Celebrating

Outstanding Practice

SJOG Disability Services

Case Study: Dysphagia & SALT Plans

Summary: The learning from a near miss choking incident helped to inform how services were improved. An example of **OUTSTANDING RESPONSE.**

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A number of people across SJOG services have some difficulties with eating, drinking and swallowing. This can cause a number of challenges for people.

Swallowing difficulties can have serious effects on physical health including complications such as malnutrition, pulmonary aspiration (fluid or food going into the lungs) and the emotional and psychological problems associated with it. If not recognised and managed correctly, dysphagia can be fatal.

We work closely with Speech & Language Therapists to develop plans that help people to eat and drink safely, and colleagues are trained in Dysphagia and people's SALT plans.

We recently had a near miss in one of SJOG's services where food wasn't prepared according to the person's SALT plan. This resulted in the person choking. Thankfully the person recovered.

This is a rare event for SJOG however a belts and braces approach was implemented to ensure we understood how this happened, and helped us improve the safe care and practice to people.

This case study is an example of **OUTSTANDING RESPONSE** and can be used as a training aid for colleagues.

Questions we needed to ask

It is important to reflect on the incident and learn from this. There were a number of ways in which we did this:

- Spoke with the person and also others who have SALT plans. What are their experiences?
- Understand the root cause of the incident e.g. why were needs not met, and what was the root cause of this?
- Are further assessments required?
- Did the person wish to make a complaint?
- Did we respond in a timely manner?
- Were we transparent?
- Did we engage with professionals well?

The following review captures the evidence of this.

We referred the incident to the Safeguarding Team

We worked closely with the local safeguarding team. We are always transparent with the safeguarding and especially when things don't go well. This is demonstration of our duty of candor. The referral was sent to the safeguarding team within 24 hrs.

A referral was made and the safeguarding team attended the service, alongside the Speech & Language Therapist. A review of the SALT plan took place and the actions taken by the team.

It was reassuring that all actions taken in this document were confirmed as robust by safeguarding e.g.:

"We are really pleased with the actions you have taken. You have gone above and beyond in your response".

"This service is always very transparent ands this is very reassuring".

We notified the Care Quality Commission

The notification was completed and checked to ensure this had all of the necessary information. This was recorded on the service quality dashboard - central register and checked during the monthly quality audit.

An updated notification did not go to CQC to inform them of the outcome of all of the actions highlighted in this case study. This would have demonstrated good practice.

We spoke to the person about his SALT plan and asked what his wishes were

We met with the person to check on their wellbeing. Although the welfare conversation was amicable and the person stated "accidents happen", so should have asked him if he wanted to make a formal complaint. We also should have recorded our apology to him. This would have been a good way to demonstrate our duty of candour.

This was picked up as part of this review and has subsequently been completed. The person chose not to make a formal complaint.

We contacted his GP & Dentist

The GP was informed of the incident and the person received a health check. He also attended the dentist to check his dentures were fitting correctly.

Additional immediate actions taken whilst awaiting investigation outcome

Email alerts by the COO was distributed to all service managers requesting a full review of SALT plans and practice. Managers were requested to have personal sight of all people's SALT preparation and practice during meal times.

Heads of operational services were requested to review this and ensure this had been recorded on the monthly quality report.

Service Managers were asked to respond back to the COO that actions had been taken and to report any concerns immediately.

We informed the SJOG EMT and Board

As COO/Nominated Individual there is a responsibility to ensure that regulations, policies and procedures are followed. Part of this responsibility is to inform the Executive Management Team immediately of a safeguarding breach. This was completed both verbally and in email to all members.

Following discussion with EMT and challenge questions asked to ensure all actions were robust, a further email was sent to board members to inform them of the situation and the actions taken. The case study exercise was also provided to the board so they were able to see the detail of our response.

Example of response emails received:

"Thank you for sharing this Lisa. Thankfully the individual is okay. However, it is tough but will help in learning. Hopefully, it will lead to greater vigilance. You are to be complimented on your response and I hope everyone will take time to read your case study exercise"

"You seem to have identified the learning quickly and shared across the organisation which is good. Sharing the reflective account is powerful and will hopefully make people think about the consequences of their actions."

Further, and more deeper discussions took place with board members at the Quality & Risk Committee a few weeks later. This was noted in committee minutes and numerous challenge questions helped us to be confident that our actions had been robust.

We met with the team

We met with the team to inform them of the incident, although most were aware by the time the meeting could be organised. There was a lot of concern for the person and also the 'what if' began to creep in.

Colleagues were offered one to one de-briefs and welfare checks were encouraged.

We developed a reflective learning exercise

A reflective learning exercise was developed using information for past choking incidents in other organisations. Challenge questions were structured throughout in order to help colleagues think deeply about their practice.

Managers were requested to discuss this in their team meeting and complete. Testing the teams current practice was important so that we were confident this was not a systemic issue.

This exercise can be used as an ongoing learning exercise and managers now have a tool to use at any point.

We completed the fact finding investigation

Its never easy to undertake fact finding investigations however it is a necessary part of the learning process. A number of colleagues were invited to discuss the events which helped to draw a detailed understanding of the incident.

Following completion of the fact finding report, this was scrutinised so that we could illuminate the areas of practice that went wrong.

