CARE ENGLAND
The voice of care

Good practice guide:

Preventing choking deaths among people with learning disabilities

SRP SERIOUS RISK PREVENTION

CALLAWAY — CARE AND SUPPORT —

iris care group

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This guidance was developed by a multidisciplinary working group comprising representatives from social care providers, Speech and Language Therapy professionals, regulatory colleagues and sector bodies, including Care England. The group brought together expertise in frontline practice, governance, clinical risk management and quality assurance to ensure that the guidance reflects both national learning and the realities of day-to-day implementation. The working group is grateful to Learning Disability England for supporting engagement with their members and for the valuable perspectives shared during the development of this guidance.

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1. Foreword

Eating is one of the most ordinary parts of daily life. It is also one of the most personal. It connects people to culture, routine, comfort and identity, and, for many, it is one of the few moments in the day that brings genuine pleasure and choice.

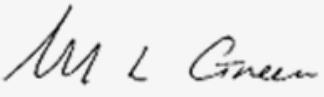
For people who are at risk of choking, eating can also carry real danger. National learning has shown, time and again, that choking remains a persistent cause of serious harm and avoidable death. What is striking is not simply that incidents occur, but that many of them share familiar features. Early signs are missed. Risks are normalised. Plans are unclear, outdated or not followed. Staff feel uncertain, unsupported or reluctant to raise concerns.

This guidance starts from a simple but important position. Choking is not an unpredictable accident. In most cases, risk develops over time and can be anticipated, understood and managed when the right conditions are in place. Preventing choking is not about removing choice or living overly restrictive lives. It is about creating environments where people are supported to eat safely, with dignity, confidence and respect for who they are.

Responsibility for choking prevention does not sit with one role or profession alone. It rests with organisations, leaders, commissioners, practitioners and systems working together. It depends on clear plans and skilled, attentive support. It also depends on psychological safety for staff to speak up and on cultures that value learning rather than blame.

This guidance has been developed to support that shared responsibility. It brings together national learning, professional standards and lived experience to set out what good looks like in practice. Its purpose is not to prescribe inflexible rules, but to support thoughtful, consistent and person-centred decision-making in everyday settings. The working group sought the views of people being supported and families through liaison with Learning Disability England as part of our commitment to ensuring that lived experience and sector perspectives informed this guidance.

Above all, this guidance recognises that eating is part of living a full life. Protecting people from harm should never come at the cost of erasing identity, culture or connection. When services get this right, safety and quality of life are not in conflict; they strengthen one another. This guidance is intended to support providers, commissioners and practitioners to embed these principles consistently in everyday practice.



Professor Martin Green OBE
Chief Executive, Care England

2. Executive Summary

Choking remains one of the most serious and preventable risks faced by people who receive care and support. National learning from safeguarding reviews, regulatory findings, and incident investigations consistently shows that incidents are rarely sudden or unavoidable. More often, early signs are missed, risks are not reviewed proactively, or everyday practice does not reflect what has been agreed.

This guidance sets out what good choking prevention looks like in practice across social care, residential and supported living settings. It is intended for providers, commissioners, managers, and frontline staff who share responsibility for supporting people to eat and drink safely, while also protecting dignity, choice, culture, and quality of life.

Effective choking prevention depends on proactive risk identification and strong everyday systems. Small changes in health, behaviour, environment, or routine can significantly increase risk if they are not recognised early. This guidance emphasises the importance of anticipating risk during admissions, transitions, and environmental changes, and maintaining clear expectations for handover, documentation, and multidisciplinary decision making.

Eating and drinking are not purely clinical activities. They are shaped by culture, identity, communication, emotional well-being, and the environments in which people live their lives. Safe practice, therefore, relies not only on clinical advice but on attentive support, thoughtful environments, and consistent application of agreed plans, including when people are eating out or participating in community life.

Commissioners play a vital role in ensuring these expectations are met. Providers are expected to demonstrate clear oversight of individuals at higher risk and maintain accurate and accessible documentation. They are expected to employ staff who understand textures, posture, pacing and supervision. They are also expected to operate reliable systems for monitoring, escalation and review. Strong partnership working with clinical teams, families, and advocates is essential, alongside accessible communication for people supported and a culture that values learning, dignity, and autonomy.

Clear processes for incident response, investigation, and learning are central to preventing repeat harm. Near misses and incidents should be used to strengthen practice and improve systems, rather than trigger blame. A culture of continuous improvement ensures that safety is embedded into everyday practice, not treated as a reactive response to events.

Above all, this guidance reinforces that safe practice must protect quality of life. People should be supported to enjoy meals and social experiences without unnecessary restriction. Risks should be well understood, openly communicated, and managed through skilled support, collaborative decision-making, and inclusive practice.

The expectations outlined in this report reflect national learning from LeDeR, CQC inspection themes, and relevant clinical guidance. They are underpinned by evidence on safe mealtime practice, early identification of swallowing difficulties, and effective multidisciplinary working.

3. Top 10 essentials for preventing choking

These core expectations apply across all settings where people receive support with eating and drinking, including at home, in the community, and when eating out. They underpin this guidance and should be reflected consistently in everyday practice.

1. Know the person and their risks
Staff must understand each person's eating and drinking needs, risks, preferences, and agreed support arrangements.

2. Follow agreed plans consistently
Care plans, risk assessments, and eating and drinking guidance must be clear, current, and followed at all times.

3. Create the right environment
Eating should take place in calm, supportive settings that reduce distraction and promote safety.

4. Support safe posture and positioning
Appropriate seating and positioning must be in place before eating or drinking begins.

5. Provide the right level of supervision
Supervision must reflect assessed risk and should never be reduced without review.

6. Support pace and portion control
People should be supported to eat and drink at a safe pace, with appropriate portion sizes.

7. Stay present and observant
Staff must remain attentive during meals and recognise early signs of difficulty or distress.

8. Act on concerns immediately
Any changes, near misses, or concerns must be reported, recorded, and escalated without delay.

9. Respect choice within safe frameworks
Informed choice and eating and drinking with acknowledged risk (EDAR) must be supported lawfully and reviewed regularly.

10. Learn and improve continuously
Incidents and near misses must be used to strengthen practice, not assign blame.

4. Scope and definitions

This section sets out the scope of this guidance and clarifies key terms used throughout the document. A clear and shared understanding of language is essential to reduce variation in practice, support safe decision-making, and avoid misunderstandings between professionals, people supported, and families.

This guidance applies to social care, residential and supported living settings where individuals may be at risk of choking. It is intended to complement, not replace, clinical assessment and advice provided by health professionals such as Speech and Language Therapists, GPs, dietitians, and other clinicians.

Definition of choking and eating, drinking and swallowing (EDS) difficulties

Choking occurs when the airway becomes partially or fully blocked by food, drink, saliva, or another object, restricting or preventing breathing. It can result in serious injury or death if not recognised and responded to promptly.

EDS difficulties, often referred to as dysphagia, describe problems with safely moving food or drink from the mouth to the stomach. These difficulties may affect one or more stages of swallowing. They can fluctuate over time depending on health, fatigue, emotional state, medication, posture, and environment. For consistency throughout this guidance, the term EDS difficulties will be used. The term “dysphagia” is retained only where it appears within the formal title of external guidance or statutory frameworks.

EDS difficulties are not always formally diagnosed and may be under-recognised in social care settings. Early signs may be subtle and can include coughing, throat clearing, changes in voice, food pocketing, prolonged mealtimes, or avoidance of certain foods.

Eating and drinking with acknowledged risk (EDAR)

EDAR refers to situations where a person chooses to continue eating and drinking in a way that carries a known risk of choking or aspiration, despite this risk being identified and explained.

EDAR is not a clinical instruction or a blanket approach. It is a decision-making framework that balances safety with personal choice, quality of life, and individual values. EDAR decisions must be informed, documented, and reviewed regularly, particularly where circumstances change.

In social care settings, EDAR requires close collaboration between the person, their family or advocates, and relevant professionals. It also requires staff to understand clearly what has been agreed and what safe support looks like in everyday practice.

Definition of feeding at risk

Feeding at risk is a term sometimes used interchangeably with EDAR, but it is important to recognise the distinction.

Feeding at risk typically refers to situations where eating and drinking continue despite known swallowing difficulties, often in the context of clinical advice that risk cannot be fully eliminated. EDAR places stronger emphasis on the person's informed choice, capacity, and values, rather than solely on clinical risk.

For the purposes of this guidance, EDAR is the preferred term, as it more clearly reflects shared decision-making and respect for autonomy.

High-risk individuals

Individuals may be at increased risk of choking due to a range of factors, including but not limited to:

- Diagnosed or suspected EDS difficulties
- Reduced muscle strength or difficulty maintaining an upright posture
- Previous choking incidents or near misses
- Neurological conditions or learning disabilities
- Impulsive eating behaviours or rapid pace of eating
- Reduced awareness of risk
- Poor posture, seating, or positioning
- Dental issues or ill-fitting dentures
- Fatigue, illness, or emotional distress
- Sedating medication or medication that causes dry mouth
- Conditions such as epilepsy or pica (persistent craving of food and consumption of non-food items with no nutritional value)

Risk is dynamic and may increase during periods of change, such as new placements, transitions, medication changes, or deterioration in health.

Choking risk beyond mealtimes

Choking risk is not limited to meals. Some individuals may place non-food items in their mouth, pocket food and access small objects such as balloons, coins or other materials that present a choking hazard.

Pica, sensory seeking behaviours, or impulsive responses can significantly increase risk outside structured mealtimes. In these situations, risk may not be linked to swallowing difficulty alone, but to environmental access and behavioural patterns.

Services should recognise that choking prevention requires environmental awareness throughout the day, not only during meals.

Environmental checks should therefore include:

- Monitoring access to small objects and packaging
- Safe storage of high-risk materials
- Awareness of seasonal or event-related items such as balloons
- Clear behavioural support strategies where relevant
- Alignment between behaviour support plans and choking risk management

Where pica or related behaviours are identified, risk management must be integrated across eating and drinking plans, behavioural support strategies and environmental controls.

Scope of practice for social care staff

Social care staff play a vital role in preventing choking through attentive, consistent, and informed support. Their responsibilities include:

- Following care plans, risk assessments, and eating and drinking guidance
- Observing and reporting changes in eating behaviour or swallowing safety
- Supporting individuals to eat and drink safely in line with agreed plans
- Creating calm, supportive environments for meals
- Escalating concerns promptly and appropriately

Clinical boundaries clarification

Social care staff do not diagnose EDS, determine clinical treatment, or determine food textures independently. Their role is to observe early signs, follow mealtime plans accurately, and report concerns immediately. They must escalate to Speech and Language Therapists or medical teams when something changes. Clinical assessment, diagnosis, texture prescription, and recommendations relating to swallowing safety fall within the remit of qualified health professionals, particularly Speech and Language Therapists.

