



# Patient Safety Alert

## Stage One: Warning

*Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder*

05 February 2015

Alert reference number: NHS/PSA/W/2015/002

Alert stage: One - Warning

Dysphagia (swallowing problems) occurs in all care settings<sup>1</sup> and although the true incidence and prevalence are unknown, it is estimated the condition can occur in up to 30% of people aged over 65 years of age<sup>2</sup>. Stroke, neurodegenerative diseases and learning disabilities can be the cause of some cases of dysphagia, and may also result in cognitive or intellectual impairment, as well as visual impairment.

The modification of liquid thickness and food texture is common practice in dysphagia management to avoid aspiration of material into the airway whilst maintaining adequate hydration and nutrition. Thickening agents are available in a range of preparations, the most common being a powdered form, supplied in tubs and commonly kept in a place that is accessible such as at the bedside.

NHS England has received details of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. Whilst this death remains under investigation, it appears the powder formed a solid mass and caused fatal airway obstruction. Analysis of the National Reporting and Learning System has identified one other similar incident that occurred in hospital:

*'HCA alerted by another patient that the patient was choking. Found to have taken the lid off a tub of thickening powder and attempted to tip it back to 'drink'. The patient is partially sighted and his condition fluctuates re conscious / alert levels. Thickener was a fresh tub today as trial re his poor swallow.....'*

Feedback from frontline staff indicates that the potential consequences of trying to swallow dry thickening powder appear under-recognised therefore there may be significant under reporting.

Whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks to patient safety. Appropriate storage and administration of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia. Individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected.

## Actions

**Who:** All providers of NHS funded care where thickening agents are prescribed, dispensed or administered

**When:** To commence immediately and be completed by no later than 19 March 2015

-  Identify if the accidental ingestion of dry thickening powder has occurred, or could occur, in your organisation
-  Consider if immediate action needs to be taken locally, and ensure that an action plan is underway if required, to reduce the risk of further incidents occurring.
-  Distribute this alert to all relevant staff who care for children or adults in primary care, emergency care, and inpatient care settings, including mental health and learning disability units.
-  Share any learning from local investigations or locally developed good practice resources by emailing [patientsafety.enquiries@nhs.net](mailto:patientsafety.enquiries@nhs.net)

---

Alert reference number: NHS/PSA/W/2015/002

---

Alert stage: One - Warning

---

### Technical notes

#### NRLS search dates and terms

The National Reporting and Learning System (NRLS) was searched on 8 January 2015 for incidents that had occurred since 1 January 2010 using the search terms 'thickening agents' OR 'thickening products' OR 'thickening powders' OR 'thickening granules' AND 'swallow'. 90 incidents with these keywords were reviewed and one relevant incident was identified which was reported as resulting in moderate harm.

#### Stakeholder engagement

Medical Specialties Patient Safety Expert Group  
Mental Health Patient Safety Expert Group  
Learning Disability Patient Safety Expert Group  
Primary Care Patient Safety Expert Group  
Surgical Services Patient Safety Expert Group  
NHS England Nutrition and Hydration Commissioning Strategy Group  
Royal College of Speech and Language Therapists  
British Dietetic Association  
International Dysphagia Diet Standardisation Initiative

#### References

- 1) Julie A. Y. Cichero et al (2013) The Need for International Terminology and Definitions for Texture-Modified Foods and Thickened Liquids Used in Dysphagia Management: Foundations of a Global Initiative Current Physical Medicine and Rehabilitation Reports <http://link.springer.com/article/10.1007%2Fs40141-013-0024-z/fulltext.html>
- 2) Martino R, Foley N, Bhogal S, Diamant N, Speechley M, Teasell R. Dysphagia after stroke: incidence, diagnosis, and pulmonary complications. Stroke. 2005;36:2756–63. Stroke. 2005 Dec;36(12):2756-63. Epub 2005 Nov 3 <http://www.ncbi.nlm.nih.gov/pubmed/16269630?dopt=Abstract>

#### Other

The National Patient Safety Agency issued a Signal on Harm from ingestion of Vernagel in September 2011. Whilst Vernagel is used to thicken urine in urinals to prevent spillage, rather than to thicken oral fluids, the mechanism of harm from airway obstruction after accidental ingestion is the same; see <http://www.nrls.npsa.nhs.uk/resources/?entryid45=132835>