NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Health and Safety Alert
November 2024

OPWDD Mortality Review Committee

Contributing Factors with Deaths Related to Choking and Aspiration

In March 2024, OPWDD's Mortality Review Committee formed a subcommittee to analyze preventable choking deaths which have occurred since the release of Administrative Directive Memorandum (ADM) # 2023-04, OPWDD Choking Prevention Initiative (July 2023). The subcommittee examined twelve (12) choking related deaths of people receiving OPWDD services. The objective of the subcommittee was to identify contributing factors beyond food consistency that may influence choking and/or aspiration related fatalities.

Key Findings

The review of the examined cases identified four primary potential areas for improvement in choking prevention:

- Health Record Consistency
- Supervision Consistency
- Awareness, Understanding, and Planning for Factors Related to Seeking or Taking Foods Unsafe for the Person
- Improvement of Emergency Response

Health Record Consistency

Findings: Case review identified inconsistencies in the person's health record, such as vague language in dining/diet plans and varying or missing information on diagnoses and/or swallowing concerns.

Recommendations:

- Ensure that there is consistent information and language about diagnoses, choking events, and/or concerns about choking or swallowing across all documentation available to all service providers.
- Use objective language in plans and ensure all health records are updated following a choking event. For example, use "must" instead of "may" or "should" when an action or step is required.
- When a choking or aspiration event has occurred, this should trigger a clinical swallow evaluation. If the person has a subsequent choking or aspiration event, further evaluation to determine the root cause of the choking/aspiration is needed.

Supervision Consistency

Findings: Case review identified the need to ensure consistency in supervision levels, particularly for individuals with known risks for choking/aspiration. Confusion arose when staff had to follow multiple levels of supervision for the person receiving services, which were often not aligned with non-mealtime food seeking behaviors.

Recommendation:

- Ensure supervision levels are clearly defined for all situations to avoid confusion and ensure compliance. Please see the OPWDD Levels of Supervision ADM #2022-01 at https://opwdd.ny.gov/regulations-guidance/adm-2022-01-levels-supervision-los for additional information on supervision levels.
- In situations where the person has a known history of attempting to access or ingest food or other items that would be unsafe for them (such as seeking or taking food that is not consistent with dietary or food consistency requirements; or engaging in pica or pica-like behavior), plans must be developed to appropriately address such behaviors (not only during mealtimes) and staff must be trained and equipped to respond to choking incidents inside and outside the residence (i.e., restaurants, the park, etc.).

Factors Related to Seeking or Taking Foods Unsafe for the Person

Findings: Case review identified behavioral related factors such as food-seeking or the opportunity to take foods (e.g., bread left on a counter) significantly increased choking risk. These events often occur during non-mealtimes or may involve people on restricted diets. In many cases, plans (i.e., IPOP) lacked sufficient, person-centered information on managing and/or responding to these events outside of the mealtime setting. Additionally, plans often did not contain periodic reevaluations or reassessments when a person had a choking event or an escalation of behaviors involving food.

Recommendation:

- When a food related incident(s) results in a plan which addresses food-seeking, pica, or other behaviors/diagnoses that may result in choking or aspiration, the person's plans must include strategies to address future events in all settings (e.g., community locations, non-residential programs) to minimize choking or aspiration risks.
- Plans are to provide specific, person-centered strategies for staff in how to both prevent and respond to these events without compounding the choking risk.
    - For example, trying to take food from a person may result in a choking event if the person rushes to put the food in their mouth to avoid it from being taken.
- Plans are to be reviewed and updated as needed, after all choking and aspiration incidents, or when there are changes in food related behaviors.
- Evaluations of events related to food should always examine other factors related to the cause of the incident beyond relegating it to a behavioral episode.
    - For example, if the person was hungry or on a medication that increases hunger.

Improvement of Emergency Response

Findings: Cases reviewed identified delays in emergency response occurred due to staff panicking or being unsure of how to react during a choking event.

Recommendation:

- Agencies should complete regular training and practice emergency drills with staff on responding to a choking event. Practice is intended to ensure staff are confident in responding to a person who is choking.

- As part of their emergency response to a choking or aspiration event, providers are to empower staff to call 911 **first** as part of any choking or aspiration protocol. Only after 911 is called should staff notify the Agency Nurse, a clinician, or management.

Preventive Measures

Persons with intellectual and developmental disabilities are at a higher risk for choking. Being proactive and prepared can save lives. Refer to ADM #2023-04, the Choking Prevention Initiative, for more detailed information on prevention, intervention and best practices regarding choking prevention at: https://opwdd.ny.gov/regulations-guidance/adm-2023-04-choking-prevention-initiative

Please address questions to nursingandhealthservices@opwdd.ny.gov