Social care staff must not alter food or drink textures, feeding approaches, or risk management strategies without appropriate professional guidance. Where guidance is unclear, conflicting, or appears unsafe, this must be escalated rather than improvised.

Clear clinical boundaries protect individuals, staff, and organisations.

Understanding swallowing safety

Swallowing is a complex and coordinated process involving physical, sensory, cognitive, and emotional factors. Safety can be affected by posture, pace, alertness, environment, and the way support is provided.

Choking risk is rarely isolated to food texture alone. It is influenced by how, where, and with whom a person eats. Changes in routine, distraction, stress, or reduced supervision can significantly increase risk.

Understanding swallowing safety requires staff to remain attentive, curious, and responsive to change, recognising that what is safe one day may not be safe the next.

5. Core principles

The following principles underpin safe, dignified and inclusive eating and drinking support. They apply across all settings, including at home, during social activities and when eating out in the community. These principles guide everyday decision-making where safety, choice and quality of life intersect.

People first

Good practice starts with knowing the person and understanding what matters to them. Each person brings their own history, culture, routines, preferences, fears and ways of communicating. Support should be shaped around the person, not imposed on them. Safety decisions should never erase identity, enjoyment or cultural meaning.

Personalised adjustments, such as adapting routines to reduce anxiety, adjusting environments to support comfort, or working with clinicians to adapt culturally significant foods, help people feel respected and understood while remaining safe.

Least restrictive practice

Safety measures must be proportionate, time-limited and regularly reviewed. Restrictions such as modified diets, increased supervision or changes to routine should be the minimum necessary to manage risk and should never become permanent by default.

Creative and flexible approaches, such as adapting textures rather than removing preferred foods, using adaptive equipment to promote independence, or stepping down supervision when skills improve, help balance safety with autonomy.

Co-production and shared decision-making

Plans are most effective when they are developed with the person, not for them. Families, advocates and others who know the person well often bring valuable insight into patterns, triggers and preferences that may not be immediately visible to staff.

This is particularly important for EDAR, where safety and autonomy must be carefully balanced. Co-produced plans are more likely to be understood, followed consistently and experienced as respectful.

Evidence-informed practice

Support should reflect current clinical advice, national guidance and learning from incidents. Teams must respond to new information and avoid relying on outdated routines or assumptions. This includes following Speech and Language Therapy recommendations, applying IDDSI (International Dysphagia Diet Standardisation Initiative) levels correctly, and using NICE guidance. It also includes embedding learning from both local and national incidents into practice, training and review.

Consistency across staff

People are safest when everyone supports them in the same way. Consistency must

extend across permanent staff, bank staff, agency workers, volunteers and anyone involved in mealtime support.

Clear, accessible plans, effective handovers and aligned documentation are essential. Conflicting or outdated information significantly increases risk and must be actively eliminated.

High-quality communication

Communication should be clear, kind and accessible for the person, and consistent across staff teams. People may require easy-read information, visuals, photos, Makaton or simple verbal explanations to understand what is happening and feel at ease.

Strong handover processes and prompt escalation of concerns support early action and reduce the risk of deterioration.

Timely multidisciplinary involvement

Choking risk is rarely managed by one discipline alone. EDS may involve physical, sensory, behavioural and environmental factors. Early involvement from Speech and Language Therapists, dietitians, GPs, dentists, PBS teams and mental health professionals helps build a full understanding of risk. Timely multidisciplinary input reduces deterioration and supports more effective, coordinated care.

Safety with dignity

People should feel safe without feeling controlled, embarrassed or overly monitored. Mealtimes should be relaxed, respectful and as close to ordinary life as possible. Dignity includes offering independence where appropriate, maintaining privacy, and supporting people to eat with others rather than in isolation, wherever this can be done safely.

Psychological safety for staff

Staff must feel safe to speak up, express uncertainty, raise concerns, report near misses and challenge unsafe practice without fear of blame. Cultures where staff feel rushed, criticised or silenced increase risk. Supportive supervision, reflective practice, team debriefs and open leadership behaviours are essential to safe care because teams learn more from honest conversations than from silence.

Calm and predictable environments

Busy, noisy or rushed environments increase anxiety and reduce safe swallowing. Calm, predictable routines support safer pacing and greater comfort. Services should minimise unnecessary noise, avoid rushing, reduce distractions and maintain consistent mealtime routines wherever possible.

Accurate and aligned documentation

Safety depends on clear, accurate and up-to-date documentation. Digital and paper records must align, outdated versions must be removed, and staff must know where to find the current plan. Misaligned documentation is a common contributor to avoidable incidents and requires active oversight.

Bringing it all together

When these principles are applied consistently, choking prevention stops being a checklist and becomes part of everyday culture. Knowing the person, working collaboratively, respecting choice, maintaining clear boundaries and communicating well are not separate tasks. They are interconnected behaviours that shape safer mealtimes.

Safety and dignity are not opposing forces. When practice is thoughtful, proportionate and person-centred, they reinforce one another. These principles set the expectation that risk is recognised early, discussed openly and managed consistently, without removing identity, autonomy or quality of life. They provide the foundation for every section that follows. Assessment, training, governance and quality assurance all depend on these core commitments being visible in daily practice.

6. Understanding the risk

Choking risk is rarely caused by a single factor. It usually develops through a combination of clinical, behavioural, emotional, environmental and systemic influences. These factors often interact over time. Understanding these factors helps staff recognise risk earlier and respond before harm occurs.

This section sets out the most common contributors to choking risk in social care settings. These factors often overlap and may change day-to-day.

Clinical factors

Clinical factors may affect a person's ability to chew, swallow or coordinate eating safely. These can include diagnosed or suspected swallowing difficulties, neurological conditions, reduced muscle strength, or changes following illness or hospital admission.

Clinical risk may fluctuate and should never be assumed to be stable. Changes in health, fatigue or recovery can alter swallowing safety quickly.

Behavioural and sensory factors

Some people may eat quickly, overfill their mouths, avoid certain textures or struggle to pace themselves. Sensory sensitivities may lead to food refusal, gagging or sudden changes in eating behaviour.

Behavioural patterns are often a form of communication. Changes in how a person eats may signal discomfort, anxiety or difficulty rather than non-compliance.

Psychological and emotional state

Emotional well-being has a direct impact on swallowing safety. Anxiety, distress, excitement or low mood can affect attention, pace and coordination during meals.

People may eat differently when they feel rushed, unsettled or overwhelmed. These changes are easy to miss unless staff are attentive and familiar with the person.

Environmental factors

Busy, noisy or unpredictable environments can increase choking risk. Distractions, interruptions, rushed routines, or unsuitable seating can all affect posture, pacing and focus.

Environmental risk is often underestimated because it feels ordinary. In practice, it can significantly change how safely someone eats.

Oral health

Poor oral health can increase choking risk. Pain, loose teeth, ill-fitting dentures, infections or reduced saliva can affect chewing and swallowing.

Oral health issues are sometimes overlooked in care planning, but should be considered whenever eating behaviour changes.

Gastrointestinal factors

Conditions such as reflux, constipation or nausea can affect appetite, comfort and swallowing safety. These may cause people to rush meals, avoid food or experience discomfort that alters eating patterns.

Physical discomfort is often expressed through behaviour rather than words.

Medication and physical health

Some medications can cause drowsiness, dry mouth, reduced alertness or muscle weakness, all of which may increase risk. Changes to medication or dosage should prompt a review of eating and drinking support.

Physical health changes, including infections or pain, can also temporarily increase choking risk.

Cultural factors

Cultural practices influence what, how and when people eat. Food types, textures, spices, portion sizes and social expectations all affect swallowing safety.

Cultural factors should be explored rather than assumed. Where risk exists, adaptation should be considered before restriction.

Systemic and organisational factors

Risk is not only individual. Systemic issues such as staffing pressures, inconsistent practice, poor handovers, unclear plans or lack of supervision can increase choking risk even when individual support needs are known.

Organisational culture plays a key role in whether concerns are noticed, shared and acted upon.

Transitions and unfamiliar environments

Transitions often increase risk. This includes new placements, hospital discharge, changes in routine, staffing changes or eating in unfamiliar environments such as restaurants or community venues.

Support should be more cautious during periods of change, with clear plans and close observation.

Near misses and early warning signs

Near misses are critical indicators of risk. These may include coughing, choking episodes that resolve, food pocketing, changes in voice, repeated throat clearing or avoidance of food.

Early warning signs should never be normalised. They are opportunities to act before harm occurs.

EDAR

EDAR may be part of a person's plan where risks cannot be fully removed. Where EDAR applies, refer to the definition and principles set out in the Scope and Definitions section.

Further information in this section is informed by national learning from LeDeR, PSIRF reviews, coroners' reports, CQC inspection findings, RCSLT clinical guidance, NICE standards and wider evidence relating to EDS, sensory processing, medication effects and safe mealtime environments.

7. Lived experience and co-production

People who are supported, along with their families and advocates, hold vital expertise about what feels safe, respectful and workable in everyday life. Effective choking prevention is strengthened when this lived experience is actively listened to and used to shape support, rather than treated as secondary to professional opinion.

This section recognises the importance of co-production in creating eating and drinking support that is both safe and meaningful.

Expertise by experience

People who eat and drink with support are experts in their own bodies, preferences and routines. Families and advocates often notice subtle patterns or changes that may not be immediately visible to staff, such as eating more quickly when anxious, avoiding certain textures, or becoming distressed in busy environments.

Valuing expertise by experience helps services identify risk earlier and respond in ways that make sense to the person.

What does feeling safe at mealtimes mean?

Feeling safe is not only about physical protection. It includes feeling relaxed, respected and understood. People may feel unsafe if they are rushed, closely watched, spoken about rather than spoken to, or placed in environments that increase anxiety.

When people feel emotionally safe, they are more likely to eat at a safer pace, communicate discomfort and engage positively with support.

Relationships, trust and supervision

Trusting relationships play a key role in safe mealtime support. People are often more comfortable accepting prompts, pacing support or supervision from staff they know and trust.

Supervision should feel supportive rather than controlling. Quiet presence, familiarity and respectful interaction reduce distress and support safer eating, particularly for people who are sensitive to feeling monitored.

Autonomy, choice and control

People should be supported to make informed choices about how they eat and drink wherever possible. Autonomy includes having a say in food choices, mealtimes, where meals are eaten and who provides support.

Supporting choice, including where EDAR is part of a plan, requires honest conversations and shared understanding. It also requires regular review. Choice should be supported within safe and lawful frameworks, not removed by default.

Culture, identity and sensory needs

Food is closely connected to culture, identity and sensory experience. Cultural traditions, religious practices, preferred flavours and sensory sensitivities all influence how people experience eating.

