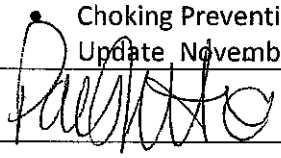
Catholic Charities Disabilities Services	
Agency Standard and Procedure	
Standard Category	Residential
Standard Title	Meals, Dining Plans, Choking Prevention
Regulations	CFR 483.480 ADM: 2012-04 ADM: 2014-04 14 NYCRR 633.16
Original Issue Date	May 12, 2015
Latest Revision Date	January 12, 2023 April 6, 2023
Number of Pages	5
Attachments	• Administrative Memo #2012-04 • Administrative Memo #2014-04 • Choking Prevention & Intervention Update November 2015
Approved by: Paula Jubic, Executive Director	

Standard: Each individual supported will receive nourishing, well-balanced meals that will include modified and specially-prescribed diets if necessary. Each individual supported will participate in dining experiences of their preference and learn skills to do so.

Responsible Clinician: For purposes of this standard, responsible clinicians include Registered Dieticians (RD), Speech and Language Pathologists (SLP), Registered Nurses (RN), and Registered Occupational Therapists (OTR).

Procedure:

Meals

1. Food is to be purchased that meets the requirements of the menu as prepared by the team and the dietary needs of the individuals supported. Food sufficient for at least three days duration will be maintained at all times. Food will be stored in an appropriate manner and temperature.

2. Each individual will be provided at least three meals daily with snacks in-between at times preferred by the individual supported.

3. Staff will be trained to prepare food in an appropriate, hygienic manner.

4. The scheduling of mealtimes will be sufficiently flexible to allow for the individual to participate in their chosen activities.

5. Food must be served in appropriate quantity, at an appropriate temperature, and at an appropriate consistency (see also below).

6. Unless the recipe calls for it (e.g. stews, casseroles, soups, stir fries, etc), or it is the preference of the individual supported, foods, especially pureed foods, will not be served mixed together to allow the individual to enjoy the tastes of various foods separately.

7. An individual supported may choose to eat at a different time.

8. Meals will be served in each residence's designated dining area. However, an individual supported may choose to eat their meal alone in another room as long as their dining plan can be followed, or there is no other clinical reason to prevent such a choice from being honored.

9. If needed, individuals supported will be provided with clothing protectors during their meals and will be included in their dining plan.

10. Dieticians will create healthy menus that will typically be low fat, high fiber, and lower sodium. Menus will be prepared in advance, posted so they can be easily reviewed by individuals supported, provide for a variety of foods at each meal, be different for the same days of each week, and be adjusted for seasonal changes. To the extent possible, individuals supported will be consulted as menus are prepared and personal food preferences will be honored. Menus will be considered to be guidelines and reasonable substitutions can be made by staff except in the cases of individuals supported diagnosed with Prader-Willi Syndrome. If an individual supported who has been diagnosed with Prader-Willi Syndrome requests a substitution, this must be done in advance and the dietician must be consulted before any substitution can be made.

11. To the extent possible, staff will model appropriate mealtime behavior and conversation by sitting at the table with individuals while they eat, and, if possible, eat with those individuals they support except staff who work in programs that support individuals diagnosed with Prader-Willi Syndrome.

12. Individuals supported will have ready access to food (see also #35 below) except for those individuals supported who have been diagnosed with Prader-Willi Syndrome.

Dining Plans

13. All individuals supported will have dining plans developed.

14. All dining plans for individuals supported will be based on a physician's order or the results of a swallowing study. These orders or results will include, but not be limited to, any caloric or nutritional restrictions, food and beverage consistency, any food allergies or aversions, etc.

15. All caloric or nutritional restrictions on a dining plan require a physician's order.

16. Dining plans will contain sections dealing with the following items: diet, consistency, adaptive equipment, dining procedures and special considerations (if any). Each section will be in conformance with any current physician's orders.

17. Dining plans will be written using current OPWDD definitions for food and liquid consistency.

18. If any staff member notices a change in an individual that may indicate that an existing dining plan is inappropriate, staff should follow the steps outlined in the standard, "Obtaining a clinical evaluation following changes to an individual's functional ability." If there is concern a restriction may be necessary, the RN will consult with the Primary Care Provider and request a referral if deemed necessary. If, in the opinion of the staff person the change is such that continuing with the current dining plan places the individual supported at immediate risk they are to notify the RN for the residence, supervisor, administrator on-call and/or the dietician immediately.

19. At no time will certain food items be restricted for an entire house. Any restrictions must be individualized and ordered by a physician.

20. Any changes to a dining plan will be based on a physician's order. A member of the Clinical Team (Clinical Coordinator, RN, LPN, Clinical Specialist) will write in any changes on the dining plan based on the physician's orders and initial. That person will attach the physician's orders to the dining plan and send to the Administrative Assistant to be updated. Once the Administrative Assistant has updated the dining plan, they will distribute it to the program.

21. All dining plans will be in writing and be present at the residence. All dining plans will be also stored electronically on the "G" drive in a folder designed for this purpose. The Administrative Assistant will be responsible to monitor this folder and update all dining plans on an annual basis or as needed.

22. Supervision level while dining definitions include:

    Independent: No supervision is needed.

    Supervised: Requires staff to be present in the dining room providing non-distracted and constant visual contact.

    Supervised with prompts: Requires physical, gestural, and/or verbal prompts throughout the meal.

    Total physical assistance: Requires total support when dining.

    One to one: Requires one staff to be assigned to one person. Such staff shall be within arm's reach of the person while dining and provide constant uninterrupted observation and supervision exclusively to that individual while seated at the table while dining.

23. Prompt level definitions include:

    Verbal: Verbally telling an individual he/she needs to slow down, put his/her fork down, take a drink, etc.

    Gestural: Using hand gestures to mime taking a drink or wiping mouth, etc.

    Physical: Staff using his or her hand and placing it on the back of the individual's hand to assist with scooping, bringing food to their mouth etc.

24. Dining plans should be developed within the first 30 days of admission.

25. Before a dining plan or any change to an existing plan is implemented, staff will be informed of the dining plan and will receive training in its implementation. The program manager is responsible to ensure that staff have been trained.

26. Individuals supported will be provided with adaptive furniture, chairs, eating utensils, and dishes designed to meet their functional or physical needs as prescribed in the physician's orders.

27. If appropriate, staff action plans will include goals to teach individuals supported to learn skills including the use of utensils, meal preparation, socialization during meals, family style dining, and ordering food in restaurants.

28. In all cases, the program manager is responsible to ensure that the house staff are current in all dining plans and are properly trained in their implementation.

