The Regulation and Quality Improvement Authority

RQIA Review of the implementation of recommendations to prevent choking incidents across Northern Ireland

May 2022

Glossary

DoH	Department of Health
GP	General Practitioner
eDAMS	Electronic Document and Management System
EDS	Eating, Drinking and Swallowing
HSC	Health & Social Care
HSC Trust	Health and Social Care Trust
HSCB	Health and Social Care Board
IDDSI	International Dysphagia Diet Standardisation Initiative
MEAPP	Mid and East Antrim Agewell Partnership
NIECR	Northern Ireland Electronic Care Record
NIMDTA	Northern Ireland Medical & Dental Training Agency
PHA	Public Health Agency
REDS	Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet
RQIA	Regulation and Quality Improvement Authority
SAI(s)	Serious Adverse Incident(s)
SPPG	Strategic Planning and Performance Group
SQR	Safety and Quality Reminder

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews, taking into consideration our four key domains:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Membership of the Expert Review Team

Dr Mo Henderson	Allied Health Professions Consultant, Public Health Agency
Anne-Marie Phillips	Patient Safety, Quality and Experience Nurse Lead, Public Health Agency
Dr Leanne Morgan	Clinical Lead, RQIA
David McCann	Assistant Director of Improvement, RQIA

Membership of the Project Team

Emer Hopkins	Interim Director of Improvement, RQIA
Dr Leanne Morgan	Clinical Lead, RQIA
David McCann	Assistant Director of Improvement, RQIA
Dr Julie Ann Walkden	Quality Assurance Advisor, RQIA
Helen Hamilton	Project Manager, RQIA

RQIA is very grateful to all HSC Trusts for contributing their time and providing evidence to support the review, especially during the COVID-19 pandemic. The Expert Review Team would wish to recognise the enthusiasm of staff along with their passion and commitment to the prevention of choking incidents within their respective settings.

Contents

Foreword

Being able to eat and drink what we want is a privilege that most of us take for granted. It is a daily pleasure that is integral to our lives.

For people with Eating, Drinking and Swallowing difficulties, food and drink may present a danger to them which has impacts that extend beyond the risk of choking, and affects the fabric of their daily lives. As Chief Executive of the RQIA, I welcome the publication of the Review of the implementation of recommendations to prevent choking. This is an important and timely review as deaths from choking continue to be a key public health concern for Northern Ireland.

We know that the vast majority of people who die from choking are already known to have Eating, Drinking and Swallowing difficulties. Many have already been assessed by a Speech and Language Therapist and have a care plan in place. Yet deaths occur due to failures in communication of the care plan and when patients are inadvertently provided with or are able to access food and drink that is not suitable or safe for them; this is of particular concern, when patients have additional vulnerabilities such as learning disability or dementia.

Since the first issuance of the Safety Quality Reminder (SQR) letter in February 2021, there have been a further 10 deaths across the region; deaths which were potentially preventable. Furthermore, the Health and Social Care Board / Public Health Agency are not satisfied with assurances from the Health and Social Care (HSC) Trusts around the implementation of the recommendations from the SQR letter. This makes the findings and recommendations of this RQIA review all the more important.

This review, like previous pieces of work, has identified weaknesses within the systems that enable staff to do their job effectively. The pandemic has seen staffing shortages of unprecedented proportions and we are grateful to those staff members who kindly contributed to this review.

However, it is important to recognise that the pandemic has made the provision of safe, effective care much more challenging and it is likely that this has contributed to some of the learning points stated in the SQR letter needing to be restated. Nonetheless, it is now of vital importance that all HSC organisations work together and prioritise the need to strengthen the systems for delivery of care to people at risk of choking.

Also important, is the quality of support and resources provided to patients, carers and families. Many individuals with Eating, Drinking and Swallowing difficulties are living with a chronic condition which impacts not just on their physical health but also on their mental wellbeing and quality of life.

It will take a sustained and co-ordinated strategy to improve both the safety of care and quality of support provided to people at risk of choking. RQIA are committed to working with DoH, SPPG / PHA, HSC Trusts and all providers of health and social care to drive improvements in services which will hopefully see better outcomes for people with Eating, Drinking and Swallowing difficulties and reduce the risk of death from choking.

Chief Executive
Regulation and Quality Improvement Authority

Executive Summary

Choking incidents that arise from a pre-existing eating, drinking or swallowing (EDS) difficulty are known to be a significant cause of preventable mortality. The need to reduce the risk of death by choking has been identified as a key public health priority in Northern Ireland (NI).

Between 2016 and 2021, there were 23 choking-related Serious Adverse Incidents (SAIs) within NI health and social care settings. Sadly these incidents led to 21 deaths; deaths which were potentially preventable[1]. Safety and Quality Reminder (SQR) of best practice guidance, issued in February 2021, derived learning from five SAIs relating to deaths from choking. The letter made six key recommendations to be implemented within Older People's, Mental Health, and Acute Services in all five HSC Trusts.

Choking continues to be a significant patient safety issue with a further ten choking-related deaths across the region since the issuance of the SQR letter[2]. In view of this, RQIA considers that a review of the implementation of the SQR recommendations will serve to provide further assurance, and identify additional learning to improve systems for the delivery of care and prevention of choking-related harm.

For the purposes of this review, we focused on work undertaken in high-risk areas within HSC acute services, day care centres and prison healthcare services. The following services were considered to be high-risk areas:

- Stroke
- Care of the Elderly
- Mental Health & Learning Disability
- Physical Disability

Terms of Reference for the Review were agreed with the Department of Health (DoH) in July 2021; review field work took place during August and September 2021.

Aims / Objectives

The review was designed to:

1. Hear the views and experiences of patients, carers and families with regard to the measures implemented to prevent choking.
2. Assess the governance arrangements and system oversight of the implementation of the recommendations to prevent choking incidents across Northern Ireland.
3. Assess the operational implementation of the six recommendations from the Safety and Quality Reminder of Best Practice Guidance letter SQR-SAI-2021-075.
4. Assess the effectiveness and impact of systems and processes designed to support the delivery of quality care.

Methodology

The Expert Review Team gathered evidence to inform its assessment through a variety of methods:

- We met with voluntary organisations who support people with EDS difficulties; participants included patients, carers and families;
- We requested information, from each of the five Health and Social Care Hospital Trusts, using structured questionnaires;
- We analysed information returned, to assess progress made on the implementation of recommendations and to develop Key Lines of Enquiry for meetings with each of the organisations;
- We conducted focus groups with relevant senior and front-line staff from the five Health and Social Care Hospital Trusts; this included staff across a selection if acute and non-acute hospital wards and in day care settings; and
- We captured the views, of a wider range of staff, via an electronic questionnaire disseminated to various staff groups working within high risk areas.

Findings

The vast majority of people who die from choking are recognised to have a pre-existing Eating, Drinking or Swallowing (EDS) difficulty; therefore, there should be sufficient opportunities for the prevention of harm. The Expert Review Team considers that all these opportunities need to be seized. We found that the current systems for delivery of care require strengthening and that there is a need to reduce variation across the region.

There is an ongoing need for mandatory staff training and improved awareness, across all relevant staff groups, to recognise and identify people at risk of choking. There remains a need for effective arrangements for onward referral, where patients are seen within acceptable timescales, and where patients and families are provided with interim advice and guidance whilst awaiting Speech and Language Therapy assessment. Following assessment there is a need for the EDS recommendations to be communicated effectively amongst members of the multi-disciplinary team and with patients, families and carers.

The systems for communication need to be sufficiently robust so that no patient, at risk of choking, is forgotten. There is a need for meal and snack times to be underpinned by strong systems for communication, supervision, and the provision of safe, suitable food. The Expert Review Team considers that catering and domestic staff are integral to patient safety and should be included in mealtime Safety Pauses; the implementation of which should progress without delay.

Transfer of care between locations and discharge home is recognised to be a pivotal time when exchange of information is crucial. We found that there is need for transfer and discharge to be supported by robust systems for communication including the documentation of EDS recommendations that are accessible to all relevant care providers, including catering staff. The Expert Review Team considers that embedding this documentation within transfer and discharge documentation, in

addition to electronic care record systems, is a further step which would enhance patient safety.

At the outset of the review, we heard from a number of patients, families and carers who provided a valuable insight into the experiences of those who live with EDS difficulties and have an increased risk of choking. The lived experience of these individuals demonstrated that the challenges of living with the condition extend beyond the risk of choking.

Whilst patient safety is the priority, it is essential that all patients, along with their families and carers, are supported in order to live well. This should include timely assessment by Speech and Language Therapy, signposting to other support and resources, and education on how to produce nutritious appealing meals that enhance enjoyment and quality of life.

Conclusion

Our review acknowledges that the extensive regional work undertaken to date is having an impact; it details many examples of good practice across HSC Trusts. However, as many of the recommendations made previously have had to be restated, there is now a need to scale up and spread this important work across the region. This should be undertaken alongside further work to embed existing improvements and must be supported by equity of resource in order to reduce variation across HSC Trusts.

The review, whilst valuable in providing an assessment of the work undertaken to date, is not the end of the journey. It is important that the Strategic Planning and Performance Group (SPPG); formerly the Health and Social Care Board[1] / HSCB) /Public Health Agency (PHA) and Health and Social Care (HSC) Trusts continue to examine and analyse choking-related adverse incidents, including near-misses, in order to further identify any system deficits, implement improvements and share learning. In addition to this, the Expert Review Team consider that a regional strategy would be beneficial in driving a co-ordinated and sustained effort to bring together and embed all the different elements that constitute safe, effective care.

In light of a further ten deaths across the region, it is now essential that all HSC organisations work together and prioritise efforts to prevent deaths from choking. RQIA is committed to working with the DoH, SPPG / PHA, HSC Trusts and all providers of health and social care to support improvements within the systems for delivery of care to people with EDS difficulties. It is our sincere hope that the 12 recommendations outlined in this report, if fully implemented, will ensure better

[1] As part of the wider transformation of Health and Social Care services in Northern Ireland, the Health and Social Care Board (HSC Board) closed on 31 March 2022. Responsibility for its functions transferred to the Strategic Planning and Performance Group (SPPG), as an integral part of the Department of Health (DoH).

outcomes for people living with EDS difficulties and see a reduction in choking-related harm.

Section 1 Introduction

1.1 Background and Context

Choking incidents that arise from a pre-existing eating, drinking or swallowing (EDS) difficulty are known to be a significant cause of preventable mortality. The need to reduce the risk of death by choking has been identified as a key public health priority in Northern Ireland (NI) by the Regional Report on Choking Review in 2018[3] and in the subsequent HSCB/PHA Special Edition Learning Matters Newsletter on Choking in 2021[4].

Between 2016 and 2021, there were 23 choking-related Serious Adverse Incidents (SAIs) within health and social care settings in NI. Sadly these incidents led to 21 deaths; deaths which were potentially preventable[5]. During the same period, there were 1383 choking-related adverse incidents reported within HSC Trusts, further highlighting the scale of the issue and the need for system-based improvements in identifying and managing eating, drinking and swallowing difficulties (EDS) in order to reduce the risk of choking-related harm.