Support should recognise and respect these factors. Where risk exists, services should explore adaptations with the person and relevant professionals rather than excluding culturally or personally meaningful foods without discussion.

Accessible communication

People need information about eating and drinking support in ways they can understand. This may include easy-read formats, visual prompts, symbols, Makaton, demonstrations or simple verbal explanations.

Accessible communication helps people understand expectations, feel more in control and raise concerns earlier. It also supports consistency across staff teams.

Co-produced planning in practice

Co-produced plans are built collaboratively and reviewed regularly. They reflect the person's preferences, risks and priorities, and are more likely to be followed consistently.
In practice, this means involving people and those who know them well in assessments, reviews and discussions about change. It also means being open to revisiting decisions as circumstances evolve.

8. Equity and health inequalities

Choking risk is not experienced equally. Some people face significantly greater barriers to accessing timely assessment, support and information. If these inequalities are not recognised and actively addressed, people are left at increased risk of avoidable harm.

Reducing inequality is not optional. It is central to safe, person-centred eating and drinking support and must be embedded into everyday practice, governance and decision-making.

This section sets out how services should recognise and respond to inequity in eating and drinking support, so that everyone receives safe, dignified and equitable care.

Unequal access to assessment and clinical support

Delays in accessing Speech and Language Therapy, dental care and other clinical input are common. Long waiting lists, fear of clinical environments, lack of transport, reduced confidence and limited practical support to attend appointments all increase risk.

Access to assessment must not depend on a person's ability to navigate systems or persist in seeking help. Services have a responsibility to identify barriers early and actively support access.

Diagnostic overshadowing

Diagnostic overshadowing occurs when physical symptoms are wrongly attributed to a person's disability, behaviour or mental health rather than recognised as clinical concerns. Early signs of EDS, fatigue, withdrawal or changes in eating pace may be missed if staff assume these are part of an existing diagnosis.

This delays assessment and increases choking risk. Staff must remain curious and avoid assumptions when behaviour or eating patterns change.

Cultural and language barriers

Food is closely linked to culture, identity and family life. Cultural misunderstanding can result in people being offered meals that feel unfamiliar or unacceptable, or in culturally important foods being removed without exploration.

Language barriers can also create confusion about texture recommendations, EDAR discussions or clinical advice. Interpreters, visual tools and clear explanations support understanding and shared decision-making.

Communication inequality

People who communicate without speech or rely on AAC, symbols, Makaton or non-verbal cues may face additional barriers. Early warning signs can be missed if staff are unfamiliar with how the person communicates discomfort or distress.

Accessible communication and continuity of staff reduce this risk and support earlier intervention.

Lack of advocacy and representation

People without family or consistent advocates face increased risk because there may be no one consistently noticing change or pushing for review. Advocacy should not depend solely on family presence.

Services must ensure people are supported during assessments, EDAR discussions and reviews, and that concerns are escalated even when external advocates are not available.

Socio-economic barriers

Financial pressures can limit access to suitable food, adaptive equipment or transport to appointments. Some people rely on cheaper, processed foods that are harder to modify safely.

Poverty influences risk and must be recognised as a safety issue, not a lifestyle choice.

Digital exclusion

As services increasingly use digital systems, people without digital access, confidence or equipment may miss appointments or misunderstand recommendations.

Services must check whether digital pathways support or exclude individuals and offer alternatives where needed.

Trauma-related barriers

Past traumatic experiences of healthcare can lead people to avoid assessments or disengage from services. This increases risk when swallowing difficulties are not identified or reviewed.

Trauma-informed adjustments, such as familiar staff support, flexible appointment approaches or quieter environments, can enable access and reduce risk.

Environmental inequality

People living in busy, noisy or overcrowded environments may experience increased anxiety at mealtimes, reducing swallowing safety.

Adjustments to the environment, routine or sensory support can significantly improve safety and comfort.

Continuity of care and staff variation

Frequent staff changes, reliance on unfamiliar agency workers or inconsistent training increase risk. Not all staff may recognise early EDS signs, correct posture or escalation pathways.

Continuity of care supports earlier recognition, consistent practice and safer outcomes.

Intersectionality and multiple disadvantages

Many people experience multiple overlapping disadvantages, such as communication barriers, poverty, trauma, limited advocacy or cultural misunderstanding. These factors compound risk. Assessment and planning must consider the whole picture, not isolated issues.

Assumptions and unconscious bias

Unchallenged assumptions about ability, understanding or risk tolerance can lead to unsafe decisions. People who appear confident or physically capable may still be at risk.
Reflective practice and supervision are essential to reducing bias and supporting equitable decision-making.

Legal duties and reasonable adjustments

Under equality legislation, services must provide reasonable adjustments to remove barriers to safe eating and drinking. Adjustments may include interpreters, extended appointments, adapted communication, familiarisation visits or support from trusted staff.
Reasonable adjustments are a safety requirement, not an optional enhancement.

Responsibilities of services and governance

Reducing inequality requires active and consistent organisational effort. Services must identify inequities early, analyse patterns of access and delay, and take action when barriers are identified. Governance systems should monitor access, track disparities and use data to understand where inequalities persist. These findings should inform training, supervision and service improvement.

Safeguarding considerations

When inequalities prevent someone from receiving safe mealtime support or timely clinical care, this becomes a safeguarding concern requiring coordinated action. Choking risk linked to poor access is not only a health issue. It is also a matter of protection.

EDAR

Understanding inequality is essential in EDAR discussions. People must receive accessible information, appropriate communication support and advocacy. Decisions should reflect the person's values, identity and preferences, not systemic barriers or assumptions.

Anticipatory practice

Equity requires anticipating barriers before harm occurs. Services should not wait for repeated missed appointments, near misses or incidents. Anticipatory practice involves adapting support early and ensuring people have the means, confidence and information to remain safe. In keeping with this approach, adjustments may include extended appointment times, interpreters, familiarisation visits, quiet waiting spaces, adapted communication tools or ensuring a familiar staff member accompanies the person.

9. Assessing and managing risk

Assessing and managing choking risk is a continuous process, not a one-off task. Risk changes over time. It is influenced by a person's health, behaviour, emotional state, environment, routines and the way support is provided. Effective practice depends on early identification, thoughtful assessment, clear planning and regular review.

Choking is rarely unpredictable. In most cases, early signs are present, but are missed, normalised or not acted on quickly enough. This guidance emphasises the importance of recognising risk early and responding proportionately, before harm occurs.

This section sets out how services should assess, manage and review choking risk in a way that supports safety, dignity and proportionality.

Identifying choking risk

Risk identification begins with attentive observation and familiarity with the person. Changes in how someone eats or drinks should always be taken seriously. This may include coughing or throat clearing, changes in voice quality, food pocketing, slower pace, avoidance of certain textures, distress during meals, or changes in behaviour around food.

Some people experience silent aspiration, where food or drink enters the airway without obvious signs such as coughing. This makes reliance on reported incidents alone unsafe. Near misses and subtle changes are critical indicators of increased risk and should prompt review rather than reassurance.

Risk should be considered proactively, particularly during admissions, transitions, hospital discharge, changes in health, medication changes, or when people are eating in unfamiliar environments such as restaurants or community settings.

Understanding who may be at higher risk

Certain factors are associated with increased choking risk, including learning disabilities, neurological conditions, cerebral palsy, visual impairment, older age, previous choking incidents, and the use of sedating or antipsychotic medication. Oral health problems, gastrointestinal issues, fatigue and illness can also significantly affect swallowing safety.

These factors do not act in isolation. Risk often increases where several factors combine, particularly during periods of change or stress. Services should proactively identify individuals at higher risk and ensure appropriate assessment and support are in place.

The role of social care staff and clinical boundaries

As stated previously, social care staff do not diagnose swallowing difficulties, but they play a vital role in identifying early signs of risk and triggering timely clinical assessment. Observation, familiarity and day-to-day contact place staff in a key position to notice change. Clinical assessment and advice relating to swallowing safety, textures and feeding strategies sit within the remit of qualified health professionals, particularly Speech and Language Therapists. Staff must not improvise or adapt guidance independently.

Where advice is unclear, conflicting or appears unsafe, this should be escalated promptly rather than worked around.

Comprehensive risk assessment

Effective assessment considers the whole picture, not a single factor. This includes physical health, medication effects, posture, fatigue, behaviour, sensory sensitivities and emotional state. It also includes environment, cultural food practices and real-world eating situations.

Assessment should reflect how the person eats in everyday life, not just in ideal or clinical conditions. This includes understanding how fatigue affects safety mid-meal, how distractions or anxiety influence pace, and how support needs may change when eating socially or in the community.

Risk assessments should be clearly written, accessible and proportionate. Overly complex or generic documents increase the risk of inconsistent practice.

Managing risk in practice

Risk management plans should set out clear, practical guidance that supports safe eating and drinking in everyday settings. This may include advice on posture, supervision, pacing, environment, communication approaches and the use of adaptive equipment. Plans must be specific enough to guide staff confidently, while allowing flexibility to respond to change. Where safety deteriorates during a meal, staff should feel confident to pause or stop eating and seek review.

Consistency is essential. Risk increases when plans are applied differently by different staff. Everyone involved in support, including bank and agency staff, must understand and follow agreed guidance. Clear handovers and aligned documentation support safe, consistent practice.

EDAR

EDAR may apply where risk cannot be fully eliminated, but the person chooses to continue eating and drinking in a particular way. EDAR decisions must be informed, accessible and regularly reviewed. Information should be shared in ways the person can genuinely understand, using visual tools, demonstrations or plain language as appropriate. Decisions should be revisited following any change in health, environment, behaviour, or after a near miss or incident.

Review, escalation and learning

Risk management does not end with assessment and planning. Plans must be reviewed whenever there is a change in health, behaviour, environment or routine, or when early warning signs emerge. Escalation pathways should be clear and timely. Delays in review, missed referrals or reliance on outdated guidance significantly increase the likelihood of harm. Patterns of concern, repeated near misses or staff uncertainty should trigger review at both individual and organisational levels.

Learning from risk is essential. Effective services use concerns, near misses and incidents to strengthen systems and practice, rather than to assign blame. This supports safer care and builds confidence across teams.

10. Assessing someone new to move in

The point of admission or transition into a new service is one of the highest-risk periods for choking. People may be unfamiliar with the environment, routines and staff, while services may be working with incomplete information or assumptions based on previous placements. Effective early assessment and risk management during this period is essential to prevent avoidable harm.

This section sets out expectations for how choking risk should be identified, managed and reviewed when someone moves into a new setting.

Gathering and reviewing information before admission

Risk assessment should begin before a person moves in wherever possible. Services should actively seek relevant information from referrers, families, advocates and health professionals. This should include details of previous choking incidents, near misses, known swallowing difficulties, EDAR discussions, Speech and Language Therapy involvement, oral health issues and medication.