Choking Prevention

29. The agency will follow and implement all practices required by OPWDD standards and guidelines.

30. Staff who assist individuals supported with dining will be trained in the OPWDD curriculum on Prevention of Choking and Aspiration. Staff will be trained to prepare food and beverages to the appropriate consistency as well as signs someone may be choking or aspirating.

31. Staffing will be at what has been deemed to be safe staffing levels to implement all dining plans and provide necessary supervision to ensure that each individual supported eats in a manner consistent with their functional abilities.

Rights Restrictions

32. Should any individual's access to food or caloric intake need to be restricted for safety or other behavioral reason, the procedures outlined in 14 NYCRR 633.16 will be followed. Additionally, all such restrictions will require a physician's order.

NYS Office For People With Developmental Disabilities
OPWDD Putting People First

Andrew M. Cuomo, Governor
Courtney Burke, Commissioner

Executive Office
44 Holland Avenue
Albany, NY 12229-0001
TEL: 518-473-1997
FAX: 518-473-1271
TTY: 866-933-4889
www.opwdd.ny.gov

ADMINISTRATIVE MEMORANDUM #2012-04

To: **DDSOO Directors**
DDRO Directors
Voluntary Provider Agency Executive Directors

From: **Dr. Jill A. Pettinger**
Assistant Deputy Commissioner
Statewide Services

Date: **August 17, 2012**

Subject: **OPWDD Choking Prevention Initiative**

Suggested Distribution:

Administrative Staff
Education and Training Staff
Program and Service Staff
Quality and Compliance Staff
Clinical Staff

Applicability: This Administrative Memorandum (ADM) applies to:

- All residential facilities certified or operated by Office For People With Developmental Disabilities (OPWDD) (including family care and supportive individual residential alternatives [IRAs] and supportive Community Residences [CRs]); and
- Free-standing respite centers certified as an IRA; and
- All day services that are operated, certified and/or funded by OPWDD except supported employment services.

This ADM pertains to the training of employees, contractors, consultants, volunteers, and family care providers (**henceforth known as applicable parties**) who have regular and substantial unsupervised or unrestricted physical contact with persons receiving services.

Purpose: To promote the health and safety of the individuals receiving services, all applicable parties of OPWDD Developmental Disabilities State Operations Offices (DDSOO), Developmental Disabilities Regional Offices (DDROs) and provider agencies are required to complete the OPWDD Choking Prevention Initiative (CPI) Part I and Part II training (if applicable) as detailed in this ADM. Beginning on the date that CPI training is required to be completed, DDSOOs, DDROs, and provider agencies must be in compliance with CPI's terminology, definitions, guidelines and food consistencies.

Background: The Choking Prevention Initiative has established a set of standardized consistent terminologies and definitions related to food preparation and food consistencies. The CPI has developed a sound curriculum which includes training materials and tools to be utilized as resources for training all applicable parties.

All agencies shall train applicable parties using the training materials as specified in this ADM. This will ensure uniformity and continuity of training for food and liquid consistency terminology and definitions for all applicable parties statewide. Supplemental training materials may be used in addition to OPWDD's training materials as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative.

The OPWDD CPI training consists of two parts. CPI Part I, **Prevention of Choking and Aspiration**, consists of an online or hard copy training that all applicable parties as defined above are required to complete. This training provides an overview of dysphagia as well as increasing awareness of the risks of choking and aspiration. Part I can be completed in approximately 30 minutes.

Part II, **Preparation Guidelines for Food and Liquid Consistency**, is a comprehensive training developed for those identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times. The training is also for direct supervisors of the above identified staff.

The required training materials are available on the OPWDD website:

http://www.opwdd.ny.gov/node/1948

OPWDD will be providing a flexible cutting board and a poster for each certified site. Both the cutting board and the poster provide a template and a description for each of the food consistencies defined by OPWDD. Images of both items are available on the website with the OPWDD CPI training materials.
(Please note that the images of the cutting board and the poster are not true to size.)

Effective date:

Training must commence within six weeks of the date of this ADM. The completion of all applicable parties' training for CPI Part I is required by 2/28/13. The completion of CPI Part II training for identified applicable parties is required by 8/30/13. The standardization of food and liquid consistency terminology, definitions and guidelines is required to be implemented by all provider agencies statewide by 8/30/13.

Training Overview:

CPI Part I "Prevention of Choking and Aspiration" Training:

The **Prevention of Choking and Aspiration** online/hard copy training emphasizes the critical importance of choking prevention for the individuals receiving services **and shall be completed by all applicable parties.** This training can be completed in 30 minutes and shall be implemented as follows:

1. Current staff or applicable parties – **all DDRO/DDSOO and voluntary providers' applicable parties must complete CPI Part I Training.** DDROs/DDSOOs are already implementing CPI Part I Training, and must complete this training by 11/1/12. Voluntary providers must **complete CPI Part I Training by 2/28/13.**
2. New staff or applicable parties – Effective on 11/1/12 all new DDRO/DDSOO and provider agency applicable parties shall complete Part I Training within three months of the hiring date for each individual. The DDROs/DDSOOs shall include this training in their "New Employee

Orientation." It is suggested that voluntary providers follow suit to ensure all new employees or service providers receive CPI Part I Training.

3. Annual refresher - Annual refresher training is NOT required. However, if there is an identified need to refresh or review the CPI materials with any identified applicable parties, the materials can be used for that purpose.

(Please Note: When the CPI PART I training is accessed online by any employee of OPWDD, completion of the course will be automatically entered into OPWDD's Training Database. For any person not employed by OPWDD, a Certificate of Course Completion is available for printing. The certificate will contain duplicate sections - one should be retained by the course participant and the other is for their training record to document completion of the training.)

CPI Part II "Preparation Guidelines for Food and Liquid Consistency" Training:

The **Preparation Guidelines for Food and Liquid Consistency** training emphasizes the critical importance of the statewide standardization of the terminology and definitions of the six food consistencies and the four liquid consistencies defined by OPWDD. **This training is required for "identified applicable parties." This means all applicable parties who regularly prepare or serve food, assist with dining, and/or provide supervision of individuals at meals and snack times.** Direct supervisors of staff described above are also "identified applicable parties" and must complete CPI Part II training. This training is NOT required for identified applicable parties who support individuals with no food or liquid consistency modifications to their diet. This training has *three* required elements:

Element I: The OPWDD Choking Prevention Initiative Guidelines entitled "Preparation Guidelines for Food and Liquid Consistency" must be reviewed. The guidelines address the terminology, definitions, and preparation of the various food and liquid consistencies. The guidelines also list foods that are known to create risks for choking and foods that should be omitted based on a required consistency for any individual.

Element II: The OPWDD training video presentation entitled, "Preparation of Food and Liquid Consistency," complements the guidelines described in Element I. The video illustrates the recommended preparation of the food and liquid consistencies referenced in the manual, and must be viewed in its entirety.