The 2018 Regional Thematic Review of choking incidents was undertaken by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA). An analysis of 798 adverse incidents, reported between 2010 and 2016, found that almost half (46%) occurred in day care settings, 28% in hospital settings and 15% in nursing and residential homes. The Review identified a need for greater staff awareness, improved access to specialist services, and a need for a standardised approach, noting a variation in policy and practice across HSC services and Trusts. It tasked the Regional Adult Dysphagia Group, now known as Dysphagia NI, to engage with stakeholders to develop an action plan for the implementation of seven recommendations arising from the Thematic Review. This work, partially resourced by non-recurrent Transformation funding, adopted a systems-based approach to the management of dysphagia, and aimed to reduce the risk of choking-related incidents through raising awareness, developing guidance, and improving standardisation across HSC Trusts in Northern Ireland.

It should be noted, however, that choking-related harm is not unique to Northern Ireland. In July 2018, NHS Improvement issued a Patient Safety Alert following a review of National Reporting and Learning System incidents in England and Wales which identified seven incidents over a two year period where patients had come to significant harm due to confusion relating to the use of imprecise terminology such as ‘soft diet’.

Following the National Patient Safety Alert, the DoH issued a circular, HSC (SQSD)16/18: Resources to support safer modification of food and drink[6], mandating all HSC Trusts to transition to the standardised terminology to describe texture modification for food and drink: International Dysphagia Diet Standardisation Initiative (IDDSI) framework. To underpin the adoption of this framework, HSC Trusts were requested to revise systems for ordering diets, implement staff training, and develop clinical protocols.

Despite these regional and national efforts, a Safety and Quality Reminder (SQR) of best practice guidance letter, issued in February 2021, derived learning from five SAIs that reiterated many of the themes and trends identified previously. It made six key recommendations to be implemented within Older People's, Mental Health, and Acute Services in all five HSC Trusts. It was subsequently re-issued in June 2021, amended to include all Programmes of Care (i.e. all HSC services), and sought second-line assurances from HSC Trusts regarding implementation; second-line assurance pertains to an assurance that the six SQR recommendations have been incorporated into the HSC Trusts' safety and quality assurance work-plans, with arrangements for monitoring in place.

RQIA considered that, as this continues to be a significant regional patient safety issue, a review of the implementation of the SQR recommendations would serve to provide further assurance, and identify additional learning to improve systems for the delivery of care and prevention of choking-related harm. Given the regional expertise that already exists through ongoing work streams, RQIA determined that this review should be undertaken in partnership with representatives from the Regional Dysphagia Group and the PHA's Safety, Quality and Experience Team who worked with the RQIA as members of the Expert Review Team. The review and its approach were agreed with the Department of Health (DoH) in July 2021.

1.2 Terms of Reference

RQIA drafted the Terms of Reference, subsequently agreed by the Department of Health, to undertake a review of the implementation of recommendations to prevent choking incidents across Northern Ireland.

1. To describe and assess the governance and system oversight of the implementation of the recommendations; giving specific consideration to the relevant actions detailed in circular HSC(SQSD)16/18.

2. To describe and assess the operational implementation of the six recommendations from the Safety and Quality Reminder of Best Practice Guidance letter SQR-SAI-2021-075

3. To assess the effectiveness and impact of, the implementation of the recommendations, on the delivery of care including transition across service boundaries

4. To seek the views of HSC Trusts on further steps which may prevent choking incidents.

5. To gather the views of service users and their carers with regard to the measures implemented to prevent choking.

6. To report on findings, identify areas of good practice and, where appropriate, make recommendations for further improvements required to prevent choking incidents.

The review focuses on work undertaken in high-risk areas within HSC acute care and day care centres. Prison healthcare services, provided by South Eastern HSC Trust, were also included.

As providers of care to patient populations that are at increased risk of choking, the following services were considered to be high-risk areas:

- Stroke
- Care of the Elderly
- Mental Health & Learning Disability
- Physical Disability

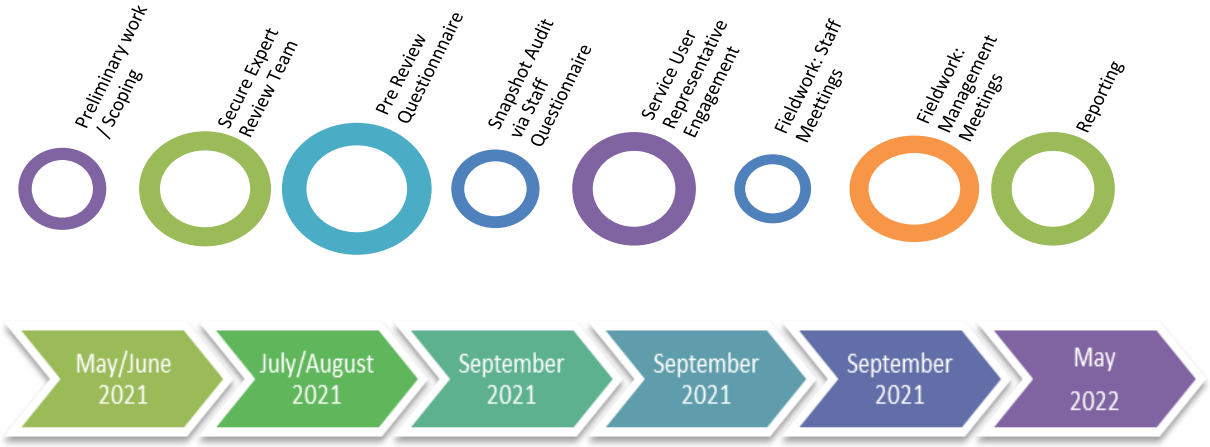
Exclusions

Care Homes and Children's Services have been excluded from this review. Although excluded, it is anticipated that the review findings and recommendations will be relevant to these services. As such, the learning from this review will be used to inform future inspection and review methodology.

Services provided by the Northern Ireland Ambulance Service Trust are also excluded from this review.

1.3 Review Methodology

RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies, agreed by our Expert Review Team, to obtain supporting information to inform our assessment:



- We undertook a review of the literature including previous learning reports to identify key themes and areas of focus.
- We designed and issued structured questionnaires to the five Health and Social Care Trusts in Northern Ireland.

- We analysed information returned to us by each of the organisations and used this to develop Key Lines of Enquiry for meetings with each of the organisations.
- We met with voluntary organisation who support people with EDS difficulties
- Where possible we met with service users, their families and carers.
- We disseminated a questionnaire to staff working within high risk areas, including acute and non-acute hospital wards and in day care settings.
- Our Expert Review Team conducted focus groups and meetings with relevant senior and front-line staff from the five Health and Social Care Trusts in Northern Ireland.
- We analysed the information gathered through our structured pre review questionnaires, meetings, focus groups and staff questionnaire responses in order to determine our key findings and recommendations.

During the course of this review, as part of the wider transformation of Health and Social Care services in Northern Ireland, the Health and Social Care Board (HSC Board) closed on 31 March 2022. Responsibility for its functions transferred to the Strategic Planning and Performance Group (SPPG), as an integral part of the Department of Health (DoH). This change is reflected within the findings and conclusions of this review.

Section 2 Reducing the risk of Choking-Related Harm in NI

2.1 Eating, Drinking and Swallowing Difficulties

Dysphagia is the medical term for Eating, Drinking and Swallowing (EDS) difficulties. It is often a sign or symptom of an underlying disease process, which may be neurological, muscular or structural in nature. The prevalence of dysphagia, and the incidence of associated choking episodes, is higher across a number of common conditions that affect the general adult population; these include stroke, mental ill-health, learning disability and dementia. In a small proportion of adults, dysphagia can be present since childhood, where prematurity, congenital structural or neurological conditions account for the vast majority of cases[7].

Regardless of the underlying cause, it is important that EDS difficulties are identified and managed appropriately. Limitations in how people eat and drink can have a profound impact on wellbeing, irrespective of any other physical, psychological or mental health co morbidities[8].

Failure to manage EDS difficulties with the relevant treatment, dietary and behavioural changes can significantly impact on a person's quality of life, respiratory status, nutritional status, and risk of choking. Potential outcomes include chest infections, aspiration pneumonia and, sadly, death.

Common indicators of an Eating, Drinking or Swallowing difficulty (dysphagia) are:

- **Coughing or choking before, during or after swallowing**
- **Difficulty or pain on chewing or swallowing**
- **Food or saliva pooling in the mouth**
- **Drooling**
- **Repeated chest infections or deterioration in respiratory conditions**
- **Changes in breathing after swallowing such as shortness of breath or wheeze**
- **Changes to voice quality such as wet, strained sounding voice**
- **Food refusal or difficulty placing food in the mouth**

EDS difficulties are managed through referral to Speech and Language Services in the first instance. Speech and Language Therapists (SLT) conduct an individualised assessment of a person's swallowing ability and needs.

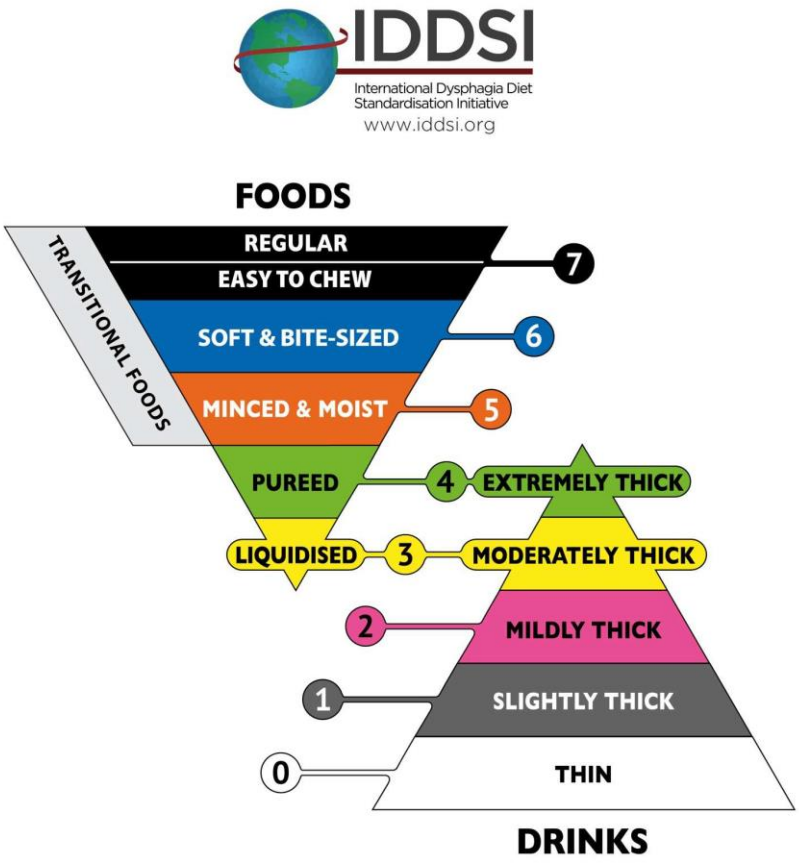
Subsequent to this, the SLT may make recommendations which are written in a care plan and communicated to the patient, their carers, staff and wider multi-disciplinary team (MDT), including catering staff. Effective management of EDS difficulties requires multi-disciplinary input from a range of Health and Social Care professionals such as doctors, nurses, speech and language therapists, pharmacists, dentists, occupational therapists, physiotherapists and dietitians.

Texture-modified diets are frequently required and the terminology utilised is important in ensuring clarity and consistency, in order to minimise the risk of the person receiving food and drink that presents a choking risk. In addition to specified dietary requirements, thickeners may need prescribed to slow the transit of food and fluids. It may also be recommended that patients receive enhanced supervision or assistance at mealtimes, which may include the use of specialist equipment. Information on dietary modifications is communicated via an SLT care plan, which was updated in October 2021, by Dysphagia NI, to include the Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet (REDS); this provides a standardised approach to communicating the needs of people with EDS difficulties.