Information gaps should be treated as risk factors in their own right. Where key details are missing or unclear, interim safety measures should be put in place rather than assuming low risk.

Initial observation and early support

People may eat differently due to anxiety, excitement, disruption to routine or unfamiliar surroundings. These changes are common during transition and should be anticipated. Staff should take time to observe how the person eats and drinks in practice, rather than relying solely on written information.

Observation should focus on posture, pace, tolerance of textures, communication of discomfort, fatigue and behaviour around meals. Increased supervision or more cautious support may be appropriate initially and should be reviewed as familiarity and confidence develop.

Interim risk management

Where swallowing safety is uncertain, services should adopt a precautionary approach while awaiting assessment or clarification. This may include closer supervision, quieter environments, pacing support or temporary adjustments agreed with clinicians.

Interim measures should be clearly documented, shared with all staff and reviewed promptly once further information or clinical advice is available. Temporary arrangements should not become embedded without review.

Clinical assessment and timely referral

If there is any concern about swallowing safety, referral for Speech and Language Therapy assessment should be made without delay. Services should not wait for incidents to justify referral.

Barriers to accessing assessment, such as long waiting times or missed appointments, should be escalated and managed proactively. During this period, risk should continue to be actively reviewed and managed.

Involving the person, family and advocates

Admissions are often stressful for people and those close to them. Clear, accessible communication helps build trust and supports safer outcomes. People, families and advocates should be involved in discussions about eating and drinking support from the outset.

Their knowledge of preferences, routines, cultural practices and early warning signs can be invaluable during this period of adjustment.

Reviewing risk as routines settle

Risk assessment must continue once the person has moved in. As routines become established and familiarity increases, support arrangements should be reviewed to ensure they remain appropriate.

Some risks may reduce as anxiety settles, while others may become more apparent over time. Regular review supports proportionate, least restrictive practice and prevents unnecessary long-term restrictions.

Documentation of handover

Clear, accurate and accessible documentation is critical during admissions. Initial assessments, interim measures and review outcomes must be recorded and shared consistently across the team.

Handovers should explicitly highlight any uncertainty, interim arrangements and actions required, rather than assuming information will be picked up later.

11. Communication, accessibility and inclusion

Safe eating and drinking support depends on people being able to understand what is happening, express discomfort or concern, and take part in decisions about their care. When communication is inaccessible or inconsistent, risk increases and early warning signs are more likely to be missed.

This section sets out expectations for communication, accessibility and inclusive practice as essential components of choking prevention.

Communication as a safety issue

Communication is not separate from risk management. It is central to it. People need to be able to indicate pain, discomfort, anxiety, fatigue or difficulty swallowing, and staff need to be able to recognise and respond to those signals consistently.

Where communication needs are not understood or accommodated, changes in eating behaviour may be misinterpreted or overlooked. Services must treat communication as a core safety requirement, not an optional adjustment.

Accessible information for people supported

People should receive information about eating and drinking support in ways they can genuinely understand. This includes information about textures, supervision, pacing, risks and agreed plans.

Accessible approaches may include easy-read materials, visual prompts, photographs, symbols, demonstrations, videos, Makaton or clear verbal explanations, depending on the person's needs. Accessibility should be reviewed regularly, as understanding and communication can change over time.

Recognising non-verbal communication

Many people communicate discomfort, distress or difficulty without words. Changes in behaviour, facial expression, body language, refusal, agitation or withdrawal around mealtimes may indicate increased risk.

Staff familiarity, curiosity and continuity are critical to recognising these signs early. Assumptions that behaviour is "challenging" or unrelated to eating can delay an appropriate response.

Consistency across staff teams

Inconsistent communication between staff increases risk. People may receive mixed messages about expectations, support or supervision, leading to confusion and unsafe practice.

Clear, consistent language should be used across teams, including permanent staff, bank staff and agency workers. Handover processes should highlight key communication needs, early warning signs and agreed approaches.

Inclusion and reasonable adjustments

Inclusive practice means actively removing barriers to safe participation. Reasonable adjustments should be anticipated rather than made reactively after incidents occur.

Adjustments may include additional time for meals, quieter environments, flexible routines, familiar staff support, alternative seating or tailored communication tools. Inclusion supports both dignity and safety.

Supporting communication during change

Communication needs often increase during periods of transition, such as new placements, changes in health, staffing changes or eating in unfamiliar environments.

During these times, staff should be particularly attentive to changes in communication and behaviour, and proactive in checking understanding and comfort.

Communication with families, advocates and professionals

Effective communication extends beyond direct support. Families, advocates and professionals must be kept informed about changes, concerns and decisions related to eating and drinking support.

Clear communication supports shared understanding, timely escalation and coordinated action, particularly where risk is increasing.

12. Multidisciplinary and integrated working

Effective choking prevention depends on coordinated working across health, social care and other relevant services. No single professional group holds all the expertise required to assess and manage eating and drinking risk safely. When information is fragmented or responsibilities are unclear, risk increases.

This section sets out expectations for multidisciplinary and integrated working as a core component of safe practice.

Shared responsibility across systems

Choking risk often sits at the intersection of physical health, behaviour, communication, environment and emotional wellbeing. These factors frequently interact. Managing this risk requires shared responsibility between social care providers, health professionals and commissioners.

Clear collaboration supports earlier identification of risk, more timely intervention and consistent application of agreed plans. Integrated working should be proactive and routine, not reserved only for incidents or crises.

Role clarity and professional boundaries

Each professional group brings a distinct role and expertise. Social care staff are central to observation, day-to-day support and recognising change. Clinical professionals, particularly Speech and Language Therapists, provide assessment and specialist advice on swallowing safety, textures and strategies.

Integrated working depends on clarity, not role blurring. Staff should understand where their responsibilities sit, when to seek advice and how to escalate concerns. Working together does not mean working beyond competence.

Timely access to clinical input

Delays in accessing clinical assessment increase risk. Where concerns are identified, referrals should be made promptly and followed up actively. Services should not wait for incidents or repeated deterioration before seeking support.

Barriers such as long waiting times, missed appointments, or fragmented pathways should be escalated and managed collaboratively. During periods of delay, interim risk management measures should be clearly agreed and reviewed.

Information sharing and coordination

Safe care depends on accurate and timely information sharing. Key decisions, changes in guidance and emerging concerns must be communicated clearly across teams and recorded consistently.

Integrated working requires systems that support continuity, particularly where multiple professionals are involved in a person's care. Assumptions that information has been shared elsewhere increase the likelihood of error.

Working with families and advocates as partners

Families and advocates often hold important information about preferences, routines, early warning signs and previous experiences. Integrated working should include them as partners in discussions and decision-making, where appropriate.

Their involvement supports continuity, trust and more informed risk management, particularly during transitions or periods of change.

Responding to disagreement or uncertainty

Differences in professional opinion or uncertainty about risk should be addressed through discussion and review, not avoidance. Where guidance is unclear or contested, services should seek clarification rather than defaulting to convenience or making untested assumptions.

Escalation routes should be clear and used constructively to support safe decision-making.

Integrated working during change and transition

Periods of transition, such as admissions, hospital discharge or changes in health status, require closer coordination. Information gaps are common during these times and should be actively anticipated.

Integrated planning during transition reduces the risk of missed information, inconsistent support and avoidable harm.

Governance and accountability

Integrated working must be supported at an organisational level. Providers and commissioners should ensure systems, agreements and relationships enable effective collaboration.

Clear accountability arrangements support timely decision-making and reduce the risk of responsibility being diffused across services.

13. Supporting choice, control and capacity

Supporting people to eat and drink safely must always sit alongside respect for choice, control and autonomy. These principles should be held together in everyday practice. Choking prevention is not about removing risk at all costs. It is about enabling people to live ordinary lives, make informed decisions and retain dignity, while reducing avoidable harm.

This section sets out how choice, control and capacity should be understood and supported within eating and drinking practice.

Choice and informed decision-making

People have the right to make choices about what, how and where they eat and drink in line with their capacity. For choices to be meaningful, people must be supported to understand the potential risks and the available options in ways that work for them.

Information should be shared clearly and accessibly, using appropriate formats, pacing and support. An agreement without understanding does not represent an informed choice. Where risks are discussed, the focus should be on enabling participation rather than discouraging or frightening people.

Understanding and assessing capacity

The capacity to make decisions about eating and drinking is decision-specific and may change over time. A person may have the capacity to make some decisions, but not others, or capacity may fluctuate depending on health, fatigue, stress or environment.

Capacity assessments should be proportionate, timely and focused on the specific decision being made. Assumptions based on diagnosis, communication style or past decisions are unsafe and unlawful. Where capacity is in doubt, this should be explored carefully and reviewed regularly.

Supporting people to maximise capacity

Supporting capacity means taking practical steps to help people understand information and express their wishes. This may include using visual aids, breaking information into smaller parts, offering choices at appropriate times, or involving people who know the person well.

Support should be adjusted as circumstances change. Capacity should not be viewed as fixed or static.

Best interests decision-making

Where a person lacks the capacity to make a specific decision about eating or drinking, decisions must be made in their best interests. Best interests decisions should consider the person's past and present wishes, feelings, beliefs and values, as well as the views of family, advocates and professionals.

The aim should be to respect the person's identity and quality of life, not simply to minimise risk. Decisions should be documented clearly and reviewed regularly, particularly if circumstances change.

EDAR

In some situations, a person may choose to eat and drink in ways that involve known risk, or best interests' decisions may support this where capacity is lacking. EDAR supports autonomy while recognising that some risk cannot be eliminated.

EDAR decisions must be informed, collaborative and regularly reviewed. They should never be used to justify inaction, poor support or lack of review. Where risk increases or circumstances change, decisions must be revisited.

Balancing safety and restriction

Restrictions on eating and drinking should be proportionate, necessary and time-limited. They should be the least restrictive option available and reviewed frequently.

Overly cautious practice can be as harmful as unmanaged risk. Removing choice without clear justification undermines dignity and may increase distress, anxiety or disengagement from support.

Review and accountability

Decisions relating to choice, control and capacity must be reviewed over time. Changes in health, environment, support or communication may alter a person's ability to make decisions or the level of risk involved.

Services must ensure decisions are recorded clearly, shared appropriately and understood by everyone involved in support.

14. Mealtime support and environmental factors

Safe mealtime practice is where assessment, planning and decision-making become real. Most choking incidents do not occur because guidance is absent. They occur because everyday practice slips under pressure, distraction, routine or familiarity. Mealtimes are dynamic, and risk can change quickly if support is not attentive and consistent. Environmental planning should also consider choking risk beyond mealtimes, including access to non-food items where pica or sensory-seeking behaviours are present.

This section sets out expectations for how mealtime support should be delivered in practice, across different settings, routines and levels of need.