Element III: Practical training in preparation of the defined food consistencies and liquid consistencies must be provided to reinforce the knowledge and skills learned. The instructor will demonstrate the difference between each of the food consistencies and if needed the difference between the four liquid consistencies.

Completion time for the CPI Part II Training will vary based on the addition of supplemental materials and the previous knowledge and skills of the participants. Class size and the number of instructors for each presentation will also play a role. Based on these variables, it is estimated that up to 4 hours may need to be allocated for CPI Part II Training.

Implementation of CPI Part II Training:

1. Current staff who are identified applicable parties - **DDROs/DDSOOs and provider agencies must complete CPI Part II training by 8/30/13.**
2. New staff who are identified applicable parties – all new identified applicable parties who regularly prepare or serve food, assist with dining, or provide supervision of individuals at meals and snack times must take the CPI Part II Training within three months of hiring date. Newly hired identified applicable parties that require the more specific Part II training must prepare the food and liquid consistencies to the satisfaction of the instructor in Element III of the training. OPWDD recommends that provider agencies incorporate CPI Part II Training into the new employee orientation training of all Direct Support Professionals who are identified parties within six months from the issuance date of this ADM. OPWDD's Division of Workforce and Talent Management is incorporating this training into the new DSA Traineeship.
3. Annual refresher* - there is no annual refresher required for CPI Part II Training; however, the online CPI Part I Training may be used as an annual refresher if a need is identified by the agency. Other supplemental training materials may also be used as long as the terminology is identical to that which has been established by the OPWDD Choking Prevention Initiative.
4. Documentation of Required Training – completion of training for each identified applicable party shall be documented and a record of the documentation shall be maintained by each DDRO/DDSOO and provider agency.

**(Please note that best practice dictates that some type of choking prevention reinforcement training relating to dysphagia, food and liquid consistency, PICA, and choking hazards be provided every year to appropriate staff or applicable parties.)*

Training Materials:

The OPWDD Choking Prevention Initiative training materials are available on the OPWDD Internet website. These training materials include:

- The online CPI Part I Training, **Prevention of Choking and Aspiration**, which is also available as a PDF copy for printing, if training is not done online; and
- the CPI Part II Training manual, **Preparation Guidelines for Food and Liquid Consistency**. A copy of the guidelines should be printed and placed in each certified residential and day program site; and
- the CPI Part II **Training video, "Preparation of Food and Liquid Consistency**." The video was created in segments to allow for the separate viewing of each defined consistency; and
- images of the cutting board and the poster that are being sent to each agency for distribution to residential and day habilitation sites; and
- a copy of the **OPWDD Food Consistency Terminology table** that can be printed and posted at each agency's discretion; and
- the **Food Consistency Terminology Physicians Reference Table** can be printed and distributed to health care providers and used when food and liquid consistencies are being ordered for the individuals we support. It also has a list of suggestions that may need to be ordered by the health care provider, such as positioning, that will ensure a safe and enjoyable dining experience.

Liaisons:

Each DDSOO has an assigned liaison responsible for implementing the Choking Prevention Initiative training at their location. Additionally, there is a DDSOO staff member assigned as a CPI Liaison for the provider agencies within the catchment area of the DDRO. The CPI Liaison will serve as a resource for the provider agencies. Each provider must designate a single point person who will be responsible for communication with the CPI Liaison. This will avoid redundancy and will allow for a smoother transition. For your reference, a list of CPI Liaisons is attached.

Additional Information:

As all provider agencies statewide will now be using a set of standardized consistent terminologies and definitions related to food consistencies and food preparation, documented CPI training of staff at one agency may be used to satisfy requirements for training of that same person at another agency (e.g. if the employee transfers). Provider agencies may still provide for training that includes their own agency specific policies and procedures.

CPI Part II Training may be modified for clinical staff based on their knowledge and skills. Appropriate clinical staff must be fully familiarized with the standardized food and liquid consistency terminology and definitions so they may provide clinical guidance while working with staff and the individuals supported in the OPWDD system.

It is recommended as a best practice that Medicaid Service Coordinators and Plan of Care Support Services (PCSS) service coordinators are provided with CPI Part II Training to enhance their service coordination.)

Provider agencies should identify their own trainers for CPI training based on their resources and staffs' knowledge and skills. Trainers may be clinicians or experienced Direct Support Professionals who are recommended and approved by a clinician to become a CPI Trainer because they demonstrate proficiency and knowledge of the OPWDD Choking Prevention Initiative.

Choking can occur very rapidly, but potential incidents of choking can be avoided through the use of proper supervision, observation and training. It is not the intent of OPWDD to change the food consistency for any individual; rather it is our intent to standardize the terminology statewide describing a particular consistency and increase awareness and knowledge of CPI through training. Together we can enhance the health and safety of the individuals served in the OPWDD system, while creating an enjoyable dining experience.

Attachment: CPI Liaison list

NYS Office For People With Developmental Disabilities

Putting People First

Memorandum

Administrative Memorandum – #2014-04

TO: Executive Directors, Voluntary Providers
Directors, Developmental Disabilities State Operated Offices
Directors, Developmental Disabilities Regional Offices

FROM: Megan O'Connor-Hebert, Deputy Commissioner
Division of Quality Improvement

Helene DeSanto, Deputy Commissioner
Division of Service Delivery

Gerald Huber, Deputy Commissioner
Division of Person-Centered Supports

DATE: October 20, 2014

SUBJECT: Office for People with Developmental Disabilities (OPWDD) Home and Community Based Settings Preliminary Transition Plan Implementation

EFFECTIVE DATE: The effective date for full compliance with the HCBS Settings final federal regulations is TBD based upon final approval of OPWDD's Transition Plan by CMS. OPWDD will be implementing an HCBS Settings Assessment based upon this Administrative Memorandum (ADM) beginning in November 2014.

PURPOSE:

On March 17, 2014, CMS issued final regulations regarding requirements for home and community-based settings in Medicaid (42 CFR 441.301 (c) (4)-(6)). These final regulations require the State to submit a transition plan at the time of an HCBS Waiver Renewal that sets forth the actions the State will take to bring the waiver system into full compliance with the HCBS Settings standards during an up to five-year time period (i.e., full compliance required by March 2019). Further details on the New York State or OPWDD specific HCBS Settings Transition Plan can be found at the following link on OPWDD's website: http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/home

A major component of OPWDD's preliminary HCBS Settings Transition Plan is to assess a sample of OPWDD's certified residential settings. The purpose of the HCBS Settings Assessment of certified residential settings is twofold: (1) to compile baseline data to use to further develop OPWDD's Transition Plan; and, (2) to facilitate the identification of system challenges and timelines needed to achieve full system compliance.