In addition to any specific dietary requirements, due consideration should be given to the palatability of food. Palatable, appealing food is recognised to be a contributory factor to a person's quality of life and enjoyment. It can also increase the level of food intake, improving nutritional status and wider health outcomes[9].

2.2 International Dysphagia Diet Standardisation Initiative Framework

The International Dysphagia Diet Standardisation Initiative (IDDSI) Framework was established in 2013 and provides international standardised terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures. Its adoption in Northern Ireland followed the DoH circular HSC(SQSD)16/18: Resources to support safer modification of food and drink[10] arising from an NHS Improvement Patient Safety Alert.



Issued on 5 July 2018, the circular directed Chief Executives of HSC Trusts to:

- Identify a senior clinical leader who will bring together key individuals and stakeholders to plan and co-ordinate safe and effective local transition to the IDDSI framework and eliminate use of imprecise terminology including 'soft diet'.
- Develop a local implementation plan, including revising systems for ordering diets, local training, clinical procedures and protocols, and agree roles and responsibilities for communicating patient information.
- Through a local communications strategy (e.g. newsletters, local awareness campaigns etc.) ensure that all relevant staff are aware of relevant IDDSI resources and the importance of eliminating imprecise terminology including 'soft diet', and understand their role in the local implementation plan.

Transition to the IDDSI framework and its supporting work streams within HSC Trusts, marked the first regional effort to improve systems for identification and management of EDS difficulties. It coincided with the establishment of Dysphagia NI, the group tasked to take forward a whole systems approach to implementing the recommendations arising from the Thematic Review, Report on Regional Choking Review Analysis 2018.

2.3 Dysphagia NI

Dysphagia NI was established in 2018. Led by the PHA regional team, it comprises representation from local HSC Trust teams, service users, carers, Statutory, Independent, Voluntary and Community Sectors. It was intended as a whole system, public health approach to supporting the safety of people with eating drinking and swallowing (EDS) difficulties across the wider health and social care system.

The group aims to improve the early identification and management of EDS difficulties in adults and has the following objectives:

- Improve awareness of dysphagia
- Standardise the approach for identifying people with dysphagia
- Standardise the approach for managing people with dysphagia
- Improve access to specialist intervention
- Work towards a co-production approach with service users and carers

As a result of the learning from the 2018 HSCB/PHA Thematic Review, Dysphagia NI was tasked to implement seven recommendations:

1. Develop a regional plan for communication of key safety messages arising from the thematic review, to include consideration of promotional materials and media aimed at raising awareness.

2. Develop proposals for consideration and approval by relevant stakeholders in relation to a regional approach to dysphagia awareness and training for all staff groups, which would carefully consider the following areas:

    - Access to awareness and training
    - Delivery options
    - Theoretical content as required by staff group
    - SLT care plan “language”/terminology including texture descriptors
    - Appropriate supervision of patients whilst eating or drinking
    - Assessment and compliance
    - Roles and responsibilities

3. Develop regional recommendations in relation to timeliness of SLT dysphagia assessment and intervention.

4. Seek regional consensus in relation to the use of Dysphagia Diet Texture Descriptors across the region. In reaching comprehensive consensus with all relevant stakeholders, agree a regional plan for dissemination and implementation using an agreed communication and assurance framework to ensure sharing with and awareness of relevant staff groups families and carers.

5. Seek and share outcomes of current improvement initiatives related to choking on food and give consideration to potential for spread to other areas.

6. Determine the value of a standardised format for swallow recommendations for use in all care settings. If agreed, engage with relevant stakeholders including professional groups to develop same.

7. Determine the value of regional guidance in relation to accurate reporting of patient safety incidents involving all patients with dysphagia. If agreed, engage with relevant stakeholders including professional groups to develop same.

In order to support these activities and to drive the necessary improvements in the systems for safe delivery of care to people with EDS difficulties, resource is allocated on an annual basis. However, funding is non-recurrent, not equitable across HSC Trusts and is confined to adult services. There is resulting variation in the composition of HSC Trust dysphagia support teams, which is acknowledged to impact on the local implementation of regional work. This represents a challenge for the whole systems, sustained approach that is required.

2.4 Safety and Quality Reminder (SQR) of Best Practice Guidance Letter

In February 2021, a Safety and Quality Reminder of Best Practice Guidance Letter SQR-SAI-2021-075 was published following a review of choking-related SAIs undertaken by the HSCB / PHA. The letter highlighted five SAIs which occurred in adults with EDS difficulties. It identified that there were missed opportunities to both recognise and support the needs of these individuals. It was found that on each occasion, there was a failure to confirm the EDS needs of the person, and a failure to communicate their needs to the wider team and to ensure safe processes were in place.

Six recommendations were made which encompassed the key learning points for staff involved with supporting the care of adults and children who present at risk of EDS difficulties:

1. When a person has identified eating, drinking and swallowing difficulties this should be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.
2. Clear mechanisms for the communication of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.
3. The needs of individuals with swallowing difficulties should be communicated at pivotal times; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others.
4. The development of a process for a safety pause before any meals and snacks should be considered e.g. “what patient safety issues for meal and snack times do we need to be aware of today?”
5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.

6. The training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

The letter was subsequently re-issued by the HSCB on 9th June 2021, amended to include all Programmes of Care (i.e. all HSC services). Assurances were sought from HSC Trusts that the six recommendations were incorporated into safety and quality assurance work-plans and that there were appropriate arrangements for monitoring in place. Whilst Dysphagia NI provides support to HSC Trusts who undertake this work, accountability for implementation lies with the respective HSC Trust.

It is the HSC Trusts' implementation of these six SQR recommendations, in addition to the relevant actions in DoH circular HSC(SQSD)16/18, that is examined by this RQIA review. The continued occurrence of choking-related incidents and deaths in Northern Ireland, and specifically the need for previous lessons learned to be restated, such as those reiterated by these SQR recommendations, support the case for this additional review work to be undertaken, in order to identify learning and drive further improvement in the systems for prevention of choking-related harm across HSC Trusts.

Section 3 Findings

3.1 The Views and Experiences of People Living with Eating, Drinking and Swallowing Difficulties

Understanding the lived experience of people with EDS difficulties is fundamental to identifying what works well in terms of supporting people within services and what can be improved in order to better meet the needs of people who are at increased risk of choking.

As part of this review, RQIA engaged with a number of voluntary agencies that provide support to people who have EDS difficulties. Structured focus groups were held with a number of voluntary workers and service user representatives. During this engagement we gained an insight into people's experiences of care and treatment, and the challenges facing people with EDS difficulties when accessing the relevant services and support.

Advocacy groups and service user representatives reported that, when they have been able to access it in a timely manner, people generally have a positive experience of care. The Review Team heard examples of good care, particularly once an SLT assessment was undertaken. We heard of positive experiences of engagement with primary care and SLT services, who were reported to treat people compassionately and holistically, taking into account their quality of life needs. We heard of the valuable support provided by day care services, particularly those with a stable workforce where staff have an opportunity to become familiar with clients and their needs. It was clear just how vital these services can be to the well-being of service users and their families. The Review Team heard of how the COVID-19 pandemic and isolation requirements have impacted adversely on both their accessibility and on the respite they provide to families and carers.

A recurring theme, arising during interviews, was the adverse impact of dysphagia on a person's quality of life. The Review Team heard of how living with an EDS difficulty can extend beyond the challenges posed by the difficulty itself, and the risk of choking, to a reported lack of enjoyment of food, anxiety around eating and drinking, poor nutrition, weight loss and associated complications, such as muscle wasting and falls. EDS difficulties, the risk of choking, and concerns around the associated impact on physical and mental wellbeing, means it is all the more important that people living with these conditions are able to access the appropriate specialist support when they need it.

However, we heard of how a lack of public awareness means that people often delay seeking help from their GP; this has been compounded by difficulties in obtaining GP appointments during the COVID-19 pandemic. We heard examples of how a lack of awareness amongst GPs regarding dysphagia as a condition means that there can be a tendency to focus solely on excluding an underlying cause leading to missed opportunities to refer onwards for an SLT assessment. We heard of long waiting times of up to 18 months for a SLT assessment.

The Review Team was also told that sometimes people are re-referred into secondary care services, such as neurology, rather than being directly referred to

SLT, which would enable people to be supported sooner within the community setting. This indicates a lack of awareness around dysphagia and the role of SLT services within primary care. One suggestion was that self-referral accompanied by signposting to advice, support and information, would reduce barriers to accessing the appropriate specialist input.

It was highlighted to the Review Team, that while patients are awaiting an SLT assessment, there can be a lack of information provided to patients, families / carers and healthcare professionals. Although information is available online, it is not always signposted or suitable for patients and their families. We heard of the wide range of materials that are available through the Public Health Agency (Dysphagia NI), NI Direct website, and voluntary agencies. It was deemed important that all people who present with EDS difficulties should be provided with basic information on how to modify their diet and reduce the risk of choking, dehydration and malnutrition, whilst awaiting a formal SLT assessment. The value of a public health campaigns in raising awareness was described as a useful mechanism to further the understanding of patients and their families, and to help reduce risk.

Although it was reported that SLT provides a much-needed service in improving safety for people with EDS difficulties, patient compliance with texture modified diets once discharged to the community, was raised as an issue. It was reported that the food can seem unappealing and people who do not fully understand the risks, either due to a lack of patient and carer information or due to a lack of capacity, may continue to consume food and drink that are not suitable for them; a factor that could be overcome with multi-disciplinary support for patients and carers to improve their understanding and provide education on how to prepare palatable and appealing meals.

We also heard examples of how delays in SLT reassessment following discharge, can mean that people remain on a modified diet that is no longer necessary as their ability to eat, drink and swallow has improved due to recovery from the underlying condition.

This highlights the importance of timely person-centred care and illustrates how delays in accessing SLT services and multi-disciplinary support, can further compound issues that affect quality of life.

3.2 Leadership, Governance and System Oversight

Strategic leadership, in addition to robust governance and system oversight, is essential to ensuring the effective implementation of, and monitoring of compliance with, both the IDDSI and SQR recommendations, to reduce the risk of incidents of choking. A systematic and co-ordinated approach is required in order to maximise the systems for safe delivery of care to people with EDS difficulties.