Preparing for meals

Good mealtime support starts before food is served. Staff should ensure the environment is calm, equipment is available, and the person is comfortable and settled. Rushed preparation, noise, overcrowding or last-minute changes increase risk.

Preparation also includes checking that the correct guidance is being followed, including textures, posture, supervision level and any specific instructions. If guidance is unclear, conflicting or unavailable, staff should pause and escalate rather than proceed on assumption.

Positioning and posture

Safe posture is essential for swallowing. People should be supported to sit upright and stable, with appropriate support for head, trunk and feet as required. Posture should be checked and maintained throughout the meal, not only at the start. As meals progress, fatigue, discomfort or movement can affect posture and increase risk. Staff should remain attentive and make adjustments as needed.

Pace, portion size and fatigue

Eating too quickly, taking large mouthfuls, or reduced awareness of pacing significantly increase choking risk. Staff should support an appropriate pace, allow adequate time between mouthfuls and recognise when fatigue is affecting safety.

Many incidents occur partway through a meal rather than at the beginning. Concentration and stamina may be reduced, particularly during longer meals or in stimulating environments. Meals may need to be paused or stopped if safety deteriorates.

Supervision and support levels

Supervision should reflect the person's assessed needs and may vary depending on health, environment, familiarity and activity. Quiet, attentive supervision that supports independence is often safer than overt or rushed intervention. Support levels should be reviewed regularly and adjusted when circumstances change. Increased supervision during illness, fatigue or unfamiliar settings is often appropriate and should not be viewed as failure.

Distraction-free mealtime standard

Rushed or distracted supervision increases risk. Mealtimes should be treated as a focused care activity, not as an opportunity to complete other tasks.

Use of personal mobile devices, multitasking or administrative work during active supervision reduces the ability to recognise early signs of difficulty such as coughing, changes in pace, fatigue or distress. Mealtime support requires active attention and physical and emotional presence.

Services should set clear expectations for staff supervising meals:

- Remain present and attentive
- Do not use personal mobile devices
- Avoid completing unrelated administrative tasks
- Monitor for early signs of difficulty throughout the meal
- Escalate concerns immediately

A calm and attentive mealtime environment is a protective factor in its own right.

Person-specific safety summaries at the point of care

High-risk individuals should have a concise, version-controlled safety summary available at the point of care. This may include texture level, supervision requirements, posture guidance and key red flags.

These summaries are not a replacement for full care plans. They are practical prompts designed to support safe, consistent decision-making during everyday activity.

Safety summaries should:

- Be clear, practical and immediately understandable
- Avoid unnecessary personal detail
- Reflect the current agreed plan
- Be reviewed whenever plans change
- Be removed or replaced immediately if outdated

Visibility supports consistency. Staff are more likely to follow guidance accurately when it is accessible, simple and located where decisions are made.

Balancing accessibility with confidentiality is essential and must be overseen through established information governance processes.

Unplanned food access and shared food risk

Choking incidents frequently occur when people access food that is not part of their agreed plan. This may include taking food from another person's plate, accepting food offered by peers, or accessing food in kitchens or communal areas without supervision.

These situations are often well-intentioned and may feel socially kind or inclusive in the moment. However, they can introduce significant risk, particularly where texture modification, portion control or pacing support is required.

Services should proactively plan for these scenarios by:

- Setting clear expectations about food sharing
- Supporting peers to understand boundaries in accessible ways
- Supervising communal eating spaces proportionately
- Ensuring high-risk foods are not left unattended
- Acting immediately if unsafe food is accessed

This risk should be anticipated as part of environmental planning, not treated as an isolated behavioural incident.

Communication during meals

Clear, calm communication supports safety. People may need prompts, reassurance or reminders that are tailored to their communication style. Staff should avoid rushing, arguing or distracting conversations that disrupt focus during eating. Non-verbal cues, such as facial expression, body tension, changes in behaviour or withdrawal, may indicate discomfort or difficulty swallowing and should be responded to promptly.

Texture modification and consistency

Where texture modification is part of a person's plan, it must be applied accurately and consistently. Incorrect textures, mixed textures or poorly prepared food significantly increase risk. Staff should understand the person's specific requirements and follow guidance exactly. Substitution, adaptation or improvisation without advice is unsafe.

Environment and sensory considerations

Noise, visual distraction, strong smells or busy environments can increase anxiety and reduce swallowing safety. Where possible, mealtimes should take place in calm, predictable settings. Adjustments may include quieter spaces, reduced distractions or flexible routines. Sensory needs should be considered as part of safety planning, not treated separately from risk management.

Eating out and meals in the community

Eating out and sharing meals in the community are an important part of ordinary life, social connection and inclusion. Choking risk should not be used as a reason to exclude people from these experiences by default.

Community settings introduce additional and predictable risk factors, including unfamiliar environments, background noise, visual distraction, altered pacing, larger portion sizes and reduced control over food preparation. These risks can usually be managed with planning and proportionate support.

Planning for eating out should consider venue choice, timing, seating, noise levels, menu options, portion size, pacing and supervision. Where texture modification is required, staff should plan in advance how this will be managed safely and discreetly.

Support during eating out should be calm and respectful, maintaining dignity and avoiding unnecessary attention. Staff should remain attentive to fatigue, distraction and changes in swallowing safety, and be prepared to pause or stop the meal if needed.

Risk management for eating out should enable participation wherever possible rather than restrict choice. Decisions should be reviewed regularly, particularly if health, confidence or support arrangements change.

Responding to concerns during meals

If a person shows signs of difficulty, distress or reduced safety, staff should respond promptly. This may include pausing the meal, offering reassurance, adjusting posture or seeking review.

Concerns should be documented and escalated as appropriate. Repeated or escalating issues should trigger review rather than being normalised or worked around.

15. Training, competence and workforce development

Safe eating and drinking support depends on staff having the right knowledge, skills and confidence to apply guidance consistently in everyday practice. Training alone is not enough. Competence develops through a combination of learning, observation, supervision and experience, supported by a culture that encourages curiosity and escalation.

This section sets out expectations for how training and workforce development should support safe, dignified mealtime practice.

Training as a foundation, not a guarantee

Training provides essential knowledge, but it does not in itself ensure safe practice. Staff may complete training and still feel unsure in real situations, particularly when circumstances change or risk increases.

Training should be seen as the starting point for competence, not the end. Services must ensure learning is reinforced and translated into practice through supervision, coaching and review.

Core knowledge and understanding

All staff involved in eating and drinking support should understand the basics of choking risk, early warning signs, posture, pacing, supervision and escalation. They should also understand the limits of their role and when to seek clinical advice.

Knowledge should be proportionate to role and responsibility. Not all staff require the same depth of training, but everyone must understand their part in keeping people safe.

Training and support

Training must be practical, hands-on and grounded in real situations. Effective training includes:

- IDDSI demonstrations
- Safe posture practice
- Escalation walk-throughs
- Case study discussions
- Emotional and behavioural aspects of eating
- Training should be repeated:
    - At induction
    - After incidents or near misses
    - After changes in clinical advice
    - At least annually

Competency frameworks and training tools

Competency frameworks should assess both technical skill and emotional readiness, including:

- Calm, attentive supervision
- Correct posture, equipment and IDDSI use
- Ability to explain plans accessibly
- Confidence to escalate concerns
- Safe response to distress or refusal
- Competency assessment should take place:
  - Annually
  - After incidents
  - When a person's needs change

This supports safe, confident practice and reinforces that attendance at training alone is not enough.

Developing and maintaining competence

Competence should be assessed in practice. This includes observing staff during mealtimes, providing feedback, and addressing gaps promptly. Confidence to pause, question or escalate concerns is as important as technical knowledge.

Competence should be reviewed regularly, particularly after incidents, near misses, changes in guidance or changes in a person's needs.

Supervision and reflective practice

Regular supervision provides space to reflect on practice, discuss concerns and reinforce learning. It supports staff to develop judgement and confidence rather than relying on rigid rules. Reflective discussion following near misses or challenging situations supports learning and reduces the risk of repeated harm. A culture of blame undermines safety and discourages escalation.

Supporting new bank and agency staff

Staff who are new to a service or unfamiliar with the people they support are at increased risk of missing early warning signs. Induction processes must ensure that staff understand key mealtime guidance before providing support. Bank and agency staff should receive clear, accessible information about eating and drinking support and be supported to ask questions. Assumptions about prior knowledge are unsafe.

Workforce stability and continuity

Continuity of staff supports safer mealtime practice. Familiarity with the person, their routines, and their communication increases the likelihood that subtle changes will be noticed early. High turnover, frequent use of unfamiliar staff or inadequate handovers increase risk and should be recognised as workforce safety issues.

Leadership responsibility for competence

Leaders and managers play a critical role in setting expectations and creating the conditions for safe practice. This includes ensuring access to appropriate training, time for supervision, and systems for monitoring competence. Workforce development should be proactive and planned, rather than reactive following incidents.

16. Governance and oversight

Good governance is what turns safe mealtime practice from individual effort into a reliable system that protects people every day. It means leaders, managers, and staff understand their responsibilities, work with clear information and processes, and feel confident to act early when concerns arise. When it works well, people feel safer, teams feel steadier, and risks are identified before harm occurs.

A strong governance approach treats choking prevention as a core organisational priority. It sits alongside safeguarding, health inequalities, clinical oversight and quality improvement, not at the margins of practice. The aim is to reduce unwarranted variation, strengthen consistency, and learn quickly from what is working and what is not.

This section sets out how governance and oversight should be structured to support safe, consistent and accountable eating and drinking practice.

Leadership accountability and role clarity

Governance is strongest when roles and responsibilities are clear. Managers, clinicians, senior leaders and boards should all understand their responsibilities in relation to mealtime safety. Staff should know who updates plans, who oversees training, who monitors trends and who signs off on decisions such as EDAR. Clear roles reduce delay, confusion and the assumption that someone else is dealing with an issue.

Legal and regulatory duties

Providers must meet regulatory requirements relating to safe care and treatment, including the safe management of risks associated with nutrition and hydration. This includes meeting obligations under Regulation 12 and relevant aspects of Regulation 14 relating to eating and drinking support, as well as Regulation 17 on effective governance. Where choking contributes to serious harm or death, statutory notifications may be required. Strong governance supports consistent compliance with these duties.

Human factors and system design

Governance must consider the real-world conditions staff work in. Rushing, noise, fatigue, unclear layouts, competing demands and poor communication all influence safety.

Leaders should observe mealtime practice, identify barriers and adjust systems so safe behaviour is the easiest behaviour. Reviews following incidents should consider system pressures and environmental factors, not just individual actions.

Workforce stability at mealtimes

Mealtime safety can be affected by staffing levels, skill mix and familiarity. Governance should monitor staffing arrangements during key mealtime periods and respond when shortages or high turnover increase risk.