The federal HCBS Settings regulations and the additional guidance that CMS has issued along with the content in this ADM is the basis for the administration of OPWDD's HCBS Settings Assessment Tool in certified residential settings. This ADM and the HCBS Settings Assessment Tools were developed in collaboration with the Regulatory Reform/HCBS Settings Stakeholder Steering Committee. Feedback and input was also sought through publishing these drafts on OPWDD's website throughout the development process and sharing drafts with other interested stakeholder groups for input and feedback.

While some of the HCBS Settings standards are already included in, or are similar to, existing OPWDD regulations at 14 NYCRR Subpart 635-10 and Section 633.4 as well as previous OPWDD guidance, OPWDD intends to promulgate State regulations for HCBS Settings in the future based upon the federal regulations, CMS guidance, and this ADM.

APPLICABILITY:

The HCBS Settings requirements will apply to all settings in which HCBS waiver services are delivered no later than March 2019. This ADM provides the basis for the administration of the HCBS Settings Assessment Tools in voluntary and state-operated OPWDD certified residential settings including Individualized Residential Alternatives (IRAs), Community Residences (CRs) and Family Care Homes. In the future, OPWDD may develop guidance and an HCBS Settings Assessment Tool applicable to non-residential HCBS settings.

This ADM describes the quality principles and standards that OPWDD will be assessing beginning November 2014, based upon the needs and preferences of individuals as indicated in their person-centered service plan.

Person-centered Planning Process Regulations and Rules published by CMS on March 17, 2014, and currently effective (42 CFR 441.301 (c) (1-3)) will be described in a different OPWDD guidance document and are not specifically addressed as a part of this ADM. **As person-centered planning is foundational to the spirit, intent, and substance of the HCBS Settings regulations, it is expected that agencies will use true person-centered planning processes and practices, in accordance with federal regulations and guidance, to ensure that the requirements contained in the HCBS Settings Regulations are met.**

It is expected that providers will use this ADM and OPWDD's HCBS Setting Assessment Tools and CMS guidance and exploratory questions to actively plan and develop proactive approaches to working towards and maintaining full compliance with the HCBS Settings federal requirements.

QUALITY STANDARDS:

The following are quality standards and characteristics that OPWDD will be assessing in HCBS certified residential settings. These standards, when taken together, support OPWDD's mission of helping people lead a richer life by:

- facilitating increased capacity for self-determination and personal control;
- supporting participation in communities;
- enhancing quality of life for individuals as they define it for themselves;
- investing in each person's developmental potential and capacity to contribute in age related roles as productive and respected community members; and,
- safeguarding the health, safety, rights, and well-being of people supported through the highest quality supports and services.[1]

The standards specifically address the person-centered habilitation planning process; delivery of person-centered HCBS funded supports and services in integrated settings; promotion and support of informed choice and rights; and standards applicable to the **nature and experience** of each person's living situation.

[1] Adapted from, "Keeping the Promise: Self-Advocates Defining the Meaning of Community Living", March 2011

These standards shall be promoted and facilitated by all providers and staff in OPWDD's service system, however, at this time; this ADM (for the purposes of OPWDD's HCBS Settings Assessment) applies specifically to the certified residential settings where HCBS waiver participants reside[2].

A. Guidance on the Habilitation Planning Process and Delivery of Person-centered HCBS Services and Supports in Accordance with These Standards[3]

In accordance with the CMS regulations (42 CFR 441.301 (c) 1-3)), the "Person-Centered Service Plan" must reflect the services and supports that are important for the individual to meet the needs identified through a functional assessment, as well as what is important to the individual with regard to preferences for the delivery of supports and services. In OPWDD's system, the Habilitation Plan is a required component of the Person-centered Service Plan (i.e., Individualized Service Plan (ISP)) for the provision of waiver habilitation services. Therefore, the Habilitation Plan and the process for Habilitation planning must also be person-centered and person-directed in accordance with the CMS regulations.

The Habilitation Plan describes the assistance that staff provides to help the person reach his/her goals and valued outcomes as identified in the overarching Individualized Service Plan (ISP). The following standards reinforce ADM #2012-01, the Habilitation Plan, and establish the starting point and foundation for meeting the HCBS Settings Standards in certified residential settings. ADM #2012-01 will be revised to include explicit reference to the HCBS Settings Regulations and the following if not already explicitly included.

- Habilitation Plans are a required attachment to the Person-centered Plan (i.e., ISP) and must be coordinated with the ISP. As such, the Habilitation Plan is encompassed in the person's service plan.
- Habilitation Plans are person-centered/person-directed, individualized, and include activities and interactions that are meaningful to the person.
- Habilitation supports and services are focused on the development of skills that are needed in order to facilitate greater degrees of choice, independence, autonomy and full participation in community life.
- Exploration of new experiences is an acceptable component of the Habilitation Plan. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. This trial-and-error process eventually enables the person to make informed choices and, consequently, to identify new valued outcomes that then become part of the ISP and the Habilitation Plan. [4]
- Accordingly, the Habilitation Plan (or alternative documentation that becomes part of the habilitation/service plan) should reflect the personally meaningful community inclusion/integration activities, the timing and desired frequency/duration of these

---

[2] All HCBS waiver participants must reside in a setting that meets HCBS Setting standards. It is assumed that a residence owned and/or controlled by the person and/or the person's family member would already meet these standards.

[3] In accordance with ADM #2012-01, "Habilitation Plan Requirements", "Habilitation services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Plans describe what staff (this term includes family care providers) will do to help the person reach his/her valued outcome(s) that have been identified in the Individualized Service Plan (ISP). Habilitation services involve staff teaching a skill, providing supports and exploring new experiences. The regulations that govern habilitation services are 14 NYCRR Parts 624, 633, 635, 671, and 686.

[4] ADM #2012-01 "Habilitation Plan Requirements", page 5, 3 c. direct quote.

activities (e.g., Sam would like to go the senior citizen center to play checkers once per week on Saturday mornings), and the supports needed for the person to fully participate (Sam needs direct individualized support by one staff person (i.e., one-to-one support) while playing checkers at the senior center to ensure appropriate social interaction with other checker players).

- Whenever possible, supports are provided in a way that maximizes use of natural and peer supports in the community, not just paid staff and providers. [5]
- The Habilitation Plan is updated in accordance with ADM #2012-01, when the individual's circumstances or needs change, or at the request of the individual. Residential providers should ensure that individuals are aware of their right to request a Habilitation Plan change. Residential providers are expected to take timely action to honor these requests.

