



IDDSI Lessons learnt

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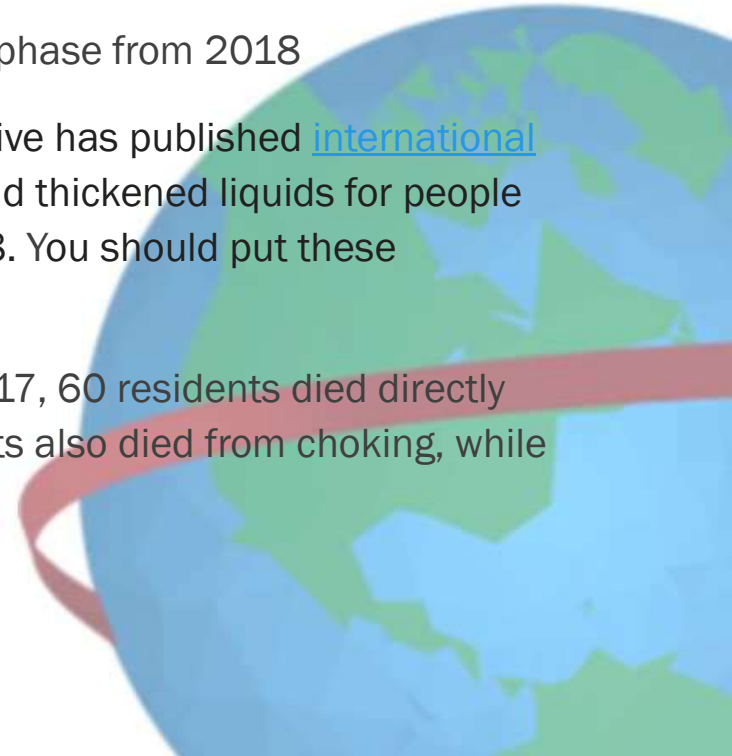


Background

IDDSI was introduced in April 2019 after a year of implementation phase from 2018

CQC state: The International Dysphagia Diet Standardisation Initiative has published [international standardised descriptors](#). These address texture-modified foods and thickened liquids for people with dysphagia. You should have been using these since April 2018. You should put these changes in place safely to protect people from choking risks.

Data from the Office of National Statistics (ONS) reveals that in 2017, 60 residents died directly from choking-related incidents in care homes. In 2016, 60 residents also died from choking, while in 2015, the rate was 62 and in 2014, 53.





Since IDDSI was introduced

Over the last few years, care home residents have died after choking on food such as chicken nuggets, dough balls, a sandwich, a piece of bread and a segment of orange, porridge, bacon and sausage.

May 2018: Resident choked on large pieces of meat after choking risk had not been identified and food had not been modified

November 2020: A coroner's inquest has found a care home resident who had Alzheimer's choked to death after being fed "nearly raw" pieces of cauliflower in cauliflower cheese. The inquest heard that resident C, 80, suffered "a gross failure" of neglect...he had needed **small soft bite sized** pieces of food (Level 6)



UK Cases

April 2019: care home has been criticised by a coroner after a resident choked to death on a **marshmallow**. The 41-year-old had been fed marshmallows by care workers despite being on a strict **pureed diet**, an inquest into his death heard. The coroner reported significant management failure

August 2019, a resident of a Care Home, was given a piece of **jam doughnut** to eat. The resident had previously suffered from a stroke and had been diagnosed with dementia. She had been assessed as being at high risk of choking and consequently was on a '**minced and moist/fork mashable**' diet. Care home fined.

May 2022: Care home resident, 74, choked to death on chicken he took from someone else's plate.

resident was on a controlled diet of "**fork mashable** food" for his own safety and took a piece of chicken from someone else's plate. This was received an accidental death verdict

Summary findings

NB Preventable deaths include:

Day care

Hospital

Care homes



.....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.

....‘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

Services considered to be high-risk areas:

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

Points identified



Access to awareness and training on food textures

SLT care plan terminology and language

Appropriate supervision

Assessment and compliance

Offering choice

Understanding risk – resident and staff



Guidance and advice is out there..

Home > Guidance for providers > Learning from safety incidents > Issue 6: Caring for people at risk of choking

Issue 6: Caring for people at risk of choking



Guidance

Dysphagia and people with learning disabilities

Home IDDSI Framework News Resources Translations FAQ A



Home What We Do Join Us Events Training Partners Shop

RCSLT competency frameworks for eating, drinking and swallowing

RCSLT dysphagia training and competency framework

Share Knowledge

10 points of best practice

1. Access to training: care AND catering and any front facing team member, leadership teams
2. Awareness for all: relatives, residents, stakeholders – information sharing to all eg relatives factsheet
3. Terminology (IDDSI): SLT assessment shared with catering teams, pre assessment guidance eg swallow log
4. Supervision at all levels: auditing ‘what good looks like’, compliance checks, demonstrations, inductions
5. Assessment: example care plans and risk assessments in induction
6. Mealtimes practices for those at risk eg ‘highly observable location for eating, support to eat and drink, right foods
7. Snacks and breakfast: tips and guidance eg planners for snacks, label and name, choice
8. Managing informed choice and mental capacity
9. Safe storage of thickeners and safe thickening of drinks – aspiration and choking management
10. First aid drills and first aid training

