Manitoba
Health, Healthy Living and Seniors

Manitoba Health, Healthy Living & Seniors (MHHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Summary:

Nursing staff were alerted by another PCH resident that a co-resident may be choking in the dining room.

The resident was found in the dining room, slumped in a chair, choking on what appeared to be a doughnut. A bag of scotch mints was also found on the lap of the choking resident.

The resident's airway was manually cleared. Emergency Medical Services (EMS) was called. The resident was found to be deceased.

The resident had a history of taking food from other residents and also from the fridge in the dining room if it was left unlocked. A choking risk was identified in their health record. Their diet was to be restricted to items that were "soft/easy to chew".

The resident had a history of impulsive behaviors and lacked insight into their behavior.

Keywords:

Resident, choking, diet restriction

Device Name *(if applicable)*: **n/a**

Drug/Name/Fluid Name: (*if applicable*): **n/a**

Type of Analysis: single event

Topic: Care Management

Findings of the Review:

Residents have access to foods that are not within many of their dietary restrictions. There is a vending machine located on the main floor of the long term care facility that contains many foods that would pose a choking risk for some residents.

The resident was identified as being at risk for choking as well as known to behave impulsively when food was present. For example, the resident would shovel food in quickly or take food from other residents.

There is supervision in the dining room during scheduled meal times only. This event took place outside of a regular meal time. The resident was in the dining room unsupervised.

Policy allows for residents and/or their family members to sign a waiver permitting them/their family member to have diet choices outside of their recommended diet order.

Recommendations for Improvement:

Discuss with Nutrition Services the possibility of relocating the vending machine to an area less accessible to residents (e.g. staff room on second floor) or removing it from the site completely.

Enhance the staff's understanding of the importance of clearing the dining room of all foods outside of regular meal times. Food items should not be available to residents when supervision is not present.

Provide education for existing staff and incorporate into the site orientation process, the details of the Diet Refusal section of the Nutrition Care Services Policy. Incorporate review of this policy by the care team into the Quarterly Review process for all residents.

Date Posted: **November 2014**