We reflected on the outcome and learning from the investigation

We reflected on the outcome findings of the report. The following findings were proven:

- There had been a custom and practice of not following SALT plans;
- There was evidence of complacency and not considering the safeguarding requirements in food preparation;
- The person had not been observed when eating his meal which the plan requests;
- There has been little focus on monitoring and reviewing practice in this area;
- All colleagues were fully trained in Dysphagia;
- All colleagues were trained in emergency first aid. Colleagues took directions from the call handler on what first aid to offer. This ultimately saved his life.
- The person received medical attention during and after the incident;
- The person was reassessed ;
- The person was supported to understand the consequences of not following his SALT plan and professionals worked with him to develop a risk assessment for this.

We worked in partnership with the people in the service

Who better to learn from than the people in services! A number of residents were aware of the incident and wanted to help in the learning process. This was powerful as they all had experience of SALT plans.

Each of these individuals were also wheelchair users who also had other co-morbid conditions that affected their bodies and torso's. This meant that any first aid practical treatment may not be as effective due to their conditions.

We discussed working with a training provider to develop a bespoke course which the residents were keen to be involved in.

The Head of Health & Safety was instrumental in these discussions and worked closely with the residents to reassure them and to consider the best training approach possible. Contact was made with a training provider and the Head of Health & Safety explained the incident and the training requirements.

We worked in partnership with a training provider

Previous first aid training did not cover choking for people in a wheelchair. The Head of Health & Safety led this part of the process as she had full involvement in the fact finding and de-briefing of colleagues and people using the service. The issue of using abdominal thrusts for a person in a wheelchair was the focus area as emergency first aid training does not consider the risks this can cause.

Discussions with the training provider were positive and bespoke training was provided to the entire team. People who use the service also attended this training and offered their experiences.

The learning from this training was embedded into people's support and risk planning records.

The training provider and SJOG are now considering this as a training course for other organisations, and people who use the service will be involved in training videos to share their experiences and help others.

Statistical Information

The Head of Health & Safety reviewed all choking incidents across the charity between 2020—2023. This was useful information and allowed us to focus on the services that required closer attention. These statistics were also reinforced by national data and research.

This information was shared with managers to illuminate the situation in SJOG.

We completed a deep dive in all SALT plans

During the senior operational meeting this incident was discussed in detail. Complacency played a key role in this incident and it was agreed that operational leads would undertake a deep dive into SALT plans. This involved:

1. Discussions with people to ensure they were satisfied with their support. Where this could not be achieved due to their mental capacity, conversations took place with support staff.
2. Testing knowledge of SALT plans by asking staff how food is prepared and whether this was in accordance with the plan.
3. Observations of practice and testing this against each SALT plan.

We developed a new policy

We didn't actually have a policy specific to Dysphagia.

We researched dysphagia and also consulted with NHS guidance on the topic, along with a number of research documents from the Royal College of Speech & Language Therapists that promoted good practice. NICE guidance was also reviewed and all of these good practice themes and guidance helped to develop this Dysphagia policy.

The policy was published on the SJOG Portal and all colleagues were informed about this new policy. Managers were asked to discuss this in their next team meeting.

We purchased equipment

We purchased LIFEVAC on the advice of the training provider. The Head of Health & Safety and some managers trialled the e-learning training for this device.

This training and equipment has been provided to all services who require it.

We asked for feedback from people using the service

The coproduction ensured a robust response to this incident and the lived experiences of people in services helped us to consider differing points of view that otherwise would have gone unnoticed.

Feedback from people included:

"I just want to thank SJOG very much for inviting me into this training as it has highlighted how staff will need to support me in an emergency situation".

" I found the training really good. I realised how important it is for me to be careful whilst I am eating and to follow my SALT plan".

"It has made me appreciate what my support staff will do for me".

"I enjoyed attending the training, it took me back to when I was working. Please can I attend more training like this?" (Feedback from the person who choked.)

We asked for feedback from teams

We asked for managers and teams feedback on how we had approached this. There was a common theme that the dysphagia reflective practice exercise had been very impactful and really made colleagues think about the consequences of complacency.

Feedback comments included:

"This was a great exercise that really brought the message home. I will always make sure I regularly check SALT plans".

"Can we have more exercises like this? The team all commented it was one of the most impactful exercises they had done".

"We are always busy but this has shown me that I need to STOP, THINK and CHECK before providing people with their meals. Thank you for sharing this".

"We take making meals for granted and incidents like this really make you sit up and think."

Actions completed

1. Reviewed and reassessed SALT plan for the person and also reviewed all other resident plans.
2. Apologise to the person and record this. The person was offered a right to complain however did not wish to do this.
3. Embedded LIFEVAC and emergency response actions to each person's SALT plan risk assessment.
4. Issued LIFEVAC equipment to services that require this.
5. Notification to update CQC of all actions and outcome completed.
6. Deep dive reviews on quality and compliance.
7. Distributed new Dysphagia policy.
8. Completed practical training for choking and people in wheelchairs.
9. Team exercise on choking and the consequences of this.
10. Fact finding investigation completed and learning shared.
11. Continued to up date EMT and the Board.
12. Feedback received from teams on impact of response and learning.