Where people at higher risk are routinely supported by unfamiliar or temporary staff, this should trigger additional briefings, closer supervision or temporary adjustments.

Workforce variation is a governance issue, not a burden for frontline staff to manage alone.

Responding to delays in clinical pathways

Delays in accessing Speech and Language Therapy, dentistry or GP input do not remove organisational responsibility for managing risk. Governance systems should monitor delays, escalate concerns and ensure interim measures are in place.

Waiting for an appointment should never mean waiting to act. Increased supervision, temporary holding plans, medication review or environmental adjustments may be required to manage risk safely.

Clear reporting structures and PSIRF alignment

Reporting structures should support the timely escalation of concerns. Staff must know whom to speak to, who is accountable for follow-up and how emerging risks will be reviewed.

Incident reviews should align with PSIRF principles, focusing on understanding what happened and why, rather than assigning blame. Learning should be shared across the organisation so that improvements in one service benefit others.

Risk registers and trend analysis

Services should maintain a choking risk register that identifies individuals at risk, the factors contributing to that risk, and the controls in place. This should include people with known swallowing difficulties, EDAR arrangements, repeated near misses or recent changes in health or support.

Regular trend analysis helps leaders identify patterns such as repeated coughing incidents, delays in updating plans, inconsistent supervision or IDDSI accuracy issues. It can also highlight clusters of incidents linked to specific times of day or staffing arrangements. Trend data should prompt action and review, not sit as descriptive commentary.

Routine audits and one-page manager checklists

Audits should be practical and focused on what matters most to safety. This includes posture, mealtime environments, supervision, texture accuracy, alignment of documentation, staff confidence and the person's lived experience of mealtime support.

Simple one-page checklists support consistent oversight across shifts and services and make it easier for managers to identify risk early. Audits should always result in clear actions, with feedback shared so staff can see how learning leads to improvement.

Monitoring training, competence and authorisation

Governance systems should monitor training completion, competence and authorisation. Leaders should know who is trained, who has completed competency checks, who is authorised to support modified textures and who requires refresher input. Competence can decline over time, particularly where staff support mealtimes infrequently. Governance must ensure people are not placed at risk because staff feel unsure, underprepared or unsupported.

Information governance and safe storage

Mealtime plans, EDAR documentation and risk assessments contain personal and sensitive information. Services must be mindful of where and how this information is stored, accessed and displayed.

Information should be:

- Stored securely in line with data protection requirements
- Accessible only to staff who need it to provide safe care
- Available at the point of care without being openly visible to others
- Paper copies displayed in kitchens, dining rooms or staff areas should be limited to what is necessary for safe practice and should avoid unnecessary personal detail. Digital access should use appropriate permissions, password protection and audit trails
- When information is accessed on mobile devices or tablets, services should ensure screens cannot be overlooked, devices are secured when not in use, and data is not stored locally without safeguards
- Version control is essential. Only the most current version of each document should be accessible. Outdated or duplicate copies must be removed promptly from physical and digital locations, as poor version control is a known contributor to repeated incidents

Balancing accessibility with confidentiality is a governance responsibility. Safe practice depends on staff having the right information at the right time, without compromising privacy or dignity.

Alignment between digital and paper records

Choking incidents frequently involve mismatched or outdated information across systems. Governance arrangements must ensure there is one clear, current version of each mealtime plan.

Digital and paper records must always match, and updates should be completed promptly. If different teams, shifts or kitchens are using different versions, risk increases significantly and must be addressed as a priority.

Milestones and performance indicators

Clear milestones help services monitor implementation and progress. These may include:

- 100% of staff completing EDS training
- All mealtime plans updated using the agreed template
- All high-risk individuals have reviewed EDAR decisions
- All agency staff briefed and signed off
- Monthly mealtime audits completed
- Trend analysis is used to monitor near misses

Board-level assurance and minimum data requirements

Boards and senior leadership teams should receive regular, meaningful information about mealtime safety. This may include incident and near miss data, training compliance, speech and language therapy referral trends, time taken to update plans, audit outcomes and the number of people identified as higher risk.

Board members should be able to explain how they know mealtime practice is safe, what data informs their assurance, and how quickly concerns are escalated and addressed.

17. Responding to and learning from incidents

How a service responds during and after a choking incident shapes the person's safety, the confidence of staff and the quality of future care. A well-handled response is calm, coordinated and honest. It protects life in the moment and creates the learning that prevents harm from recurring.

This section brings together what good practice looks like at every stage, from the first moments of an incident to the organisational learning that follows.

Immediate response

During a choking incident, staff need to act quickly, calmly and with confidence. This includes making the environment safe, following first aid and emergency procedures, using the person's mealtime or EDAR plan to inform immediate support where relevant and calling emergency services when required.

Preparation supports an effective response. Some services use laminated guidance cards in dining areas, so essential steps remain visible under pressure. Others use short scenario-based practice, so actions feel familiar rather than overwhelming. Calm, rehearsed action protects life and reduces the risk of further injury.

A post-incident medical review should always be considered. Some people experience delayed aspiration symptoms such as changes in breathing, fever, fatigue or changes in behaviour. These signs may develop hours later rather than immediately; where aspiration or delayed respiratory deterioration is a concern, people should be observed closely in line with clinical guidance, with escalation to clinical partners at the first sign of concern.

Grab folders and checklists

Grab folders support safe and timely response by providing immediate access to essential information. This may include emergency response steps, mealtime and EDAR plans, contact details, allergy information and reporting templates.

Some services include a brief reflection checklist so staff can record key details while the event is still fresh. This supports more accurate reporting and helps capture small but important details that might otherwise be lost.

Notifications

Once the immediate situation is safe, timely notification is essential. This may include the registered manager, family, Speech and Language Therapy, the GP, safeguarding partners and, where required, the local authority or regulator.

Clear notification processes support transparency and ensure follow-up actions begin promptly. Simple "who to contact" guidance in grab folders or staff areas can help staff act confidently, particularly outside normal working hours.

Duty of Candour

Families should receive honest, compassionate communication following an incident. Duty of Candour conversations should explain what is known, what is still being explored and what will happen next.

Clear timelines, reassurance that learning will take place, and space for questions help build trust. These conversations should avoid speculation while acknowledging the impact of the incident on the person and those close to them.

Emotional support and debriefing

Choking incidents can be frightening for staff and deeply distressing for the person involved. Without space to process the event, staff may carry anxiety, guilt or reduced confidence into future practice.

Services should offer an immediate check-in and a more reflective debrief once the situation has settled. Staff who experience significant distress should have access to additional support.

The person who experienced the choking may also need emotional support. It is common for people to develop temporary anxiety around eating, slow their pace or avoid certain foods. Staff should notice these changes and provide reassurance, pacing support, graded reintroduction to foods and time to rebuild confidence.

Others in the setting may also be affected. Simple, accessible explanations can help people understand what happened, that support was provided and that the environment remains safe.

Treating near misses as high-value learning

Near misses often provide the clearest opportunity to prevent future harm. Staff must feel safe to report them.

A pattern of near misses should always prompt review, even if individual events appear minor. Psychological safety is essential. If staff feel judged or blamed, near misses go unreported, and learning is lost.

This section reflects national learning on incident response and safety, including principles from PSIRF, regulatory expectations, clinical guidance and evidence on system factors that contribute to choking risk.

Learning review and contributory factors

After any choking incident or near miss, a proportionate learning review should take place to understand what contributed to the event. The purpose is learning, not blame.

Effective reviews look beyond the moment of the incident and consider the wider context. This includes what was happening before, during and after the meal, supervision levels, environment and equipment, pacing, staffing arrangements, communication and documentation, and any changes in the person's presentation.

Reviews should avoid reductionist explanations such as “human error” or assumptions that the person simply ate too quickly. These explanations limit learning. Instead, reviews should explore system pressures, unclear guidance, rushed environments, inconsistent practice or missed early warning signs.

Where risks repeat or where there are concerns about the quality of internal review, an independent assessment should be considered. External input can reduce blind spots and strengthen confidence in findings.

Turning learning into action

Learning is only meaningful if it leads to change. Reviews may identify the need to update mealtime plans, adjust IDDSI levels, revise pacing guidance, change seating or environment, provide refresher training, replace equipment or seek urgent clinical review.

Actions should be implemented promptly and clearly communicated. Learning should not remain in reports without follow-through.

A clear feedback and learning loop is essential. Teams should revisit the incident to check whether changes have improved safety. Without this step, learning is often diluted or forgotten.

Updating documents consistently

All versions of documentation must be updated following an incident. This includes digital records, paper plans, mealtime mats, EDAR documentation, handover notes and any copies used by kitchen or agency staff.

Mismatched or outdated documentation is a recognised contributor to repeated incidents and must be addressed immediately.

Sharing learning across the service

Learning should extend beyond the individual service or team. Brief updates, shared reflections or short learning alerts help prevent similar risks elsewhere.

Patterns often repeat across services. Sharing learning strengthens organisational safety culture and reduces avoidable harm.

Escalation to senior leadership

Serious choking incidents or repeated near misses should be escalated to senior leadership and included in governance and board assurance processes.

Senior oversight ensures visibility of themes, resource implications and system-level risks. Clear escalation reinforces accountability and prevents concerns from remaining hidden at the operational level.

18. Partnership with families and advocates

Families and advocates hold insight that staff cannot gather from records alone. They often understand a person's history, routines, cultural food traditions and early signs of discomfort or anxiety. Their involvement is essential for understanding how someone experiences mealtimes and what helps them feel settled, safe and respected.

Strong partnership improves assessment, strengthens consistency and reduces avoidable harm. It also supports dignity, identity and trust.

Some people do not have close family networks. In these situations, independent advocates or key workers play an equally important role. Their involvement protects the person's rights, helps ensure decisions reflect who the person is, and reduces the risk of disadvantage where family support is absent.

This section sets out how services should work in partnership with families and advocates to support safer, more consistent and more person-centred eating and drinking practice.

Working together in assessment and planning

Families and advocates should be actively involved in assessments, reviews and conversations about eating and drinking support. They often notice subtle patterns that may not be immediately visible to staff, such as eating more quickly when excited, avoiding certain textures at home, or becoming anxious in noisy environments.

This insight helps shape safer, more personalised plans. Joint planning also supports cultural respect. Many traditional meals hold emotional meaning, and working together to adapt them safely avoids unnecessary restriction while maintaining dignity.

Ongoing communication and meaningful involvement

Partnership should extend beyond formal reviews. Ongoing communication, regular check-ins and clear explanations support trust and meaningful involvement over time.

Communication should be jargon-free and supported by visuals or practical examples where helpful. Families and advocates should feel that their knowledge shapes decisions, not that it is added as an afterthought.