It is important to recognize that the person-centered planning process is not the end goal. The person-centered planning process should be designed to result in outcomes ensuring the person has more choice and control in his/her life. The provider has an obligation to ensure that the choices being offered are not from a "profoundly limited menu" [6]. Some questions to consider when thinking about progress and results from the person-centered planning process with the person includes:

- Is the person enjoying a healthier and more satisfying life on their own terms?
- Does the person have a clearly defined role in directing their planning process?
- Does the person have more choice and control?
- Is his/her participation in the community genuine and meaningful as he/she defines it?
- Are the person's relationships authentic (i.e., real, meaningful)?[7]

Practice guidance on person-centered planning and service delivery can be found on OPWDD's website under the "Person-centered Planning" link at:
http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning.

B. HCBS Waiver Service Provision Is Required to Support Full Access to the Greater Community to the Same Degree of Access as Individuals Not Receiving HCBS:

HCB services, supports, and settings must be designed to facilitate full access to engage in community life; seek employment and work in competitive integrated settings; engage in meaningful activities; explore meaningful relationships and social roles; reside in the home of choice; and share in other hallmarks of community living in accordance with individualized needs and preferences identified in the person's habilitation/service plan and to the same degree of access as individuals without disabilities. HCBS settings must seek to optimize and not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

In practice, when considering whether people share in the hallmarks of community living to the "same degree of access as individuals without disabilities", it is helpful to consider and compare/contrast how you live your own life and the day to day choices and compromises that you make in your home, workplace, and community and the negotiations necessary to develop and

[5] Adapted from, "Keeping the Promise: Self-Advocates Defining the Meaning of Community Living", March 2011, page 17
[6] Ibid, page 2
[7] ibid

pursue your own interests and important relationships. The rights and responsibilities that we all experience every day such as having consideration for other people that we live with, having a job/going to work/fulfilling work commitment/volunteer commitment, respecting our coworkers, making choices within our income/budget, etc., are also useful to consider as we support people to navigate community life and consider the benefits and consequences of their actions. The expectations for people with disabilities should be the same as for any other person living in the community. All people have the responsibility to consider the thoughts and needs of others while exercising their own rights, priorities, and preferences.

In addition, when considering "same degree of access" to life in the community for the people we support, we need to ensure that people with disabilities are not segregated or isolated from people without disabilities and ensure that support and service delivery practices are not "institutional" in nature. There are a number of critical factors to consider when making this determination:

- the purpose of the activity; are people interested in the activity, will they see people they know or with whom they have common interests?
- the number of people from the residence participating together and whether people were offered a choice on whether or not to participate;
- the larger environment in which the activity is occurring (e.g., a larger group may be more appropriate participating in an activity where other large groups congregate such as a community concert as long as individuals are interested and staff support is sufficient to help the group participate positively);
- the intent and anticipated outcomes for people participating in the activity; and,
- peoples' feelings about the activity and how supports are delivered during it; are staff supports available to help individuals fully participate in the activity?; are individuals mandated to stay together (e.g., everyone in the group goes to the rest room together with paid staff or stands together on the food line?).

For example, a "group trip" in an agency bus or van can be isolating/segregating and appear institutional (even if unintentional) if people are congregated together and mandated to stay together with only each other and paid staff when at/engaging in the activity; and while at the activity, there are displays of "supervision", power or control exerted by staff over residents drawing unwanted attention to the group. This can make residents feel isolated and different from the larger community of people around them. It also exhibits institutional service delivery characteristics to the greater community. These characteristics would not be considered "full access to the community" to the "same degree of access" as people who do not receive HCBS.

There is recognition that not all people have had sufficient opportunity to discover the activities that are of the greatest interest to them and that during some activities individuals may not be engaged or may actively resist the activity. This is often a normal course of learning and both staff and natural supports should facilitate learning opportunities and "listen" to the person to best understand their ongoing interests. Learning and "listening" requires noting any verbal, vocal, gestural and behavioral communications exhibited by the person and putting them in context with the person's life experiences. This learning is best achieved in a small group or individually as support givers will need to be flexible during the activity to accommodate the person's response to the environment and event.

There is an expectation that providers/staff will adhere to the services and activities identified in the person's Plan and honor the rights and standards outlined below. However, if individuals place themselves or others around them in danger (i.e., **there is an immediate, serious, and credible threat to the health and safety** and/or circumstances of immediate jeopardy to the person or others as a result of exercising these rights while following the Plan), it is expected that the provider/staff will take appropriate action necessary to address the situation. Once the immediate crisis is over, the provider/staff is expected to reassess the person's preferences and needs using a person-centered planning process and to update the person's habilitation/service plan accordingly[8]. This process should include consideration and support for the person's informed choices; reflection of risk factors and positive safeguarding measures in place to minimize them including individualized back-up plans and strategies when needed.

Facilitate Informed Choice and Protect Rights

HCBS residential settings and staff delivering services and support shall promote and address the following standards outlined below in accordance with the person's Habilitation Plan and ISP and the principles outlined above:

- Encourage and support individuals to freely choose and control their own schedules and activities including both scheduled and unscheduled activities (e.g., when to eat, when to sleep, what to watch on television, preferred activities in and out of the home, impromptu preferences, etc.) in the same manner as people without disabilities. **The provider/site must ensure that sufficient support is available based upon peoples' priorities in their Plans for scheduling and activity preferences[9].**

- Spontaneity in choice of activities should be encouraged and supported whenever possible, no different than non-disabled individuals who live with others and enjoy the freedom to pursue an interest on the spur of the moment as well as the possible disappointment when lack of planning sometimes impacts being able to make necessary arrangements to participate or not participate (e.g., a person wants to go to the craft fair but it is only open another 2 hours). Providers and staff may need to consider not only paid staff but also use of natural supports such as family members and non-paid members of circles of support as individuals increasingly exercise greater control over their schedules and activities.

- It is also important to note that a person may not be able to participate in a regularly scheduled/planned activity due to illness or other appropriate reason (e.g., the person may be feeling ill and not want to participate in Community Habilitation on a given day and instead need to stay home). These circumstances must also be supported by the provider/staff.