The 2018 DoH circular, HSC (SQSD) 16/18, had stipulated that HSC Trusts identify senior leaders to engage with stakeholders and co-ordinate transition to the IDDSI framework. This was to be underpinned by revised systems for ordering food, staff training and the development of clinical procedures and protocols, supported by a

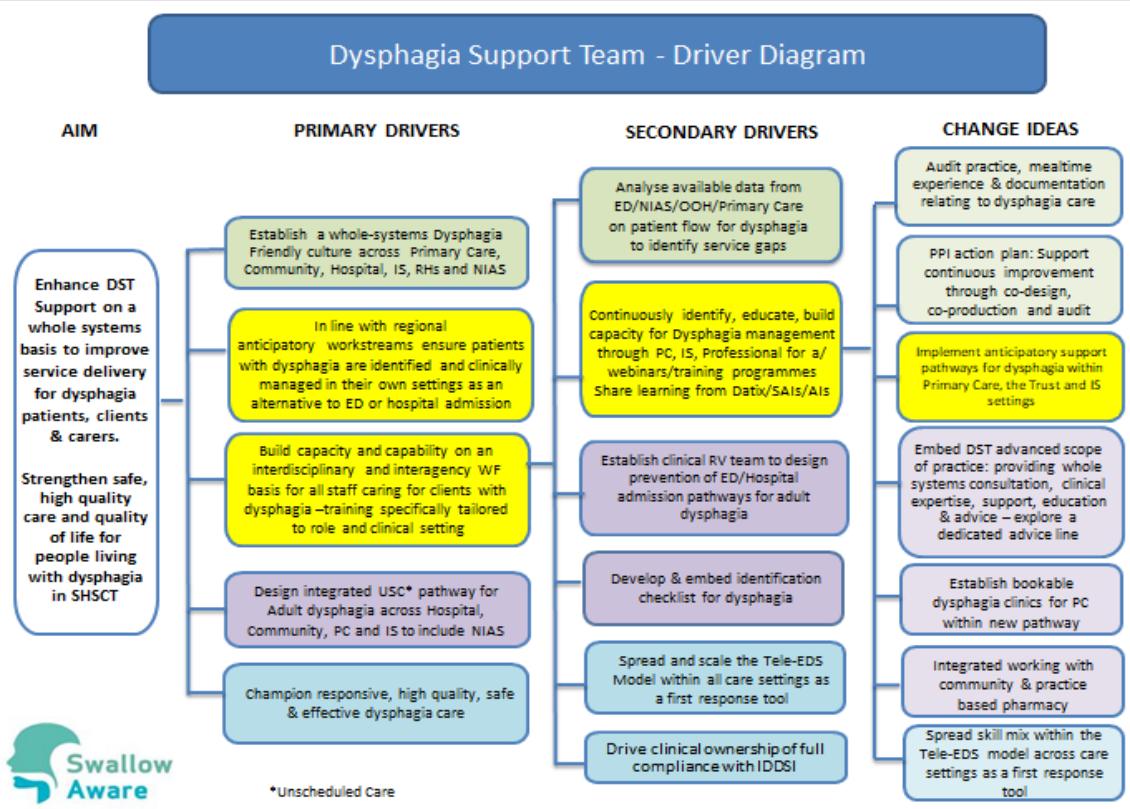
communications strategy. All HSC Trusts evidenced to the Review Team that the requirements set out in this DoH circular had been met.

All HSC Trusts have established strategic teams to oversee the implementation of the SQR recommendations. HSC Trusts have either resumed the previously formed IDDSI implementation steering groups or subsumed implementation of the SQR recommendations into the work streams of existing HSC Trust Nutritional Committees. However, the Review Team found that there was variation in the composition of HSC Trust strategic teams, in addition to variation in governance arrangements and systems oversight of the implementation of SQR recommendations. Whilst most HSC Trusts demonstrated appropriate arrangements, the Review Team found that there was a need for more cohesive strategic oversight, for better, sustained and co-ordinated implementation, alongside improved governance systems around reporting and monitoring of risk within some HSC Trusts.

Despite this variation, all HSC Trusts demonstrated a commitment to supporting the needs of people with EDS difficulties, and to implementing and improving systems to reduce the risk of choking. This commitment was best exemplified by the sustained whole-systems approach adopted by the Southern HSC Trust, evidenced by the improvements implemented by the Dysphagia NI SHSCT Team.

Good practice example:
Southern HSC Trust Dysphagia Support Team

In 2018, commissioned by Dysphagia NI, the Southern HSC Trust established the SHSCT Dysphagia Steering Group to lead on IDDSI implementation. In January 2019 a dedicated Dysphagia Support Team (DST) was appointed which aims to strengthen safe, high quality care and quality of life for people living with dysphagia and to oversee the implementation of the regional recommendations following the Regional Choking Review Analysis - Thematic Review (2018). Subsequently the membership of the Trust Dysphagia Steering Group was broadened to become aligned with No More Silos (NMS) Trust infrastructure to form the Dysphagia NMS Steering Group. The key objectives of this group are outlined in the driver diagram below:



Source: Southern Health and Social Care Trust (2021)

All HSC Trusts welcomed the commissioning of Dysphagia NI teams, which has led to system improvements in the delivery of care to people with EDS difficulties. The establishment of such teams was described by several HSC Trusts as the "beginning of an ongoing journey" to support the needs of people with EDS difficulties. The Expert Review Team considers that the different strands of work to improve both the safety and nutrition of people with EDS difficulties should be integrated and embedded into a sustainable framework with consistent structures in place within HSC Trusts, as opposed to the distinct 'Short Task and Finish Groups' described by one HSC Trust and evidenced in others.

The Review Team consider that the lack of a sustained effort within one HSC Trust was at least partly due to inequitable provision of non-recurrent transformation funding, the impact of which was evident; the Review Team was informed that it had been especially challenging to implement the SQR recommendations amidst the additional pressures and capacity issues posed by the COVID-19 pandemic.

Despite challenges arising from inequity and variation, it was evident that learning from specialist Dysphagia NI teams had been cascaded across HSC Trusts, representing evidence of an effective regional approach to improving the systems for delivery of care to people with EDS difficulties. However, the Expert Review Team considered that this approach could be further strengthened at policy-level by the development of a regional strategy to ensure that systems for delivery of care and reduction of risk are co-ordinated across organisational boundaries and targeted according to population need. Such a strategy should focus not just on reducing the risk of choking but also on improving nutritional outcomes and hydration for people with EDS difficulties.

Recommendation 1 **Priority 2**

HSC Trusts and commissioners should work together to ensure that both strategic and multi-disciplinary implementation teams are adequately resourced and have both the capacity and capability to effectively implement the SQR recommendations. DoH should lead the development of a regional strategy to drive a sustained and co-ordinated effort to reduce the risk of choking and improve nutritional outcomes for people with EDS difficulties.

3.3 Identification, Risk Assessment and Care Planning

Identification of People at Risk of Choking

Robust systems for the identification of people with EDS difficulties are essential to reducing the risk of choking and improving patient outcomes. It requires good awareness amongst multidisciplinary teams, effective mechanisms for the delivery of staff training and high-quality accessible resources to support staff, patients and carers.

As stated previously, all HSC Trusts evidenced that the requirements set out in the DoH circular, HSC (SQSD)16/18, regarding implementation of the IDDSI Framework had been met. One of these recommendations mandated a communications strategy to raise awareness amongst relevant staff groups of the importance of

standardised IDDSI terminology and this will have additionally served to raise awareness about dysphagia and the associated risk of choking. However, the Expert Review Team considers that a sustained approach to awareness raising, and one which is not restricted to particular staff groups, is required. One effective method is the recruitment of dysphagia champions, who with support from Trust Dysphagia NI Teams, can help to disseminate information, educate staff and advocate for best practice in ensuring patient safety when delivering care to those with EDS difficulties. The Expert Review Team found that although there may be dysphagia champions across high-risk areas within some HSC Trusts, front-line staff were not always aware of them, which indicates an underutilisation of key staff members to educate colleagues, disseminate learning and champion patient safety.

Staff training is crucial to ensure that staff have both improved awareness and the requisite competencies to recognise EDS difficulties and other risk factors for choking, in addition to knowing when and how to refer for an SLT assessment.

SQR Recommendation 6 states that the training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them. Implementation of the IDDSI Framework required training of relevant staff groups across all HSC Trusts. Dysphagia NI has endorsed Health Education England Training and made it accessible within the HSC Learning Centre platform; this is supplemented by Dysphagia NI regional training materials and staff guidance. All HSC Trusts described arrangements for staff accessing regional e-learning via the HSC Learning Centre platform; HSC Trusts described training provided at induction and also ongoing access to training for existing staff. The Northern HSC Trust described a Dysphagia Induction Checklist for new staff members, which the Expert Review Team considered to be a useful tool.

Across HSC Trusts, regional training is augmented, to varying degrees, by additional training delivered via a mix of local HSC Trust e-learning and face-to-face sessions delivered by SLTs in various formats. In the Northern HSC Trust, Dysphagia training is a mandatory requirement for all staff who provide care to patients who present at risk of EDS difficulties; this includes catering staff and managers of these relevant staff groups. However, it should be noted that neither regional nor local dysphagia training is mandatory in all high-risk areas in every HSC Trust, and in some HSC Trusts critical staff groups such as catering are not provided with access to training.

Equally, not all HSC Trusts were able to describe robust systems for oversight and monitoring of compliance with training requirements. The Expert Review Team considers that catering staff play a vital role in ensuring that patients are provided with meals, snacks and drinks in accordance with Eating, Drinking and Swallowing (EDS) recommendations. Failure to mandate and provide appropriate training for them marks a considerable omission; this is also the case for other staff groups working within high-risk areas.

During fieldwork sessions with front-line staff, it was apparent that, despite all HSC staff having access to regional dysphagia e-learning through the HSC Learning Centre platform, not all were aware of its existence or availability to them. In one HSC Trust, awareness of available training resources was noted to be particularly

poor amongst front-line day care staff indicating that implementation of SQR Recommendation 6 was yet to encompass all high-risk areas. The HSC Trust strategic team conceded that COVID-19 pressures coupled with a lack of capacity had impacted on the prompt and effective implementation of SQR recommendations; work is underway to address this. Regardless, more work is required regionally to improve awareness of available training resources amongst relevant HSC staff groups.

Training is most effective when provided regularly and supplemented with staff resources. All HSC Trusts described dissemination of IDDSI and Dysphagia NI staff guidance and resources with some HSC Trusts also providing staff with local resources to augment their understanding of dysphagia and how to mitigate the risk of choking. Such resources included posters, leaflets, fact sheets, checklists disseminated via email, social media or in hard copy; the content of which is embedded in policies and guidelines within some HSC Trusts. Utilising a variety of different media is recognised to be helpful in raising awareness and reinforcing learning acquired via traditional training methods. The Expert Review Team also considers that Dysphagia Champions can play an important role in signposting and dissemination of resources and that existing HSC Trust mechanisms for sharing patient safety information should be utilised to share resources and learning. For example, in the Belfast HSC Trust, SAFETEMBER, which comprises an annual series of patient safety events each September, was used to roll out HSC Trust and Dysphagia NI resources.

Recommendation 2 **Priority 1**

Each HSC Trust should ensure that dysphagia training is mandatory for relevant staff groups working across high-risk areas (Stroke, Care of the Elderly, Mental Health and Learning Disability and Day Care settings) and any other service areas where care is provided to people with EDS difficulties. Relevant staff groups should include all clinical, domestic and catering staff. Each HSC Trust should ensure that there are robust systems in place for monitoring compliance with mandatory training requirements.

Access to Speech and Language Therapy Services

Accessible SLT services are essential to ensuring prompt assessment of people with EDS difficulties so that care planning and appropriate evidence-based recommendations for any dietary, behavioural and supervision adjustments can be made. Prolonged waiting times can either increase the risk of choking, or lead to restrictive measures being implemented for unnecessarily long periods in the interim; for example: Nil By Mouth directives within Stroke Care settings.

Whilst all HSC Trusts described effective arrangements for referral to SLT services, following the identification of a possible EDS difficulty, there was marked variation across HSC Trusts in reported waiting times for both urgent and routine SLT assessments. This reflects a variation in the capacity and capability of HSC Trust SLT teams. There was also a disparity in reported waiting times according to service area with acute services reporting quicker access than day care settings. In the absence of further data, which was not gathered due to it falling outside the ToR for

this review, it is not possible to conclude whether referrals are vetted appropriately according to individual clinical need or whether it is more dependent on the service area from where the referral has been made. Regardless, it was noted that in no HSC Trust is there a full seven day SLT service, meaning that even the most urgent referrals for high-risk patient populations, such as those who have received a stroke diagnosis, may wait a period of time for assessment.