Families as partners in prevention

Where families want to be involved, services can share simple, accessible information about early warning signs, posture, pacing, fatigue and texture requirements. This is not clinical training, but it supports confidence and consistency during visits or time spent together.

Shared understanding helps everyone notice changes early and respond in similar, supportive ways.

Communication after incidents

If an incident or near miss occurs, communication with families should be timely, transparent and compassionate. Families need clear explanations of what is known, what is still being reviewed and what actions are being taken.

Sharing early learning, within appropriate information-sharing boundaries, helps build trust and reassures families that concerns are being taken seriously. Some families may carry anxiety long after an incident, particularly if they have experienced choking previously. Offering time to talk, explaining changes to support plans and creating space for questions helps reduce ongoing worry.

Clear expectations and boundaries around food brought into services

Families may bring food from home or prepare favourite dishes for special occasions. This can be comforting and reassuring for the person.

Services should set clear, kind expectations about what is safe, how textures need to be prepared, and when checks are required before food is served. Agreeing this early helps prevent misunderstandings and keeps everyone aligned around safety.

When families and the person do not agree

There may be times when families hold a different view of risk than the person themselves. This is common and often rooted in fear or past experiences.

Staff should support calm, respectful conversations, acknowledge emotions and return to the principles of the Mental Capacity Act to guide decisions. The person's rights, wishes and values remain central, while families' concerns should be heard with empathy and respect.

Advocates and people without family involvement

Advocates play a critical role where people do not have family support or have difficulty expressing their views. They help ensure decisions about supervision, texture modification, environment and EDAR reflect the person's identity and preferences rather than organisational convenience.

Their involvement is particularly important in the best interests and EDAR processes and supports balanced, lawful decision-making.

19. Quality assurance and continuous improvement

Quality assurance is what holds this whole approach together. Safe mealtime practice is not something a service achieves once and then assumes will continue. It changes as people change and shifts as staff rotate, routines alter, new team members arrive, or pressures increase. Choking prevention must be treated as continuous, everyday work, built into how teams think, communicate and behave.

Strong services understand quality assurance as both a practical process and a cultural responsibility. The practical side focuses on audits, data, documentation and follow-up. The cultural side centres on curiosity, psychological safety and the confidence to speak up early when something does not feel right. When both work together, risk reduces, and people experience calmer, safer mealtimes.

This section sets out how services should use quality assurance processes and culture to support consistent learning, early risk identification and continuous improvement in mealtime safety.

A culture of psychological safety

Psychological safety, as outlined in the Core Principles and Governance sections, underpins effective quality assurance. Staff must feel confident to report near misses, uncertainty and variation in practice so learning can occur early. A learning culture invites honesty rather than blame. Leaders set the tone through their responses, showing curiosity instead of criticism.

Reflective practice and supervision support staff to explore what they noticed, what felt difficult and what could be improved. When people feel safe to raise concerns, organisations gain access to their most valuable source of learning.

Human factors and system design

Modern safety science highlights the role of human factors. Incidents are often shaped by system pressures such as noise, layout, staffing levels, workload, competing demands or poor access to equipment.

Quality assurance should consider these factors and adjust systems so that safe practice is easier to achieve. This shifts the focus from blaming individuals to designing safer routines and environments.

Audits as a learning tool, not a policing tool

Audits should confirm whether plans match practice, not simply whether documents exist. This includes reviewing supervision, posture, seating, IDDSI accuracy, communication tools and the mealtime environment.

Where digital care planning or recording systems are used, managers should review food diaries and mealtime records regularly to ensure meals reflect current clinical guidance.

Where photographs are used to support texture verification or assurance, they must be checked for accuracy, clearly labelled and aligned with the person's current plan. Digital records should support safe practice, not replace oversight.

Spot checks should take place at different times of day. A rushed breakfast can reveal risks that may not be visible during a calm lunch. Variation is often where risk hides.

Digital documentation checks

Conflicting or outdated documentation is one of the most common contributors to choking incidents. Quality assurance must ensure that digital plans, printed copies, kitchen information and mealtime mats all reflect the current version.

Digital tools only improve safety when they are actively used. Dashboards, alerts and real-time data should link directly to audits, supervision and review processes, rather than existing in isolation.

Trend analysis and dashboards

Patterns reveal risk long before serious harm occurs. Digital dashboards and reporting tools can help track trends in near misses, coughing episodes, texture errors, referral delays and time taken to update plans. These tools should support early identification of patterns and prompt review before risk escalates.

Emotional and sensory patterns also matter. Repeated anxiety, withdrawal or distress during meals should be treated as safety signals, not only behavioural concerns.

Recognising quality drift

Even strong teams can drift from expected standards over time if practice is not actively reinforced. Regular refreshers, short reflective check-ins and supportive supervision help maintain consistency and reduce the gradual erosion of safe practice.

Closing the loop

Identifying actions is not enough. Services must check whether those actions have made a difference. This may include follow-up observations, staff feedback or reviewing incident trends after changes are introduced.

Closing the loop turns learning into genuine improvement and prevents issues from quietly reappearing.

Review and update the schedule

Mealtime safety is dynamic. Plans and systems should be reviewed:

- After every incident or near miss
- After changes in health, behaviour or environment
- When new SLT advice is received
- Every six to twelve months routinely
- When national guidance is updated

Implementation remains strong when leaders check progress regularly and adjust promptly.

Annual choking learning summary

An annual organisation-wide review helps consolidate learning, identify emerging themes and set priorities for improvement. This supports board assurance and ensures learning is shared across services rather than remaining localised.

Peer review and benchmarking

Peer review provides a fresh perspective. Inviting colleagues from another service to observe mealtime practice can highlight habits or drift that teams no longer notice themselves.

Benchmarking across services helps identify where practice is strong and where improvement is needed, supporting shared learning rather than isolated problem-solving.

Involving people and families in quality assurance

People and families often notice things staff may miss. They may observe pacing differences at home, unnecessary food restrictions or rising anxiety around meals.

Their feedback strengthens accuracy and relevance, particularly when reviewing easy read materials, environmental adjustments or changes to routine.

Quality assurance for agency and temporary staff

Agency and temporary staff are frequently involved in national EDS incidents. Quality assurance should examine how these staff are briefed and whether their practice aligns with the permanent teams.

Where variation is identified, onboarding processes, briefing materials or supervision arrangements should be strengthened.

Stronger links to workforce planning

If incidents cluster around specific shifts or times of day, this may indicate staffing or competency gaps. Quality assurance findings should inform workforce planning, deployment and training priorities.

20. Technology and innovation

Technology can support safer mealtime practice when it improves consistency, early recognition, communication and learning. Its purpose should be to enhance person-centred practice, not replace it. Digital tools should be simple, well governed and genuinely useful in day-to-day care.

Technology only improves safety when it is well governed, understood by staff and embedded into everyday practice.

This section sets out how technology and innovation can be used responsibly to support safer, more consistent and more person-centred eating and drinking support.

Making technology meaningful

Innovation should make practice easier, not more complex. Staff need time, training and reassurance to use digital tools confidently. Technology should support clarity, early detection and communication, while human judgement remains central.

Digital care planning and shared information

Digital care planning platforms allow mealtime guidance to be updated instantly, so staff are always working from the most accurate version of a person's plan. Shared care records make it easier for Speech and Language Therapists, GPs, dietitians and other professionals to add recommendations that staff can view immediately, reducing the risk of outdated or conflicting information.

Photo documentation tools can support IDDSI accuracy by allowing staff to upload images of prepared meals for checking. This is particularly helpful for kitchen teams and services where consistency across shifts has previously been difficult to maintain.

Portable access to digital plans supports continuity of care beyond the service. Staff can check posture guidance, IDDSI levels and emergency steps when supporting people in the community, during outings or at family meals.

Real-time alerts and early warning tools

Many digital systems provide simple prompts that act as safety nudges. These may remind staff to check posture, confirm supervision levels or monitor hydration. Some platforms track early warning indicators such as repeated coughing, prolonged mealtimes, drooling or changes in appetite.

When patterns begin to cluster, systems can prompt a review before risk escalates. Emerging tools also support trend analysis by identifying delays in updating care plans, gaps in training and repeated texture inconsistencies. This allows managers to intervene earlier and reduce unwarranted variation across teams.

Digital governance and system-wide learning

For technology to improve safety, it must be monitored and used consistently. Services must audit digital systems regularly to check for outdated plans, missed alerts, inconsistent versions and gaps in data. Digital and paper plans must always align.

Some systems allow alerts to be linked to competency records, ensuring prompts are only sent to staff who are trained and authorised. Dashboards can show trends in incidents, near misses, texture variance and training completion, supporting evidence-informed leadership decisions.

Simulation training and workforce confidence

Simulation-based tools are widely recognised as an effective way to prepare staff for choking incidents and high-risk situations. Practical drills help staff remain calm and confident during emergencies.

Simulation can also focus on posture, pacing and supervision in realistic environments, supporting learning around the subtler aspects of safe mealtime practice. These tools provide a safe space for staff to explore what felt overwhelming or confusing before encountering it in real-time.

Posture and seating technology

Sensor-assisted seating and posture reminders are becoming more common. These tools provide gentle feedback when someone shifts into an unsafe position, reducing reliance on repeated verbal prompting.

In busy dining environments, posture technology can help maintain safety and reduce repeated coughing. For some people, this can significantly improve swallowing safety and comfort.

Assistive communication technologies

Technology can support people to express food preferences, discomfort or anxiety more clearly. Tools such as talking mats, symbol libraries, touchscreen boards and prerecorded phrases allow people to take a more active role in their own mealtime decisions.

These tools are particularly valuable during Mental Capacity Act and EDAR discussions, where people may need support to understand information and communicate what matters to them. Improved communication leads to more personalised decisions and reduces reliance on service assumptions.

Supporting safety beyond the home

Technology strengthens safety during community activities. When plans, EDAR documentation and emergency steps are accessible on a phone or tablet, staff do not have to rely on memory alone.

Families often find reassurance in knowing that staff supporting their relative away from the service still have full access to essential, up-to-date information.

21. Toolkit, templates and practice infrastructure

Toolkit contents

The toolkit contains essential documents, templates and visual guides that support safe and consistent mealtime practice, including:

- Mealtime plan templates (toolkit 6.3)
- Choking risk screening tools (toolkit 1.2)
- Checklists for managers and staff (toolkit 2)
- EDAR documentation templates (toolkit 1.4)
- Handover sheets for permanent and agency staff (toolkit 3)
- IDDSI aligned texture modification guides (toolkit 2.4)
- Incident reporting and root cause analysis templates (toolkit 1.5)
- Competency assessment tools (toolkit 3.1)
- Easy Read materials for people and families (toolkit 6 and 7)
- Visual posters on posture, pacing and supervision (toolkit 6.4)

Design may vary, but core content must remain intact to ensure safety.