---

[8] Federal Register /Vol. 79, No. 11 /Thursday, January 16, 2014 /Rules and Regulations , 2961, first column

[9] With regard to freedom and control of schedules and activities, CMS states that a person's ability to receive services identified in the person-centered service plan should not be infringed upon by any provider for any reason. Further, CMS states that preventing an individual from receiving any service identified in the person-centered service plan is a direct violation of the person-centered plan requirements and the home and community based setting requirements specified in this regulation. Additionally, any setting not adhering to the regulatory requirements will not be considered home and community based. The supports necessary to achieve an individual's goals must be reflected in the person-centered service plan as required under § 441.725(b) (5). **2966 Federal Register** / Vol. 79, No. 11 / Thursday, January 16, 2014

- Facilitate and optimize informed choice regarding services and supports and who provides them.
- Enable individuals to freely choose with whom to interact.
- Ensure that individuals are provided with appropriate services and supports to exercise their right to control their own personal resources to the full extent of their ability.
- Support individuals to make informed choices by exploring with the person the potential consequences and responsibilities of the decision making. Through this process, staff is expected to explore and promote positive approaches to safeguards that enable the person to have "dignity of risk". More information on this topic can be found on OPWDD's website at http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning/risks-and-safeguards. In addition, OPWDD's optional Strengths and Risks Inventory Tool is a helpful resource to assist the person to explore with support staff and others in their circle the risks that are non-negotiable, informed choices that involve tolerable risk, and positive safeguarding approaches (http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning/other-resources)
- Protect individuals from coercion and use of rights modifications, restraints, restrictive interventions and related interventions that are not clinically necessary (see Section C Rights Modifications below for additional information).
- Inform and provide individuals with a mechanism to file anonymous complaints.
- Ensure individualized physical accessibility in the person's residence.
- Encourage, respect and support people's observance of cultural, religious/spiritual, and other preferences in accordance with the person's choices and background.
- Ensure that individual independence and freedom is not abridged for convenience of staff and/or by well-meaning but unnecessarily restrictive methods of providing services and supports.
- Ensure that provider/residential policies and procedures do not include blanket restrictions on individual autonomy, independence and/or HCBS Settings standards.
- Use plain language and accessible methods to communicate effectively with the person and facilitate the use of any necessary adaptive devices/equipment based on the person's assessed needs.
- Ensure satisfaction with activities, supports, and services and address areas of dissatisfaction timely to result in tangible changes.

Additional Standards in OPWDD Certified Living Spaces:
In addition to the expectations outlined above, certified residential settings and staff delivering supports and services shall address and promote the following in accordance with individual preferences and the strengths, needs, capabilities, and goals of each person in their Plan. Any need to modify the rights outlined above or below must be approached in accordance with Section C of this ADM.

- **Occupancy Agreement to Specify Rights and Responsibilities Comparable to Tenancy Rights**
  - **Ensure that individuals have a written occupancy agreement that addresses, at a minimum, the due** process and appeals comparable to tenancy rights provided under NYS law. The occupancy agreement shall also address the person's rights and

responsibilities regarding their housing and the circumstances under which he/she could be required to relocate.[10] In addition, it shall provide information regarding the process for requesting a change in living arrangement/home and/or roommate. [11]

- Occupancy Agreement provisions could be incorporated into the Notice of Rights required by 633.12 issued by providers if the complete document is written in plain language and/or is otherwise accessible to the person; contains all the necessary requirements; is signed by the person and/or their representative if applicable; and there is a process to ensure that these rights are reviewed at least annually with the person and more often if needed. It is recommended that the annual review coincide with the review of the person's ISP and/or Habilitation Plan.

Please note that the right to have protections and appeals comparable to tenancy rights cannot be modified for any reason.

- **Access to Food, Meal(s), and Storage of Food** [12]
  - Individuals shall have access to food, meal(s), and storage of food (e.g., individuals may purchase and store their own snacks or special food and keep food for themselves; kitchens, refrigerators, and pantries are not locked or **if any safety measures need to be implemented for the needs of a particular individual, the other residents have a means of ready access**).

  - Individuals shall have input on food options provided (e.g., choices are offered for meals and/or in menus).

  - Although mealtimes may occur at routine times as is the case in most households, an individual may choose to eat at a different time or may choose to eat their meals alone in another room if desired (with needed dining safeguards in accordance with the person's Plan).

- **Access to Areas of the Home**:[13]
  - Individuals shall have free access to common areas of their home such as kitchens, laundry rooms, cabinets, closets and other rooms of the house. Such rooms shall not have posted hours of operation and shall not be locked. **If any safety considerations need to be implemented for a particular individual, the other residents should have a means of ready access.** Rules may not be posted unless the individuals residing in the home agree to a schedule that enables equal access for everyone. One exception with regard to universally free access may be the need for safe storage of household cleaning or maintenance materials.

- **Right to have Visitors and Freedom of Association**[14]:
  - Individual freedom to associate with whomever someone wants must be supported. Individuals shall be given the ability to choose and direct with whom he/she interacts

[10] Adapted from CMS Exploratory Question #7 (3 bullets below), page 6
[11] ibid
[12] Federal Register /Vol. 79, No. 11 /Thursday, January 16, 2014 /Rules and Regulations. 2965, 2966,
[13] ibid
[14] ibid

and when. Individuals may have visitors of their choice at any time without approval by the residence administrator, and individuals have the right to privacy with their visitor(s). Visitation should be done in a way that respects the rights, preferences, and safety of the person and other individuals in the home.

- In addition, staff conduct shall reflect and demonstrate that the home is the individual's home, not the staff's home. This means that visitors to the home are for the benefit of the residents of the home, not the staff.

- A residence may require visitors to sign in and/or notify the residence administrator that they are in the home or other such policies/procedures to ensure the safety and welfare of residents and staff as long as such policies and procedures do not unnecessarily restrict visitors for the convenience of staff and/or undermine freedom of association.

- Individuals may have access to the internet and telephone at any time and may choose to have private telephone numbers in their rooms and/or private cell phones (laptops, computers, or other communication devices) for use at any time at their own expense.

- **Choice of Living Arrangement/Roommate[15]:**
As part of the person-centered planning ISP process, individuals have the right to choose where they live from among setting options including settings that are not disability-specific and the option for a private unit in a residential setting. These choices are based upon the individual's needs, preferences, and, for residential settings, resources available to the person for room and board. [16]

  - Residential providers are expected to have a mechanism to assess satisfaction/dissatisfaction with living arrangement and provide individuals with a confidential opportunity to discuss issues or concerns regarding their roommates.

  - Revisiting choice of living arrangement with residents periodically is also expected as with all of us, preferences may change.

  - Residential providers/staff are also expected to provide people with opportunities to work with the provider/residence to achieve the closest optimal roommate situation.

  Sometimes, coaching and assistance in problem resolution and compromise and teaching people how to communicate during a conflict is what is needed to help support people to get along with each other in their home. However, if these efforts are not effective and/or the person does not want to engage in problem resolution, the agency must have a process that supports the person to move to another room or residence if the person chooses to do so. Individuals who are unhappy with their living arrangement and/or have issues with their roommates/housemates and do not want to live with them/there anymore shall receive timely support and assistance from the provider/residential staff in coming up with alternative options. The provider should have a process that supports the person to move

[15] ibid
[16] ibid

to another room or residence if the person chooses to do so. The residential provider's assistance could also take the form of assisting the person to connect with their service coordinator, family members, and circle of support to explore potential opportunities such as: a single room through one's own apartment/self-directed supports; shared living opportunities with other people the person chooses to live with; certified or non-certified supportive housing opportunities; Family Care homes; other certified residential settings; etc..