When there is a delay in SLT assessment, it is crucial that patients, families / carers and staff are provided with appropriate information on how to support the patient's EDS needs whilst awaiting specialist input. During fieldwork, it was commonly reported by front-line staff that uncertainty on how to proceed, coupled with concerns about the risk of choking and not meeting the patient's nutritional or quality of life needs, was leading to heightened anxiety, particularly in the context of protracted waiting times. In some HSC Trusts, patients and carers are signposted to UK Health Security Agency and Office for Health Improvement and Disparities (formerly known as Public Health England) guidance, which offers useful information on how to practically manage problems whilst awaiting an SLT assessment. However, as it is not specific to Northern Ireland, it does not contain information relating to regional or local support services. The Expert Review Team identified that there is a need for regional guidance offering interim advice to patients, carers and staff on how to manage EDS difficulties in a proportionate manner that mitigates risk whilst patients are awaiting an SLT assessment. Such improvement work could be subsumed into existing regional efforts to address issues in relation to dysphagia and the risk of choking.

Recommendation 3 **Priority 2**

HSC Trusts and commissioners should work together to review the capacity and capability of multidisciplinary teams, with a particular focus on Speech and Language Therapy, to meet the needs of the patient population and ensure that timely assessment and intervention is provided, where required. The Public Health Agency should develop regional guidance and resources to support patients, carers and staff to manage EDS difficulties whilst awaiting an SLT assessment.

Documentation of the EDS recommendations

A key outcome of the SLT assessment is the care plan. SQR Recommendation 1 states that "when a person has identified eating, drinking and swallowing difficulties this should be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans". Written documentation of these EDS recommendations forms one of the key mechanisms for communication, referred to in SQR Recommendation 2, which states that there should be "clear mechanisms for the communication of swallowing [EDS] recommendations to those who are providing food or caring directly for individuals with swallowing difficulties".

Accurate unambiguous documentation using the correct IDDSI terminology is crucial for patient/client safety. In October 2021, Dysphagia NI, in partnership with Trust SLTs, developed the Regional SLT Eating Drinking and Swallowing Recommendations Sheet which was launched across HSC and all sectors in an

attempt to standardise documentation and reduce variation. It is the implementation of the SLT EDS recommendations that reduces the risk of choking, whilst empowering people to manage their dietary needs in accordance with their eating, drinking and swallowing ability. As such, clear and visible documentation is a crucial component not just in improving patient safety, but also in maximising quality of life. The inclusion of the most up-to-date SLT EDS recommendations within the appropriate sections of the patient's paper-based and electronic health records is vital to ensuring that staff can easily access the relevant information, particularly following high-risk times such as handover or following transfer of the patient to another service. It is worth noting that this document is not included within regional nursing or discharge information.

All HSC Trusts reported mechanisms for ensuring that SLT EDS recommendations are documented in the clinical records and that terminology is compliant with the ISSDI framework. Some HSC Trusts described processes, such as safety huddles, for ensuring that the wider team was aware of the EDS recommendations. This was deemed to represent good practice as it serves as a useful mechanism to highlight patients with EDS difficulties as part of a daily briefing and can alert members of the multidisciplinary team to their needs. For example, it may alert pharmacists to any medication adjustments and healthcare assistants to the patient's EDS requirements.

The Expert Review Team identified that there is variation in practice in terms of where EDS recommendations are located. Within acute services it was common for the EDS recommendations to be documented within the medical notes. In some HSC Trust services, the EDS recommendation sheet was also included in the nursing notes and at the patient bed-side, which was deemed to represent good practice. However, it is important that the SLT Regional EDS recommendations are kept in their original format as summarising whilst transcribing can introduce room for error and pose a potential risk.

Another useful mechanism for alerting staff to the EDS recommendations is the use of electronic care records, which can be particularly helpful if discharging home or transferring between services. The South Eastern HSC Trust have been using NIECR Swallowing difficulties alerts and alerts on their Electronic Document and Management System (eDAMS) since 2021. The Northern HSC Trust reported that they were planning to trial a 'Dysphagia Alert' on the Northern Ireland Electronic Care Record (NIECR), where EDS recommendations can be uploaded and shared with the multi-disciplinary team.

PARIS, an electronic care system commonly used in Mental Health and Learning Disability settings, has also been utilised by SLTs to document care plans and record EDS recommendations. The Expert Review Team consider that all relevant electronic care records should be utilised to alert staff to EDS difficulties and to record and share recommendations with multi-disciplinary teams, receiving teams upon transfer and GPs following discharge. It would also be beneficial to have EDS recommendations embedded within standard discharge documentation to facilitate sharing of information between acute and community services.

Recommendation 4 **Priority 2**

HSC Trusts should ensure that there are established processes to ensure that SLT EDS recommendation sheets are visible and accessible to all members of multidisciplinary teams within services. SLT Regional EDS recommendations should be included as part of any standard transfer and discharge documentation. SLT Regional EDS recommendations should also be incorporated into Electronic Care Record systems, accompanied by an 'alert' where this function is available.

3.4 Systems to Support Communication between Staff at Pivotal Times

Robust systems for communication between staff are essential to ensuring that all staff involved in the care of individuals with EDS difficulties are aware of their needs; this is vital to reduce risk, particularly at times when patients are presented with food or when care is transferred between acute services or to the community. SQR Recommendation 3 states that "the needs of individuals with swallowing difficulties should be communicated at pivotal times; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others".

Handover is a well-established mechanism for communicating information between teams who are changing over between shifts. An effective handover is particularly important as omission of important information or relaying inaccurate information can lead to inadequate care delivery and adverse outcomes. All HSC Trusts reported that the nursing handover is utilised to share information regarding patients with EDS difficulties, including their dietary and supervision requirements. Many reported that this is supplemented through the use of written information on handover documentation and on ward whiteboards. The Expert Review Team considers that this is good practice.

Safety briefs, also known as huddles, are staff meetings that are held during the course of a shift and focus on key patient safety issues. Less well-established than handover, they are recognised to be an effective way for staff to communicate and address areas of risk. Many HSC Trusts reported that safety briefs and huddles were used to alert staff to and communicate the needs of those with EDS difficulties who are at risk of choking. The Expert Review Team considers that this is a useful tool to mitigate risk within the context of busy clinical settings.

Communication between teams is essential when patients transfer care, particularly when moving between facilities or being discharged to the community. HSC Trusts described a variety of mechanisms for transferring information between services including verbal handover between key staff members and written correspondence.

Day centre staff within some HSC Trusts reported challenges in receiving information on up to date SLT EDS recommendations for patients with SLT care plans. It was stated that this information was not always included in the referral, and can be difficult to access or locate within clinical records. The Expert Review Team considers that embedding up to date EDS recommendations within standard transfer and discharge documentation would again be helpful in this regard.

Mealtimes and the Use of Safety Pauses

Meal and snack times within services that provide care to patients with EDS difficulties constitute high-risk times for incidents of choking. Robust systems to support the safe provision of food are essential to reducing harm from dysphagia. To date, regional work has focused on raising awareness of staff on the importance of due diligence when patients are provided with food and drink within healthcare services. For example, the PHA / Dysphagia NI has led a Swallow Aware campaign to support safe swallowing at mealtimes. It uses the PATH mnemonic as an 'aide memoire' for staff to ensure that the patient's position and degree of alertness are appropriate, alongside the texture of the food and availability of help or assistance with eating and drinking[11].

Other initiatives such as Mealtimes Matter provide a framework for safe delivery of care at meal and snack times. A key tenet is that staff temporarily suspend provision of non-urgent clinical care and divert their attention and focus to providing supervision and assistance at mealtimes; this is overseen by a member of the nursing team acting as a dedicated mealtime supervisor. Safe care delivered at this time is augmented by the use of Safety Pauses. A Safety Pause is a tool to support communication between staff at mealtimes. SQR Recommendation 4 states that there should be "a safety pause before any meals and snacks should be considered e.g. 'what patient safety issues for meal and snack times do we need to be aware of today?'". Despite this forming an SQR Recommendation, it was clear during fieldwork that Safety Pauses are less well-embedded than other systems to support patient safety; some staff felt that a standardised approach to Safety Pauses would be beneficial.

HSC Trusts described being at different points along the implementation process. Front-line workers within some HSC services purported that Safety Pauses were not yet utilised, which was reflected in the staff survey; whilst 169 (32%) respondents reported that Safety Pauses were in place, 82 (16%) stated they were never used and 272 (52%) were 'unable to answer'. The Expert Review Team considers that work should progress without delay to implement and embed Safety Pauses across all high-risk areas.

The use of bedside signage and personalised placemats can be useful adjuncts for alerting staff to the needs of patients with EDS difficulties. However, the Expert Review Team was informed that within some services these have inadvertently increased risk due to not being up to date with the most recent EDS recommendations, and may also unintentionally breach patient confidentiality. Nonetheless, when the Regional SLT EDS is used in its original format and not translated, the Expert Review Team considers that they can support the safe delivery of food to people with EDS needs.

Recommendation 5 Priority 1

All HSC Trusts should ensure that there are robust systems to facilitate sharing of information between staff. These may include: safety briefs, bedside signage and a

mealtime Safety Pause. Each HSC Trust should ensure that a Safety Pause is implemented at mealtimes across all high-risk areas (Stroke, Care of the Elderly, Mental Health and Learning Disability and Day Care settings); supported by effective arrangements for monitoring and auditing of compliance.

3.5 Systems for Ordering, Preparing and Distributing Food

Robust systems for ordering, preparing and distributing food are essential to ensuring that patients are provided with the correct food for their needs. An error during any of the processes for food ordering, preparation or distribution can result in inappropriate food being given to a patient with the potential to pose a significant risk of choking.

DoH circular HSC (SQSD) 16/18 stipulated that all HSC Trusts should revise their systems for ordering diets in line with the IDDSI Framework. All HSC Trusts reported implementation of a revised system supported by staff training and updated policies. It was noted that there is variation in the types of systems used across HSC Trusts and services. Most reported using paper-based menu cards, some of which have a supplementary section on IDDSI requirements. One HSC Trust reported using an electronic system, the Saffron system. Although the South Eastern HSC Trust described a robust system for checking that the correct IDDSI-compliant order is placed, the majority of HSC Trust food ordering systems do not link with the patient's requirements, set out in their SLT care plan, and are instead reliant on staff to complete the meal request correctly. It was reported by catering staff across some HSC services that occasionally meal requests are incorrectly completed, posing an element of risk.

The Expert Review Team considers that integrating catering staff with the wider multi-disciplinary team is essential to enhancing patient safety, and that catering staff should be viewed as equal partners in the delivery of a safe service to patients with EDS difficulties. SQR Recommendation 2 states that there should be "clear mechanisms for the communication of swallowing recommendations to those who are providing food or caring directly for individuals" to "include all staff (domestic and catering)".

Whilst some HSC services reported that nursing staff and SLTs link directly with catering to provide catering staff with information on a patient's EDS recommendations, and include catering staff as part of the Safety Pause, this was not a universal finding. It was clear during fieldwork that catering staff in some HSC Trusts can feel they are working in silos and, at times, anxious regarding the level of risk posed by fragmented systems.

