NSW Health

NSW GOVERNMENT

Updated: Minimising choking risk in mental health consumers

SAFETY INFORMATION 004/24

Issue Date:	13 June 2024
Replaces:	SI:001/17 Choking Risk in Mental Health Consumers
Content reviewed by:	Ministry of Health Mental Health Branch, Clinical Excellence Commission, Agency for Clinical Innovation, NSW Speech Pathology Advisors Network
Distributed to	Chief Executives; Directors of Clinical Governance; Director, Regulation and Compliance Unit
KEY MESSAGE:	Mental Health Staff need to be aware of risk of choking in mental health consumers and required actions.
ACTION REQUIRED BY:	Chief Executives, Directors of Clinical Governance
REQUIRED ACTION:	1. Distribute this Safety Information to all relevant clinicians and clinical departments to increase awareness of choking risk in mental health consumers. 2. Ensure clinical staff have the skills and knowledge to implement clinical recommendations. 3. Include this Safety Information in relevant handovers and safety huddles. 4. Report any incidents into ims+ and/or to the TGA.
DEADLINE:	N/A
We recommend you also inform:	Directors, Managers and Staff of: • Mental Health Services • Medical Services • Nursing and Midwifery • Allied Health
Website:	https://www.health.nsw.gov.au/sabs/Pages/default.aspx http://internal.health.nsw.gov.au/quality/sabs/index.html
Review date:	June 2025

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FOR NSW HEALTH STAFF ONLY

Safety Information is current at the issue date.
Printed copies are uncontrolled.

SI:004/24 Updated: Minimising choking risk in mental health consumers

What is updated in the Safety Information from 001/17?

This Safety Information replaces Safety Information Choking Risk in Mental Health Consumers (SI:001/17). It includes additional information regarding the risk of choking and updated recommendations.

Situation

Clinical incidents involving consumers choking in mental health inpatient units have been reported. Choking can occur due to both food and/or medications obstructing the consumer's airway.

Background

People with mental illness have a high incidence of dysphagia [1] (difficulty swallowing) which can result in choking and death.

Increased choking risk in mental health consumers

The following conditions can contribute to an increased risk of choking in mental health consumers:

- sedation/drowsiness
- inattention
- dry mouth
- dysphagia
- abnormal swallowing reflexes
- dystonic reactions
- tardive dyskinesia
- poor dentition
- impulsive behaviours and eating behaviours associated with psychiatric disorders and/or comorbid neurological disorders (e.g., tachyphagia/fast eating syndrome) [1,2,3,4].

It is important to note that some of the above conditions may be adverse effects of medication used in this cohort of consumers. For example, certain antipsychotic and antidepressant medications can cause dysphagia and dry mouth. Additionally, mental health consumers of older age are likely to have increased susceptibility to the side effects of antipsychotic medications.

Signs and symptoms of dysphagia include:

- difficulty in swallowing, drooling
- coughing, spluttering, throat clearing, shortness of breath, or a 'gurgly' sounding voice during or after oral intake
- difficulty chewing, containing food within, or clearing residue from, the mouth

- complaint of feeling 'something stuck' in the throat
- nasal, oral or pharyngeal regurgitation
- increased time required for eating, drinking and taking oral medications
- recurrent chest infections.

Recommendations

- Ensure monitoring for dysphagia signs and symptoms is included in the comprehensive assessment on admission to mental health inpatient units (see NSW Health Guideline *Physical Health Care for People Living with Mental Health Issues* [GL2021_006]). Ask consumers and/or their carer/family about the presence of signs and symptoms.
- Determine baseline diet on admission. Implement an appropriate diet and level of supervision for at-risk consumers.
- Refer to speech pathology services for assessment and care when indicated.
- Ensure the consumer is alert and in an upright position before oral intake, including medications.
- Provide education to consumers/carers/families on safe swallowing, eating, medication administration, and oral hygiene practices.
- Ensure documentation and handover, in all transitions of care, includes clinical risks such as dysphagia and choking.
- Ensure clinicians have the necessary skills and knowledge to respond to a choking event, including escalating care through the local Clinical Emergency Response System.

References

1. K. J. Aldridge, and N. F. Taylor, Dysphagia is a Common and Serious Problem for Adults with Mental Illness: A Systematic Review. *Dysphagia*. vol. 27, pp 124–137, 2012.
2. G. Cicala, M. A. Barbieri, E. Spina and J. de Leon, A comprehensive review of swallowing difficulties and dysphagia associated with antipsychotics in adults, *Expert Review of Clinical Pharmacology*, vol. 12, no. 3, pp. 219-234, 2019.
3. D. P. Kulkarni, V. D. Kamath, J. T. Stewart, Swallowing disorders in schizophrenia. *Dysphagia, vol. 32,* pp. 467-471, 2017.
4. S, Guthrie, J. Baker, J. Cahill, and B. Hemsley, Mealtime difficulties in adults with mental health conditions: an integrative review. *Journal of Mental Health*, vol. 32, no. 2*, pp.* 504-516, 2023.