It is important that all providers/staff and circles of support members listen to the person in terms of where they would like to live and who they would like to live with and make every effort to support the person to help make these choices a reality. In practice, this means considering the choices of people moving into a new home as well as the choices of people currently living in a home and any risk management needs.

- **Right to Personal Space and Privacy[17]:**
  - **Privacy:** Individuals shall have the ability to lock their rooms for personal privacy and to control access from unwanted external entry. The locking mechanisms will allow for the entry of support or help in an emergency. Appropriate staff members may have a key with the agreement of the individual.[18]

    Individuals may keep their own key and may lock the door to their private space. Individuals may have keys to the house they live in.

  - **Personal Items and Decorations**: Individuals are encouraged and supported to decorate and keep personal items in their rooms (decorations must conform to the lease/written occupancy agreement as well as building/fire safety codes and licensure requirements/rules in certified settings and must not violate the law).

C. *Modifications of these Rights or Conditions*

In some cases, the needs of a person may dictate that he or she cannot safely access these rights or that certain modifications to these rights may be needed or required. Careful consideration is required for modifying an individual's rights and must be an integral part of an ongoing person-centered planning process. The OPWDD Strengths and Risks Inventory Tool is a helpful guide to use in the person-centered planning process when exploring the person's informed choices and positive safeguarding approaches. This person-centered planning process also includes the involvement of a circle of family and friends who the person and their advocates trust and choose, and may include input from other sources in the community.

The rights modification process should ensure a person's right to live safely with the supports they choose and should foster his/her independence and responsibility. Rights should not be modified outside of the person-centered planning process or without the informed consent of the person or authorized surrogate. The only exception to this is if there is an emergency situation in which the person places themselves or others around them in immediate jeopardy (i.e., there is an immediate, serious, and credible threat) in accordance with 633.16 (2)). In this case, the provider/staff will

[17] ibid
[18] Federal Register Vol. 79, No. 11 /Thursday, January 16, 2014 /Rules and Regulations 2964. First column

take immediate and appropriate action necessary to address the crisis situation. Once the immediate crisis is over, the provider/staff is expected to reassess the person's preferences and needs using a person-centered planning process and to update the person's habilitation/service plan accordingly[19].

This ADM recognizes that there may be times when an approved rights modification for one person affects the lives of other people living in the home. In such a circumstance, providers must make every effort to avoid limiting the rights of others in the home; and if all else fails to mitigate the impact of the rights modification on others. Providers should facilitate conversations and seek input from the people a rights modification may impact. If it is determined that an individual's rights are modified due to the needs of another peer living in the home, then this must be discussed with individual(s) affected by the rights modification, or their authorized surrogate and documented in the site specific Plan of Protective Oversight (POP) required by 686.16 (a). During the person centered planning process, the impact of the modification and the efforts or means used by the provider to reduce or lessen the impact on the person who does not require the rights modification, should be discussed and documented in each affected person's Plan (i.e., ISP or Habilitation Plan). The person's Plan must be signed indicating their consent, or that of their authorized surrogate, to the modifications in the home. The site specific POP shall describe the rights modifications in the home and any methods and accommodations needed to minimize the impact on others in the home; and be reviewed and approved by the agency Human Rights Committee or other specially-constituted committee charged with reviewing and approving rights modifications.

Providers shall disclose any rights modifications that may affect a person who is considering moving into the home by disclosing the site specific POP. This disclosure must include the specific rights modifications necessary including a description of the modification in the home, the impact on all residents in the home, and how the home will honor the residents' rights related to access (e.g., all access to food in this home must be locked including refrigerator, pantry, cabinets, and food maintained by individual residents. Residents may choose to have a key to these locked areas and/or request access from staff at any time depending upon each resident's individualized preferences and functional needs assessment).

Any modification of the rights or conditions outlined in this ADM must be supported by a specific assessed need or legal requirement, and must be justified in the person-centered service plan (or a required attachment, e.g., Behavior Support Plan, IPOP, Habilitation Plan) as follows:

1. Identification of the specific and individualized assessed need or legal requirement;
2. Documentation of the positive interventions and supports used prior to any modifications;
3. Documentation of the less intrusive methods of meeting the need that have been tried but did not work;
4. A clear description of the condition that is directly proportional to the specific assessed need;
5. Inclusion of regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Inclusion of established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

[19] Federal Register /Vol. 79, No. 11 /Thursday, January 16, 2014 /Rules and Regulations , 2961, first column

7. Inclusion of the informed consent of the individual; and,
8. Inclusion of an assurance that interventions and supports will cause no harm to the individual

Special exception for #2 and # 3 above: The ADM recognizes that, at times, an individual's behavior that may result from a disability or disorder documented in a clinical assessment poses an immediate jeopardy to the person or others. In these instances, attempts to try proactive interventions or less intrusive methods in place of a rights modification would likely result in serious harm, injury, or potential death to the person or others. Under these circumstances, the agency must provide a clear written justification, supported by clinical documentation, for omitting these important steps (e.g., a person has an observed, documented history of choking when eating solid foods. Appropriate clinical assessments have recommended a modified diet. A capacity assessment determined that the person does not understand the risks involved if he/she continues to eat solid food. The person must be on a modified consistency diet (e.g., ground; pureed; etc.) in this case, and trying less intrusive alternatives to prevent ingestion of solid foods would likely cause serious health problems or death.)

IMPLEMENTATION ACTIONS EXPECTED OF RESIDENTIAL PROVIDERS AND STAFF

Providers are expected to use this ADM and OPWDD's HCBS Setting Assessment Tools and CMS guidance and CMS Exploratory Questions to actively plan and develop proactive approaches to working towards and maintaining full compliance with the HCBS Settings federal requirements. The information outlined below is actions/activities and/or additional quality principles and standards recommended for provider action plans.

1. **Governance**: The Board of Directors of each organization shall have appropriate oversight of the organization's commitment to these standards and the organization's continuous quality improvement plans and strategies involving these principles.
2. All organizational policies and procedures, training materials, and other applicable documents should be consistent with the HCBS Setting standards. Ensure that the organization implements policies, procedures, and practices that clearly define its commitment to the promotion and protection of individual rights. Policies, procedures and practices should be reviewed and amended if there are any blanket rules/restrictions/practices that limit individual choice, autonomy, and/or any of the rights or conditions outlined in the HCBS Settings federal regulations and this ADM.
3. Organizational self-assessment practices and strategies that review the demonstration of these quality standards in day to day operations should be undertaken for continuous quality improvement.
4. Agency training, orientation, and other applicable and ongoing communication, training, and learning mechanisms should be reflective of these expectations. This includes teaching and encouraging respect for each person supported as a unique individual with preferences, interests, rights, dignity, and self-determined goals. Providers should teach listening, learning and responding in ways that honor individuals and increase individual control; teach how to honor individual rights, dignity, and self-determination and how to support individuals to exercise control and choice in their own lives as well as compromise and conflict resolution. Agency staff should also receive training in cultural competence.
5. There should be active communication with stakeholders including staff and individuals served on these principles and solicitation of feedback from individuals served and their

advocates on how to do better through satisfaction surveys, focus groups, residence meetings, and other applicable forums.