A variety of processes were described for the safe distribution of meals, which is largely undertaken by domestic staff. These included checking requirements with the designated member of the nursing team responsible for supervising mealtimes, the use of trolleys to ascertain correct patient meals, verifying requirements with patients themselves, and referring to bedside signage and placemats. The Expert Review Team considers that embedding the Safety Pause will further strengthen the system for safe distribution of food.

Equally important is that catering and domestic staff are provided with the appropriate training. Whilst some HSC Trusts provide training for catering staff, this was not the case across the board. As per Review Recommendation 2, the Expert Review Team considers that Regional Dysphagia Awareness training should be mandatory for all relevant staff groups, including catering and domestic staff.

Good Practice Example: Dysphagia Menu Programme

The Dysphagia Menu Programme is an improvement initiative which was developed in partnership between the South Eastern HSC Trust, community catering staff, SLTs, dietitians, residential and day care managers, service users and service user representatives. The purpose of the programme is to provide a systematic, safe approach to the provision of appropriately textured foods for people with EDS difficulties within SEHSCT residential and day care settings.

The overall aim of the project is to offer meal choice and equity to all service users in residential and day care facilities. It additional aims to stop using frozen, pre-modified meals and for facilities to produce nutritious, enjoyable, IDDSI compliant meals.

The programme was rolled out in seven residential homes & two day centres; it included a three week menu cycle developed for all residents including those on a texture-modified diet. A snack and tea trolley menu was also developed. Over 60 recipe cards were designed and nutritionally analysed.

The training was designed to ensure that all relevant catering staff are aware of the terminology for dietary modification and testing methods and how to implement these. Equipment was procured for all locations, and the training extended to demonstrate the use of this equipment. The training showed the actual practicalities of achieving IDDSI levels when cooking from fresh.

IDDSI compliance was monitored during implementation via a programme of audit, demonstrating 100% compliance. Furthermore, the developed menus are compliant with nutritional guidelines and have been demonstrated to be cost effective.

The Trust sought service user feedback regarding freshly made meals compared with pre-prepared meals. 100% of respondents reported an improved experience. Service users were very positive in terms of both the visual appeal and taste of the freshly prepared meals; many reported that this enabled them to feel like they were having the same foods as their families. Additional nutritional support and calorie intake was also achieved.

The South Eastern HSC Trust is currently exploring options with Dysphagia NI for scaling up and spreading this initiative across the region.

Recommendation 6 **Priority 1**

All HSC Trusts should ensure that there is a robust mechanism for communicating the needs of patients with EDS difficulties to catering teams. Across high-risk areas, catering staff and domestic staff should be included as an integral part of the multi-disciplinary team and should be involved in the mealtime Safety Pause. Systems for ordering food should include a mechanism to check that the correct IDDSI-compliant meal has been ordered for patients with EDS difficulties.

3.6 Safe Storage of Food, Fluid and Thickening Agent

Storage of Food and Fluids

Secure storage of food and fluids is essential to avoid at risk patients accessing foods that are unsuitable, which may lead to an episode of choking; this is of additional importance in settings where there are patients who lack capacity. It should be noted that there have been recent deaths in Northern Ireland as a result of patients lacking capacity gaining access to unsuitable foods. It is for this reason that SQR Recommendation 5 states that HSC Trusts should "ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely".

Four out of five HSC Trusts reported having Trust guidance on the safe storage of food and fluids that pose a risk of choking. However, a variation in practice was identified across services, partly dependent on the type of ward (open bays or single rooms), the patient population, staff:patient ratio and the nature of facilities, with some estates offering better storage options than others. It was also acknowledged by some HSC Trusts that despite their efforts to securely store food and fluids, ensuring that patients do not access unsuitable foods can be a challenge; particularly when visitors may bring in snacks and service users may seek to share food with each other. The Expert Review Team heard how this risk is mitigated by enhanced supervision from staff at meal and snack times. Nonetheless, it is crucial that all reasonable steps are taken to avoid patients accessing unsuitable foods and fluids. These may include patient and family education, strict policies around visitors bringing food and drink into services, and identifying suitable storage spaces, ideally away from patient areas. Some HSC Trusts reported auditing compliance with safe storage of foods and fluids; the Expert Review Team considers this to be good practice.

Recommendation 7 **Priority 1**

All HSC Trusts should ensure that there are robust systems for the secure storage of foods and fluids that pose a risk to individuals with eating, drinking and swallowing difficulties. Each HSC Trust should audit compliance with secure storage of food fluids across high-risk areas.

Prescription, administration and storage of thickening agent

Thickening agent is frequently prescribed as part of dysphagia management, to thicken liquids, slow transit and prevent aspiration. It most commonly exists in powder form, and prior to an NHS England Patient Safety Alert in 2015, would frequently have been stored at the patient bedside. The Patient Safety Alert, highlighted the risks associated with swallowing thickening powder and subsequent to the issuing of this, the majority of healthcare providers have transitioned to secure storage.

All HSC Trusts, with the exception of one, have Trust policies for the safe storage of thickening agent. However, variations in practice for the storage of thickening agent were described; these included:

- storage in medicine cabinet,
- a locked cupboard,
- locked bedside drawer,
- ward clinical area, and
- kitchen

Frontline staff reported delays accessing thickening powder from medicine cabinets which typically rely on one member of staff holding the keys. It was reported that this could inadvertently increase risk due to consumption of non-thickened liquids.

The Expert Review Team considers that systems for the safe storage of thickening agent should take into account the need for staff access, and that liquids which require to be thickened should not be stored or left in areas accessible to patients with EDS difficulties, particularly where there are concerns around patient compliance or capacity.

All staff working in high-risk areas should be aware of the risks of thickening agents and ensure their safe storage to prevent accidental ingestion. All HSC Trusts reported that staff involved in the administration of thickening agent had received the appropriate training. Some HSC Trusts reported auditing compliance with safe storage recommendations and also inclusion of storage of thickening agent as an item on the Safety Brief; the Expert Review Teams considers this to be good practice.

Recommendation 8 Priority 2

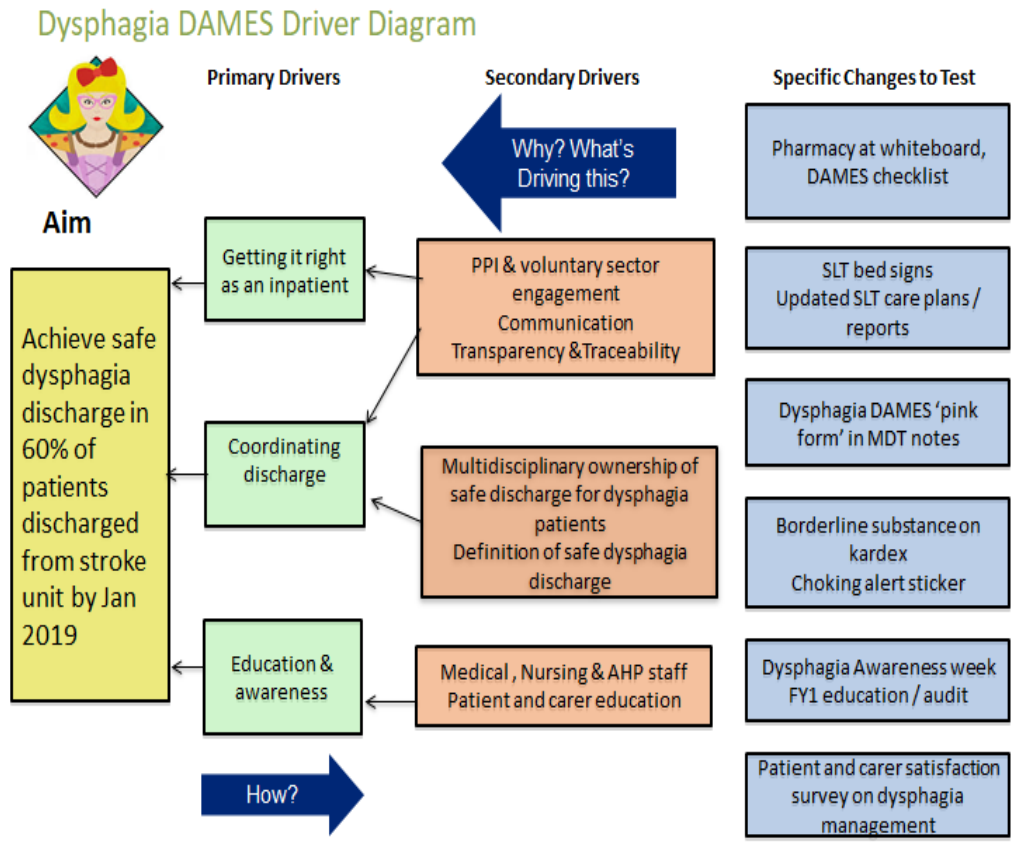
All HSC Trusts should ensure that there are effective systems for the secure storage of thickening agent. In relation to the prescribing of thickeners, the DoH / Strategic Planning and Performance Group (SPPG) / PHA and HSC Trusts should work together to implement the learning from the DAMES project regionally.

Good Practice Example:
DAMES Project

DAMES was a quality improvement project undertaken in the Belfast Health and Social Care Trust. It focuses on multidisciplinary management of swallowing difficulties within the stroke service, particularly at the point of discharge. It aims to address the disparity between hospital and community in terms of how thickener and medications are prescribed.

The DAMES checklist is embedded within the medicine Kardex and includes the following elements:

D - dietary supplements
A - appropriate thickener
M - modification of medication
E - education
S - swallow care plans



Compliance with all components of the checklist is deemed to constitute a safe discharge. All SLT reports from Stroke services now incorporate these components.

The project has succeeded in increasing the proportion of patients with the appropriate medication and thickening agent prescribed, in addition to improving the provision of dysphagia information to patients, carers and GPs.

3.7 Communication with Families and Carers

Effective communication with families and carers is essential to ensuring that they have a clear understanding of the patient's EDS needs and the EDS recommendations. SQR Recommendation 2 states that there should be "clear mechanisms for the communication of swallowing recommendations" to "families and visitors". All HSC Trusts services should have arrangements in place for engaging with families following the identification of a patient's EDS difficulty, following their SLT assessment, and prior to discharge home. Like staff, families and carers should be educated on the EDS requirements and the specific IDDSI terminology, which is relevant to the patient.

Families and visitors should be advised against bringing in inappropriate foods or snacks for an individual's IDDSI levels. They should be provided with information and encouraged to check with staff before providing food to an individual with dysphagia. In particular, it is important that families and carers are supported to understand the associated risks in terms of choking, malnutrition and dehydration. They should be provided with sufficient information and resources to enable them to support patients on a day-to-day basis. Where required, training should be provided on how to use thickening agent and prepare IDDSI complaint meals prior to the patient's discharge home. Within the community setting, families and carers should be supported to provide the individual with nutritious and appealing meals, whilst knowing how to seek help if the patient's condition or ability to eat, drink or swallow changes.

The majority of HSC services reported robust arrangements for communicating with families and carers, which is largely undertaken by nursing and SLT staff. Across most HSC Trusts, day care settings were highlighted as providing good opportunities for engagement with carers. However, this was not a universal finding. Front-line staff within Day Centres at one HSC Trust described unsatisfactory arrangements citing patient confidentiality as a barrier to engaging with families over the telephone; it should be noted that where patients with capacity consent to having their information shared, this should not be an issue and where individuals lack capacity, communication with family members is in their best interest. Nonetheless, it is acknowledged by the Expert Review Team that the COVID-19 pandemic has made family engagement more difficult. HSC Trusts should ensure that in the absence of face-to-face opportunities for meetings, alternatives should be offered such as virtual meetings or telephone communication. This should be supplemented with written information and signposting to resources and other agencies that provide support.

