral hygiene
- Educate clinical staff about the risks and signs of dysphagia, how and when to refer to a speech pathologist and the choking risks related to antipsychotic medications
- Ensure staff have training in how to respond to a choking event

References

1. Ruschena D, Mullen PE, Palmer S, Burgess P, Cordner SM, Drummer OH et al. Choking deaths: the role of antipsychotic medication. British Journal of Psychiatry. 2003; 183:446-450.
2. Warner J. Risk of choking in mental illness. The Lancet. 2004; 363:674

Suggested actions by Local Health Districts/Networks

1. Ensure this Safety Information is distributed to all relevant staff to ensure awareness of the risk of choking in mental health consumers
2. Ensure staff members are aware of the steps to minimise the risks to consumers and how to respond appropriately to a choking event