Mandatory documents

To support consistent, evidence-informed practice, the toolkit should include:

- A detailed mealtime plan template with mandatory fields (toolkit 6.3)
- A choking risk screening tool for admission and review (toolkit 1.2)
- An EDAR recording template with structured prompts (toolkit 5.1)
- An incident escalation flowchart (toolkit 2.3)
- Visual guidance on IDDSI testing (toolkit 2.5)
- Easy Read materials explaining safe eating and drinking (toolkit 6)

These templates reduce variation between staff, teams and shifts.

Induction and agency staff essentials

The toolkit should include a short, non-negotiable induction checklist outlining the key information staff must know before supporting meals (toolkit 3.3), including:

- Texture level
- Supervision requirements
- Posture and positioning needs
- Escalation steps
- EDAR agreements where relevant

This reduces avoidable variation, particularly during staffing changes.

Supporting practice through visibility

Tools must be visible and accessible to be effective. They should be available in:

- Kitchens
- Dining rooms

- Staff offices
- Induction packs
- Digital platforms or tablets

Digital access is particularly important for night staff and agency staff. Personal information must be stored securely, with appropriate access controls and compliance with data protection requirements.

Reflective and post-incident tools

The toolkit should include:

- Quick reflective sheets for immediate post-incident use (toolkit 5.3)
- Templates for learning reviews and debrief discussions (toolkit 5.2)
- Prompts for recognising emotional impact on staff and people supported (toolkit 5.4)

Capturing early observations and reflections helps services learn faster and prevents repeat harm.

Easy Read and accessible resources

Generic Easy Read materials are often insufficient. Personalised resources are more effective and may include:

- Photos of the person's own meals
- Their actual plates, utensils and seating
- Step-by-step posture or pacing guides
- Visual sequencing or objects of reference
- Plain language explanations

These resources support understanding, autonomy and meaningful involvement.

Technology-supported tools

Examples include:

- Alerts to review plans after incidents or hospital admissions
- Prompts to complete texture checks or supervision checks
- Digital noticeboards displaying updated mealtime guidance

These systems support consistency, particularly in busy environments.

Governance alignment

Toolkit documents must adhere to the governance and version control principles outlined in the Governance and Oversight section.

22. Conclusion

Safe mealtime practice is not just about technique, policy or clinical guidance. It is about people. It is about knowing someone well enough to notice when they are tired, anxious or simply having a different day. It is about slowing the pace, creating calm and treating every meal as a moment of dignity rather than a task to complete. Choking prevention sits at the heart of that work and depends on steady collaboration across staff teams, families, advocates and health partners.

This guidance brings together what people with lived experience, families and practitioners have been saying for years. Choking rarely happens without warning. It most often occurs when small risks line up, when early signs are missed, or when environments become rushed or inconsistent. The more services understand these patterns, the better they become at noticing them early and responding with confidence rather than panic.

Frontline staff carry much of this responsibility day by day through quiet attentiveness, emotional steadiness and small adjustments that often go unseen but prevent harm. This work deserves recognition. Staff hold people's comfort, safety and dignity in their hands, and their skill often makes the difference between a meal that feels safe and one that does not.

Families and advocates bring history, insight and emotional truth. They often notice subtle changes long before services do. Their voices ground this guidance in real lives, and their partnership will continue to shape how the sector learns, adapts and improves. A safe mealtime is a shared creation and works best when everyone is part of the conversation.

Leaders also set the tone. When leadership is steady, curious and transparent, staff feel safe to speak up, ask questions and raise concerns. Psychological safety is not optional in choking prevention. It is foundational. People only report near misses or uncertainty when they trust that the response will be fair, supportive and focused on learning.

This report is intended to support services to reflect on their own practice, ask the right questions and strengthen what they already do well. It does not replace professional judgement or clinical advice. Instead, it sets a clear expectation that choking prevention is a shared responsibility, one that must be actively led, reviewed and learned from over time.

The guidance aims to build systems that notice risk early, respond quickly and adapt without delay. It encourages consistent training, clear documentation, confident decision-making under the Mental Capacity Act and effective communication between disciplines. It reminds services that a person's emotional state, sensory needs and cultural identity matter just as much as clinical indicators.

Safe practice is never finished. It develops day by day, shift by shift. It requires curiosity, reflection and honesty. It requires the confidence to say, "something feels different today", and the willingness to act on it. When teams approach mealtimes with this mindset, preventable harm reduces, and quality of life improves.

Many choking incidents are preventable. When the right culture is combined with the right tools, understanding and relationships, mealtimes become moments of connection rather than fear. The real measure of this guidance is not how it reads, but how it changes what people experience at the table, every day.

About Callaway Care and Support

Callaway Care and Support is a provider of residential care and supported living offering specialist services in North West London. They offer support for individuals with learning disabilities, autism, behaviours of concern, dual diagnosis and complex health needs. A pathway to independence is at the core of their support model. Callaway Care and Support have a large and diverse portfolio of properties that can adapt to suit the needs of the individual, not the business. They strive to deliver person-centred, high-quality care and support within the community. Their vision is that people they support will have a better quality of life: living locally where they feel safe, valued, and included in their communities, with access to effective personal support that promotes independence, choice, and control.

Callaway Care and Support
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About Iris Care Group

Iris Care Group provides the full pathway of services for people with learning disabilities, autism, mental health issues and personality disorders, along with neurodegenerative conditions and Acquired Brain Injury. They provide treatment and care for complex mental health conditions. Their domiciliary care, supported living, residential and nursing services allow people to live independent, meaningful lives in the community, whilst their specialist hospitals provide assessment, care and treatment. They take pride in offering innovative, effective, safe, compassionate and empowering care and support in high-quality environments.

2026 Iris Care Group
Unit 1
Castleton Court, St Mellons Business Park
CF3 0LT

About Care England

Care England is the largest and most diverse representative body for independent providers of adult social care in England. It is a registered charity that works collaboratively with its members, stakeholders, and the government to implement the foundations of a sustainable future for adult social care. Care England represents small, medium, and large providers, including single care homes, small local groups, national providers, and not-for-profit voluntary organisations and aims to improve the quality of care and ensure the health and safety of both staff and residents in care settings and advocates for sustainable policies and practices that address the sector's workforce challenges.

Care England
2nd Floor
2 Devonshire Square
London EC2M 4UJ

About Serious Risk Prevention

Serious Risk Prevention (SRP) focuses on the risks most often linked to deaths, prosecutions and reputational damage in adult social care, including choking and EDS difficulties, scalding and drowning, epilepsy related harm including SUDEP, bowel and constipation-related harm, self-harm and suicide. SRP's Crisis Stabilisation service offers targeted support for organisations facing immediate challenges, using proven strategies and insight from their prevention work to help teams manage urgent situations with confidence.

SRP is a specialist service of EMLR Consulting Ltd
info@emlrconsultingltd.com

23. Appendices

The appendices below provide supporting material that strengthens understanding, assurance, and application of the guidance. Operational tools, templates and workforce resources are provided separately within the Preventing Choking Toolkit.

Appendix 1: Case studies and practice examples

This appendix contains illustrative case studies and practice examples that demonstrate person-centred approaches, multidisciplinary collaboration and learning from experience. These examples show how risk is identified, managed and reviewed in real-world settings, and how systems adapt following learning.

This appendix includes:

- Positive practice examples
- Multidisciplinary working examples
- Person-centred and environmental adaptation examples
- Cultural food adaptations
- Learning from near misses
- Examples of system-level change following incidents
- Learning from enforcement and regulatory action

Case study 1:
See accompanying document: High fidelity composite cases at https://www.careengland.org.uk/wp-content/uploads/2026/03/High-fidelity-composite-cases.docx

Case study 2:
See accompanying document: Link to Inquest-Coroner at https://www.careengland.org.uk/wp-content/uploads/2026/03/Link-to-Inquest-Coroner.docx

SRP case study 3:
See accompanying document: Strengthening eating, drinking and swallowing safety at https://www.careengland.org.uk/wp-content/uploads/2026/03/strengthening-eating-drinking-and-swallowing-safety.docx

Regulatory learning - good practice examples and case studies
Available at: Good Practice Examples and Case Studies (https://www.careengland.org.uk/wp-content/uploads/2026/03/Good-Practice-Examples-and-Case-Studies.docx)

Learning from Enforcement – CQC Prosecutions
Available at: Learning from enforcement - CQC prosecutions at https://www.careengland.org.uk/wp-content/uploads/2026/03/Learning-from-enforcement-CQC-prosecutions.docx

Appendix 2: Glossary

Definitions of key terms used throughout the guidance to support shared understanding across providers, families, professionals, and commissioners.

Glossary of terms at https://www.careengland.org.uk/wp-content/uploads/2026/03/Glossary-of-terms.docx

Appendix 3: References and supporting evidence

This appendix sets out the national and international evidence base underpinning this guidance, including statutory frameworks, clinical guidance and national learning programmes. These sources define statutory duties, regulatory expectations and system-level safety requirements relevant to eating and drinking safety.

This appendix includes:
- Regulatory frameworks
- National learning programmes and population-level insight

Regulatory frameworks
These sources set out statutory duties, regulatory expectations and system-level safety requirements.

- **Mental Capacity Act Code of Practice:** https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- **Care Quality Commission (CQC) Assessment Framework:** https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessment-framework

- **NHS England Patient Safety Incident Response Framework (PSIRF):** https://www.england.nhs.uk/patient-safety

National learning programmes and population-level insight
These sources support learning from harm, mortality reviews and health inequality data at a national level.

- **NHS England Learning from Deaths and LeDeR Programme:** https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/ and https://leder.nhs.uk/

- **Public Health England Learning Disability Mortality Review:** https://www.gov.uk/government/publications/learning-disabilities-mortality-review-annual-report

- **Public Health England Health Inequalities Data:** https://www.gov.uk/government/publications/people-with-learning-disabilities-health-inequalities

Appendix 4: Toolkit Navigation Page

A guide to accessing and using the separate Preventing Choking Toolkit, including how providers locate, select, and apply Toolkit resources in both digital and paper formats.

This appendix explains the Toolkit structure, how resources are grouped, and how providers can select proportionate tools based on need and risk.

See accompanying document: https://www.careengland.org.uk/wp-content/uploads/2026/06/Toolkit-Navigation-Page.docx

Preventing Choking Toolkit available here: https://smartdirectory.careengland.org.uk/white-papers/preventing-choking-deaths-among-people-with-learning-disabilities

Appendix 5: Key Questions and Answers (Q&A)

A consolidated reference section addressing common questions arising from the guidance. This appendix supports ease of use without interrupting the core narrative of the document.

See accompanying document here: https://www.careengland.org.uk/wp-content/uploads/2026/04/Appendix-8-FAQs-.docx

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The voice of care

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