Good Practice Example:
Family and carer engagement on the Head and Neck Oncology Ward

The Head and Neck Oncology ward in the Western HSC Trust describes robust arrangements for engaging families and carers prior to a patient's discharge.

A multi-disciplinary discharge planning meeting is held with the service user and their family and/or carers; this comprises representation from nursing, social work, speech and language therapy and dietetic services.

The purpose of this meeting is to discuss and determine recommendations for ongoing management at home; the aim is to fully involve families, giving them time to ask questions and/or to raise any concerns they may have. This also helps to ensure anything that is needed is put in place before the service user goes home. Importantly, it provides an opportunity to educate families on the patient's EDS needs, the associated risks, what the IDDSI requirements are, and how to provide safe, nutritious and appealing food.

Following discharge, the service user is reviewed by Speech and Language Therapy and an opportunity is provided for family members and carers to attend.

Recommendation 9 **Priority 1**

All HSC Trusts should ensure that there are effective mechanisms for communication with families and carers of patients with EDS difficulties, who should be appropriately engaged to understand the patient's needs and EDS recommendations. Prior to discharge home or at the point of dysphagia diagnosis in community settings, families and carers should be provided with education, information resources and a means to accessing further support if required.

Awareness of Dysphagia within the Community

In addition to the need for HSC Trusts to provide patients, families and carers with the appropriate education and resources, there is a need for greater public awareness of dysphagia, its associated risks and implications, and how to access support.

Public health campaigns can be delivered by a variety of mechanisms but tend to be most effective when undertaken in partnership with HSC Trusts and as part of a sustained and co-ordinated effort.

Good Practice Example: Hard to Swallow Campaign

In 2020 the Mid and East Antrim Agewell Partnership (MEAPP) partnered with Dysphagia NI and the Northern Health and Social Care Trust to produce the Hard to Swallow[i] social media campaign and information booklet.

The aim of this was to support individuals with swallowing difficulties in the community, and their carers, and to provide advice on self-care. This resource is particularly valuable to those waiting for their first appointment.

The campaign was supported by a number of awareness sessions for the general public, on how to recognise signs and symptoms and how to access support for EDS difficulties.

Furthermore, MEAAP has worked with a local chef and has produced IDDSI compliant recipes for those with EDS difficulties; this provides information on diet modification, making foods easier to manage and how to make foods more nutritious and appealing.

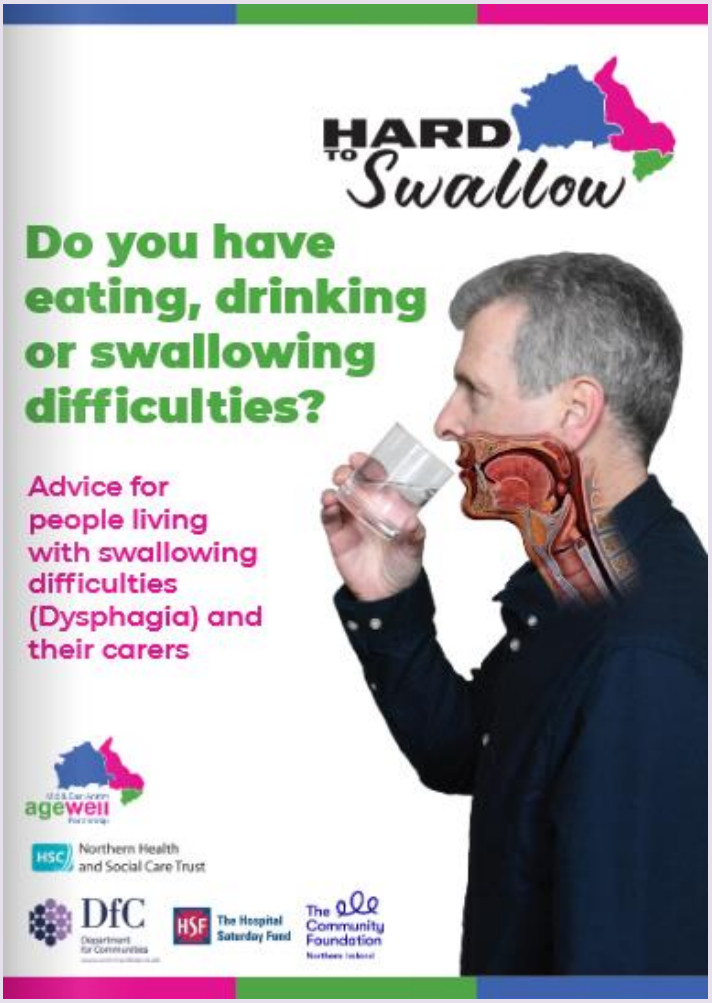


Figure 1. Front cover of Hard to Swallow Booklet, which can be accessed at: https://www.meaap.co.uk/hardtoswallow/

There is also a need for greater awareness and training amongst primary care staff, including GPs, who are often the first point of contact. The benefits of improved awareness are clear: people seek help sooner, are referred and managed at an earlier stage and the risk of choking is reduced.

Training is most effective when it begins at undergraduate level. Improved awareness amongst nursing and medical students serves to provide a strong foundation for building the requisite knowledge and skills once qualified. The Expert Review Team considers that there is a benefit to engaging with academic institutions in Northern Ireland to ensure that there is adequate coverage of dysphagia and the risk of choking in the relevant undergraduate curricula of all healthcare professionals.

Recommendation 10 **Priority 3**

The Public Health Agency and HSC Trusts should work together to scale up and embed the Hard to Swallow Campaign. The Northern Ireland Medical & Dental Training Agency (NIMDTA) and HSC Trusts should ensure that GP trainees are provided with sufficient training on how to recognise and manage Eating, Drinking and Swallowing difficulties, including when to refer for Speech and Language Therapy assessment. Ulster University and Queen's University Belfast should ensure that the recognition and management of EDS difficulties is included on the undergraduate curricula for medicine and nursing degrees.

3.8 Compliance with Eating, Drinking and Swallowing recommendations

EDS recommendations, made after an individualised risk assessment, are intended to reduce the patient's risk of choking whilst improving nutrition and hydration. Failure to adhere to these can lead to patient harm. The Expert Review Team found that on the whole, this is acknowledged by HSC Trusts and front line teams, with some HSC Trusts reporting regular auditing of staff adherence to EDS recommendations, which is reported to have improved compliance.

In healthcare scenarios, patient compliance often refers to compliance with medical treatment, such as medication. It is important to note that food, including texture-modified food is not a medical treatment. Nevertheless, compliance with EDS recommendations such as texture modified diets, and the use of thickening agent is vital in reducing the risk of choking in individuals with EDS difficulties. Food and drink are inextricably linked to enjoyment and quality of life, which makes it all the more difficult for patients to strictly adhere. This can present challenges for staff who seek to optimise patient safety whilst respecting a patient's wishes and autonomy.

It is important that staff recognise their professional responsibility and accountability for the delivery of safe patient care. Whilst care should be individualised and patient-centred, for those patients who have been risk-assessed by SLT to be at increased risk of choking, it would not be appropriate to provide food or drink that is known to be unsuitable as this is knowingly placing a patient at risk of harm. The ethical principle of non-maleficence, or 'do no harm', should apply. Often, patient requests may arise from a lack of understanding of the risks, or from provision of texture-modified diets that are unappealing, increasing the temptation to consume food

which has been prohibited. In these circumstances, patient and family education, alongside the provision of food that is safe but appealing, may improve compliance.

However, the Expert Review Team recognise the challenges for staff, particularly in day care settings where service users may report on what they usually eat at home, and persist with their request on this basis; this reflects a real life example, which was shared during fieldwork, and served to demonstrate the uncertainty and vulnerability felt by staff. Other difficult scenarios may include circumstances where there may be a desire to prioritise quality of life over the risk of shortening life, such as in cases of advanced and incurable disease. It is crucial that when these challenging ethical dilemmas arise that there is a multi-disciplinary discussion with the patient, their family and carers to support eating and drinking with acknowledged risk[12]. Education on the risks and benefits of the EDS recommendations should be provided in a way that patients and their families can understand. An assessment of the patient's capacity to understand the information and make decisions should be undertaken, where required. The clinical team should attempt to fully understand the reasons for the patient's wishes, and the implications of compliance and non-compliance for the patient's health and quality of life. Staff should be supported to manage complex cases utilising a multi-disciplinary approach and should be facilitated to seek a legal or ethical opinion, where required.

Where there is any doubt about whether the SLT risk-assessment remains applicable, such as where a patient's ability to eat, drink or swallow appears to have improved, then a further assessment should be offered. In any case, if a patient is risk-assessed to be at increased risk of choking then it is reasonable to decline a request for unsuitable food or drink on the basis that it may cause harm. Ongoing patient and family engagement in such cases will be important for maintaining a good provider-patient relationship.

Recommendation 11 **Priority 2**

All HSC Trusts should update their local dysphagia policy to include guidance on HSC Trust arrangements for managing ethically complex cases, where there is patient non-compliance with EDS recommendations. This should be aligned to Royal College of Speech and Language Therapists (RCSLT) guidance on 'Eating and Drinking with Acknowledged Risks'.

3.9 Learning from Choking-Related Harm

Learning from harm, so that improvements can be made in the systems for delivery of care in order to avoid similar harm occurring in future, is an essential aspect of ensuring patient safety. However, it is reliant on the reporting of incidents in the first place, so that learning can be derived and improvements subsequently implemented. Despite the development of a regional trigger list[13], the Expert Review Team found that there was a lack of awareness amongst front-line teams on what should be reported as a patient safety incident. It is likely that there is significant under-reporting of near-miss events. This may arise due to certain staff groups such as domestic or catering staff not having access to incident reporting systems. It may also arise due to a lack of understanding of the benefits of reporting or a fear of

repercussions through mechanisms for professional accountability, should the findings reflect that best practice was not adhered to.

Furthermore, when incidents are reported, the Expert Review Team heard limited evidence that learning is shared with relevant clinical areas outside where the incident occurred; with the exception of Serious Adverse Incidents, which have well-established mechanisms for the sharing of findings and recommendations. This failure to share learning more widely represents a missed opportunity to improve patient safety across ward-boundaries.

At a regional level, the HSCB / PHA have undertaken detailed retrospective analysis of choking incidents in Northern Ireland, such as that which has been published in the Thematic Review. However, there is scope for concurrent analysis of patterns, trends and themes of adverse incidents, including near-misses, to be undertaken at HSC Trust level. Such an example of good governance would help to identify system issues at an earlier stage and provide an opportunity to implement improvement and share learning across the system.

Recommendation 12 **Priority 1**

All HSC Trusts should raise awareness amongst staff of the regional trigger list and should foster a culture of reporting choking incidents, including near-misses, with staff from all staff groups being supported to submit an incident report.

Where individual cases are examined, these should be reviewed in accordance with 'just culture' principles[14]. Each HSC Trust should have arrangements for trend and theme analysis of adverse incidents, the learning of which should be used to inform improvements within HSC Trusts and shared across the system.

Section 4 Conclusion and Recommendations

4.1 Conclusion

Choking-related harm continues to be a significant patient safety issue in Northern Ireland. Since the Safety and Quality Reminder (SQR) was issued in February 2021, there have been a further ten choking-related deaths across the region[15].

