PURPOSE:
Implement and educate patient/caregiver on precautions that prevent aspiration.

CONSIDERATIONS:
1. Precautions should be taken with all patients who are unable to protect their airway to prevent the involuntary inhalation of foreign substances, such as gastric contents, oropharyngeal secretions, food or fluids, into the tracheobronchial passages.
2. Patients at particular risk for aspiration include those whose normal protective mechanisms are impaired.
3. Major risk factors include:
   a. Decreased level of consciousness (confusion, coma, sedation).
   b. Documented previous episode of aspiration.
   c. Neuromuscular disease and structural abnormalities of the aerodigestive tract.
   d. Depressed protective reflexes (cough or gag).
   e. Presence of an endotracheal tube.
   f. Persistently high gastric residual volumes.
   g. Vomiting.
   h. Need for prolonged supine position.
   i. Diagnosis of dysphagia.
4. Additional risk factors:
   a. Poor oral care.
   b. Malpositioned feeding tube.
   c. Presence of a large-bore naso-enteric tube.
   d. Non-continuous or intermittent tube feeding.
   e. Delayed gastric emptying.
   f. Oral surgery or trauma.
   g. Abdominal/thoracic surgery or trauma.
   h. Transport.
5. Potential outcomes from aspiration include: airway obstruction and asphyxiation, chemical pneumonia, bacterial pneumonia and/or death.

EQUIPMENT:
None

PROCEDURE:
1. Keep head of bed (HOB) elevated 30-45 degrees at all times unless medically contraindicated. If HOB cannot be raised, position patient in reverse Trendelenberg at 30-45 degrees unless medically contraindicated.
2. Perform mouth care every 4 hours and as needed. Avoid triggering the gag reflex when performing care activities, especially mouth care.
3. Monitor respiratory status and level of consciousness as follows when taking vital signs:
   a. Auscultate breath sounds. Vesicular (normal) breath sounds should be heard over the distal lung field.
   b. Observe respiratory efforts.
   c. Determine ability to effectively manage secretions.
4. Consult speech therapist for patients with dysphagia, as needed, and as ordered by healthcare provider.
5. Consult dietitian for diet evaluation, as needed (requires physician’s order).
6. If patient receiving enteral feedings, See Digestive - Gastrostomy or Jejunostomy Tube Feeding.
7. Monitor patient when eating/drinking:
   a. Instruct family or caregiver to do the same.
   b. Observe adequacy of swallowing.
   c. Follow speech pathology recommendations from swallow assessment and consult before feeding patients with dysphagia diagnosis or a tracheostomy and/or on a ventilator.
8. Maintain calm environment when the patient is eating or drinking.
9. If patient is unable to manage own oral secretions, nasopharyngeal suctioning may be indicated, consult with healthcare provider and refer to nasopharyngeal suctioning policy as needed.
10. Keep wire cutters at HOB of patient with wired jaws and instruct patient and caregiver in use.
11. Notify healthcare provider immediately for any signs or symptoms of aspiration such as tachypnea, cough, crackles, cyanosis, wheezing, fever or apnea as these will usually develop within two hours of the aspiration.

AFTER CARE:
1. Document in patient’s record:
   a. Maintenance of aspiration precautions.
   b. Respiratory rate, effort and quality.
   c. Patient’s response to eating/drinking and adequacy of swallowing.
   d. Instructions to patient/caregivers or family.

REFERENCES