6. Practices should be undertaken that make clear that the needs and preferences of people served determine the types of supports provided. Providers need to promote practices that enhance individual decision making (e.g., schedules, activities, staff hiring, training, supervising, evaluating, etc.), and in other areas where individual input and autonomy can be promoted and facilitated.
7. As direct support professionals are the foundation of the developmental disability service system and their day to day interactions with people with disabilities directly impact on the quality of life of every person served, providers/residential staff should ensure that the National Alliance of Direct Support Professionals (NADSP) Code of Ethics is fully embraced within the agency/residences) and that the provider is implementing the Direct Support Competencies in accordance with OPWDD's requirements (see Administrative Memorandum # 2014-03 and links:
http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies
http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/core_competencies/code-of-ethics).

REVIEW BY THE OPWDD DIVISION OF QUALITY IMPROVEMENT

The Division of Quality Improvement will be assessing OPWDD certified residential settings (IRAs and CRs) beginning November 1, 2014, through September 30, 2015, for the purpose of compiling baseline data to further develop OPWDD's Transition Plan to address system challenges. Family Care Homes are also expected to be assessed by OPWDD beginning in 2015.

In accordance with OPWDD's HCBS Settings preliminary Transition Plan, it is anticipated that these standards will become part of the OPWDD's certification/licensing requirements no earlier than October 2016 for certified residential settings and such standards will be promulgated in OPWDD's state regulations.

CHOKING PREVENTION & INTERVENTION UPDATE NOVEMBER 2015

Choking occurs when a person's airway becomes blocked by food or other objects, or when liquid enters the airway during swallowing. It is very important that people remain aware of choking hazards, know how to prevent choking and how to respond when a person appears to be choking.

CHOKING AWARENESS

Choking Indicators: Individuals may not be able to communicate that they are choking or have something stuck in their throat, esophagus or airway. Knowing the sounds and gestures that are typical for a person in distress will assist in recognizing that a person is in trouble. There may be only one sign of choking or there may be many visual or auditory signs including the following:

- Grabbing at the neck or throat
- Appearing distressed or panicked
- Waving the arms
- Gasping for air
- Gagging
- Displaying continuous, unusual or severe forceful coughing
- Skin, lips and nails turn red, then blue as oxygen levels drop
- Noisy breathing/wheezing can indicate a partially blocked airway that can become a fully blocked airway
- If a person is conscious and cannot cough, speak, or breathe, assume the airway is blocked
- If the individual is unconscious, assume the airway is blocked
- Person abruptly leaves the table and/or runs to another room (e.g., bathroom)

CHOKING INTERVENTION

If the airway appears blocked, immediately take action to unblock the airway. If alone, call 911, take object out of mouth only if you can see it and perform abdominal thrusts. If two or more persons can respond, one person should respond to the individual in distress while the second person calls 911.

CHOKING PREVENTION

Awareness of Choking Risks and Causes:

- Health issues that affect swallowing and gag reflexes (e.g., cerebral palsy and other neuromuscular disorders, neurological impairments, gastroesophageal reflux disease and the aging process)
- Eating or drinking too fast and/or not chewing food thoroughly
- Eating while talking, laughing or in unsettled or volatile environments
- Eating in a moving vehicle or while walking or moving around
- Food-seeking and taking behaviors (from others, from storage or from waste receptacles), and/or secretive eating
- Eating or drinking while under the effects of sedating medication or alcohol as certain medications such as anticonvulsants, psychotropic medications and sedatives can make swallowing difficult
- Failing to provide food/drink in the manner and consistency needed by an individual to prevent choking
- Failing to provide an individual with the supervision and support they require during non-meal and mealtime
- Failing to adhere to clear and correct instruction on food consistency or to maintain dining support and supervision in an individual's service plan and/or Individualized Plan of Protective Oversight

Certain foods such as meat (especially hot dogs), bread, popcorn and peanut butter are difficult to swallow and can increase the likelihood of a choking emergency, regardless of whether the person has been identified to be at risk. Certain foods due to their shape, size and the possible tendency to eat in one bite (e.g., grapes, large marshmallows, hard candy, baby carrots, tortilla/nacho chips) can increase the likelihood of choking. Even people with no identified special needs can benefit from reminders to eat slowly, chew well, and take 1-2 bites. Non-food objects such as coins, pen/marker caps, and balloons may lodge in airway and pose a risk especially for people who display pica and mouthing behaviors.

Identifying Needs

Assessment & Service Planning

- Individuals should be assessed by an appropriate professional to determine proper food and/or liquid consistencies. Service Plans are to document the determined consistencies per OPWDD's standardized food consistency language as follows:
  - Whole
  - Cut to size – 1 inch pieces, ½ inch pieces, ¼ inch pieces
  - Ground: rice size and moistened
  - Pureed: smooth and creamy, no lumps and not runny

- Standardized language for the thickening of liquids is to the consistency of:
  - Nectar
  - Honey
  - Pudding

- Individuals should be assessed to determine other strategies necessary to aid in safe eating. Strategies should be documented in their service plans. This may include:
  - Level and type of supervision and assistance to provide when the individual is eating
  - Strategies to guide the person in pace of eating or portioning of bites
  - Positioning for safe eating
  - Necessary equipment, whether adaptive or routine, to assist the person in safe eating, safe positioning while eating, etc.

Providing Preventive Strategies:

Delivery of Services/Safeguards, Training & Monitoring:

- Training should be provided to and implemented by direct support staff and staff's competency should be monitored through the following:
  - Preparing food according to each individual's service plan for dining utilizing OPWDD training materials such as the "STOP Choking Hazards" Cutting Board and Poster
  - Providing appropriate supervision and support to each individual according to their needs and service plan
  - OPWDD choking prevention curriculum

  - Attentiveness to environmental risks and elimination of objects that are triggers for pica related ingestion

- Best Practices include training staff members (and monitoring competency) in:
  - First aid and CPR
  - Providing a safe and calm dining atmosphere
  - Providing safe situations and locations for eating (e.g., avoid eating while agitated, laughing, yelling; not in moving vehicles or while walking, etc.)
  - Practicing appropriate response to choking scenarios (e.g., practice choking "drills")

For additional information on Choking Prevention, please visit:
www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/choking_prevention_training_resources