The vast majority of people who die from choking are recognised to have a pre-existing Eating, Drinking or Swallowing (EDS) difficulty, meaning that there should be sufficient opportunities for the prevention of harm. The findings of this review demonstrate that all these opportunities need to be seized, and that the current systems for delivery of care require strengthening. Although the regional work undertaken to date is having an impact, there is now a need for further work to embed these improvements, supported by equity of resource across HSC Trusts; this is evidenced by the fact that many of the recommendations made previously have had to be restated. Whilst we found many examples of good practice across HSC Trusts, many of which been highlighted in this report, there is now a need to scale up and spread this valuable improvement work across and within Trusts. A regional strategy would be beneficial in driving a co-ordinated and sustained effort to bring together and embed all the different elements that constitute safe, effective care.

The lived experience of people with EDS difficulties demonstrates the challenges of living with the condition; challenges that extend beyond the risk of choking. Whilst patient safety is the priority, it is essential that individuals, along with their families and carers, are adequately supported in order to live well. This should include timely assessment by Speech and Language Therapy, signposting to other support and resources, and education on how to produce nutritious appealing meals that enhance quality of life and compliance with the EDS recommendations.

Equally, it is essential that the systems within which staff work are designed to maximise patient safety. It is important that every aspect where there is an identified risk is addressed, to ensure that staff are supported to provide safe and effective care to people living with EDS difficulties. This begins with mandatory staff training and improved awareness, across all relevant staff groups, to recognise and identify people at risk of choking. It requires effective arrangements for onward referral, where patients are seen within acceptable timescales, and where patients and their families are provided with interim advice and guidance whilst awaiting assessment. When identified as at risk of choking and the appropriate EDS recommendations are made, it is important that this is communicated amongst members of the multi-disciplinary team and with patients, carers and families. The systems for communication should be sufficiently robust so that no patient, at risk of choking, is forgotten. The delivery of care at high-risk times such as meal and snack times should be underpinned by strong systems for communication, supervision, and the provision of safe, suitable food. Catering and domestic staff in this context are integral to patient safety and, as such, should be included in mealtime Safety Pauses, the implementation of which should progress without delay. Transfer of care between locations and discharge home are recognised to be pivotal times when the exchange of information is particularly crucial; such times should be supported

by robust systems for communication including the provision of documentation of clear, unambiguous EDS recommendations that are visible and accessible to all relevant care providers, including catering staff. Embedding this documentation within transfer and discharge documentation, in addition to electronic care record systems, is a further step which would enhance patient safety.

This review, whilst valuable in providing an assessment of the implementation work undertaken to date and identifying the need for further improvement, is not the end of the journey. It is important that the SPPG / PHA and HSC Trusts continue to examine and analyse choking-related adverse incidents, including near-misses, to further identify any system deficits, implement improvements and share learning. RQIA is committed to working with DoH, SPPG / PHA, HSC Trusts and all providers of health and social care to support improvement in the systems for delivery of care, in order to ensure better outcomes for individuals living with EDS difficulties.

4.2 Summary of Recommendations

The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report.

Priority 1 - completed within 6 months of publication of report

Priority 2 - completed within 12 months of publication of report

Priority 3 - completed within 18 months of publication of report

Recommendation 1 **Priority 2**

HSC Trusts and commissioners should work together to ensure that both strategic and multi-disciplinary implementation teams are adequately resourced and have both the capacity and capability to effectively implement the SQR recommendations. DoH should lead the development of a regional strategy to drive a sustained and co-ordinated effort to reduce the risk of choking and improve nutritional outcomes for people with EDS difficulties.

Recommendation 2 **Priority 1**

Each HSC Trust should ensure that dysphagia training is mandatory for relevant staff groups working across high-risk areas (Stroke, Care of the Elderly, Mental Health and Learning Disability and Day Care settings) and any other service areas where care is provided to people with EDS difficulties. Relevant staff groups should include all clinical, domestic and catering staff. Each HSC Trust should ensure that there are robust systems in place for monitoring compliance with mandatory training requirements.

Recommendation 3 **Priority 2**

HSC Trusts and commissioners should work together to review the capacity and capability of multidisciplinary teams, with a particular focus on Speech and Language Therapy, to meet the needs of the patient population and ensure that timely assessment and intervention is provided, where required. The Public Health Agency should develop regional guidance and resources to support patients, carers and staff to manage EDS difficulties whilst awaiting an SLT assessment.

Recommendation 4 **Priority 2**

HSC Trusts should ensure that there are established processes to ensure that SLT EDS recommendation sheets are visible and accessible to all members of multidisciplinary teams within services. SLT Regional EDS recommendations should be included as part of any standard transfer and discharge documentation. SLT Regional EDS recommendations should also be incorporated into Electronic Care Record systems, accompanied by an 'alert' where this function is available.

Recommendation 5 **Priority 1**

All HSC Trusts should ensure that there are robust systems to facilitate sharing of information between staff. These could include: safety briefs, bedside signage and a mealtime Safety Pause. Each HSC Trust should ensure that a Safety Pause is implemented at mealtimes across all high-risk areas (Stroke, Care of the Elderly, Mental Health and Learning Disability and Day Care settings); supported by effective arrangements for monitoring and auditing of compliance.

Recommendation 6 **Priority 1**

All HSC Trusts should ensure that there is a robust mechanism for communicating the needs of patients with EDS difficulties to catering teams. Across high-risk areas, catering staff and domestic staff should be included as an integral part of the multi-disciplinary team and should be involved in the mealtime Safety Pause. Systems for ordering food should include a mechanism to check that the correct IDDSI-compliant meal has been ordered for patients with EDS difficulties.

Recommendation 7 **Priority 1**

All HSC Trusts should ensure that there are robust systems for the secure storage of foods and fluids that pose a risk to individuals with eating, drinking and swallowing difficulties. Each HSC Trust should audit compliance with secure storage of food fluids across high-risk areas.

Recommendation 8 **Priority 2**

All HSC Trusts should ensure that there are effective systems for the secure storage of thickening agent. In relation to the prescribing of thickeners, the DoH / Strategic Planning and Performance Group (SPPG) / PHA and HSC Trusts should work together to implement the learning from the DAMES project regionally.

Recommendation 9 **Priority 1**

All HSC Trusts should ensure that there are effective mechanisms for communication with families and carers of patients with EDS difficulties, who should be appropriately engaged to understand the patient's needs and EDS recommendations. Prior to discharge home or at the point of dysphagia diagnosis in community settings, families and carers should be provided with education, information resources and a means to accessing further support if required.

Recommendation 10 **Priority 3**

The Public Health Agency and HSC Trusts should work together to scale up and embed the Hard to Swallow Campaign. The Northern Ireland Medical & Dental Training Agency (NIMDTA) and HSC Trusts should ensure that GP trainees are provided with sufficient training on how to recognise and manage Eating, Drinking and Swallowing difficulties, including when to refer for Speech and Language Therapy assessment. Ulster University and Queen's University Belfast should ensure that the recognition and management of EDS difficulties is included on the undergraduate curricula for medicine and nursing degrees.

Recommendation 11 **Priority 2**

All HSC Trusts should update their local dysphagia policy to include guidance on HSC Trust arrangements for managing ethically complex cases, where there is patient non-compliance with EDS recommendations. This should be aligned to Royal College of Speech and Language Therapists (RCSLT) guidance on 'Eating and Drinking with Acknowledged Risks'.

Recommendation 12 **Priority 1**

All HSC Trusts should raise awareness amongst staff of the regional trigger list and should foster a culture of reporting choking incidents, including near-misses, with staff from all staff groups being supported to submit an incident report.

Where individual cases are examined, these should be reviewed in accordance with 'just culture' principles[16]. Each HSC Trust should have arrangements for trend and theme analysis of adverse incidents, the learning of which should be used to inform improvements within HSC Trusts and shared across the system.

References

[1] Special Edition Learning Matters: Risk of serious harm or death from choking on foods, Issue 18, October 2021. Available at: Learning Matters - September 2021 - Issue 18 (hscni.net); Cited February 2022

[2] Special Edition Learning Matters: Risk of serious harm or death from choking on foods, Issue 18, October 2021. Available at: Learning Matters - September 2021 - Issue 18 (hscni.net); Cited February 2022

[3] Report on the Regional Choking Review Analysis - thematic review, February 2018. Available at: https://www.publichealth.hscni.net/publications/report-regional-choking-review-analysis-thematic-review
; Cited February 2022

[4] Special Edition Learning Matters: Risk of serious harm or death from choking on foods, Issue 18, October 2021. Available at: Learning Matters - September 2021 - Issue 18 (hscni.net); Cited February 2022

[5] Special Edition Learning Matters: Risk of serious harm or death from choking on foods, Issue 18, October 2021. Available at: Learning Matters - September 2021 - Issue 18 (hscni.net); Cited February 2022

[6]Circular HSC (SQSD) 16/18, 5 July 2018, Resources to support safer modification of food and drink. Available at: http://www.hscbusiness.hscni.net/pdf/HSC%20(SQSD)%2016%2018%20%20Resources%20to%20support%20safer%20modification%20of%20food%20and%20drink%20-%20FINAL.pdf; Cited February 2022

[7] Pediatric Dysphagia: Physiology, Assessment, and Management July 2015. Available at: https://www.karger.com/article/fulltext/381372; Cited January 2022

[8] Is Dysphagia Under Diagnosed or is Normal Swallowing More Variable than We Think? Reported Swallowing Problems in People Aged 18–65 Years. Leslie, P., Smithard, D.G. *Dysphagia* 36, 910–918 (2021). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7680995/; Cited February 2022

[9] Issues associated with the use of modified texture foods. Keller, H., Chambers, L., Niezgoda, H. *et al*. *J Nutr Health Aging* 16, 195–200 (2012). Available at: https://link.springer.com/article/10.1007/s12603-011-0160-z; Cited February 2022

[10]Circular HSC (SQSD) 16/18, 5 July 2018, Resources to support safer modification of food and drink. Available at: http://www.hscbusiness.hscni.net/pdf/HSC%20(SQSD)%2016%2018%20%20Resources%20to%20support%20safer%20modification%20of%20food%20and%20drink%20-%20FINAL.pdf; Cited February 2022

[11] The PATH to safe swallowing at meal times. Swallow Aware. HSCNI. Available at: PATH_Poster_A4_09_20.pdf (hscni.net); Cited February 2022

[12] Eating and Drinking with acknowledged risks. Royal College of Speech and Language Therapists. Available at: Eating and drinking with acknowledged risks | RCSLT; Cited February 2022

[13] Dysphagia Incident trigger List. Adverse incident reporting relating to swallowing. Swallow aware. HSCNI. Available at: DYSPHAGIA INCIDENT TRIGGER LIST POSTER - Draft 3.pdf (hscni.net); Cited February 2021

[14] A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. Gross negligence manslaughter in healthcare: The report of a rapid policy review. June 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717946/Williams_Report.pdf; Cited January 2022

[15] SQR-SAI2021-075: Risk of serious harm or death from choking on foods. Available at Non-Compliance of 3rd line assurance re SQR-SAI-2021-075 -.pdf . Cited March 2022

[16] A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. Gross negligence manslaughter in healthcare: The report of a rapid policy review. June 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717946/Williams_Report.pdf; Cited January 2022

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street,
Belfast
BT1 4LS


Tel: 028 9536 1111


Email: info@rqia.org.uk


Web: www.rqia.org.uk


Twitter: @RQIANews

ISBN 978-1-908660-62-6