Protocol For Managing Children with Airway Obstruction/Inhaled Foreign Body

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Worcestershire has three sites where emergencies can present

1. Worcestershire Royal hospital (WRH) which is staffed with 24 hour ENT, Paediatric and anaesthetic cover
2. Alexandra Hospital (AHR) which is staffed with 24 hour paediatric* and anaesthetic cover.
3. Kidderminster Hospital and Treatment Centre (KTC) which has a minor injuries unit and a nurse led minor injuries unit

*under review

Ambulance cases are not taken to KTC and are brought directly to WRH. It is theoretically possible for a member of the public to walk into KTC with an ill child but in practice this does not happen. Ill children are taken to AHR.

This protocol addresses the problem of a child presenting to any of the above sites

This guideline is for use by the following staff groups :

ENT Surgeons, General Surgeons, Anaesthetists

Lead Clinician(s)

Mr Martin Porter	Consultant ENT Surgeon
Dr Mike McCabe	Consultant Anaesthetist
Approved by ENT Directorate meeting on:	31st January 2019
Review Date: This is the most current document and should be used until a revised version is in place:	31st January 2021

Key amendments to this guideline

Date	Amendment	Approved by:
March 2014	New Document	
August 2016	Document extended for 1 2months as per TMC paper approved on 22nd July 2015	TMC
March 2017	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
January 2019	Document reviewed and approved with no changes	Martin Porter

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Details Of Guideline

Background

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Ambulance cases are not taken to KTC and are brought directly to WRH. It is theoretically possible for a member of the public to walk into KTC with an ill child but in practice this does not happen. Ill children are taken to AHR.

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Inhaled foreign body

If a child presents to KTC or AHR with a good history of a foreign body i.e. a report of

1. Choking
2. Cyanosis or
3. Witnessed inhalation

and the child is **stable** with no evidence of drooling/tachypnoea and has equal breath sounds then they should be transferred to WRH if **three years old or over**. If **under three years old**, then they should have a chest X-ray and be assessed by the A&E middle grade (or consultant) and a referral to Birmingham Children's Hospital (BCH) via the on call ENT registrar for BCH. The mode of transfer to be agreed between BCH and local staff.

If a child presents to WRH either directly or via another unit and they are stable and three years old then the on call paediatric and ENT doctor (bleep 866) should be called. The on call ENT middle grade should be contacted as appropriate. If it is agreed that an inhaled foreign body is probable the on call ENT consultant may suggest a bronchoscopy and removal of the foreign body at WRH. This should be performed

- by consultant Surgeon or under his direct supervision
- by consultant anaesthetist
- within 12 hours of reported inhalation.

If the child is **not stable** i.e. has any of the following

- Drooling
- Tachypnoea
- Abnormal breath sounds
- Respiratory distress
- Abnormal CXR

then A&E must call the ITU registrar on call (bleep 702 for WRH or via switchboard for AHR) and the paediatric registrar on call (bleep 653). If they diagnose a foreign body the on call ENT registrar is called.

If the child is **under** three years old then the KIDS (Kids Intensive Care and Decision Support) service will be called (0300 200 1100) and the consultant ENT and anaesthetist informed. The consultant ENT and anaesthetist will make themselves available in case the child deteriorates before the arrival of the retrieval team and an emergency procedure is unavoidable.

If the child is three years old or over the on call ENT consultant may elect to offer bronchoscopy and removal at either WRH or AHR. If the child is at AHR then the on call ENT will go via WRH theatres and personally bring with them the paediatric bronchoscopy and paediatric laryngoscopy trays to AHR.

Monitoring Tool

How will monitoring be carried out? Audit

Who will monitor compliance with the guideline? ENT Directorate

STANDARDS	%	CLINICAL EXCEPTIONS
Compliance with standards	100	Nil

Contribution List

Key individuals involved in developing the document

Name	Designation
Mr Martin Porter	Consultant ENT Surgeon
Dr Mike McCabe	Consultant Anaesthetist

Circulated to the following individuals for comments

Name	Designation
All ENT consultants	
Patti Paine	Divisional Director of Nursing & Midwifery
David Whitelock	Anaesthetic Consultant – Clinical Governance Group
Tim Smith	Consultant Anaesthetist A.H
Dana Picken	Matron - Paediatrics
Aiden Norman	Consultant Anaesthetist W.R.H
Chris Hetherington	Consultant A&E
Beth Williams	Consultant A&E

Circulated to the following CDs/Heads of department for comments from their directorates / departments

Name	Directorate / Department
Mr Graham James	Divisional Medical Director - Surgery
Dr Karen Kerr	Clinical Director - Anaesthesia
Dr Andrew Short	Divisional Medical Director – Women & Children Division

Circulated to the chair of the following committees / groups for comments

Name	Committee / group
Dana Picken	Paediatric Surgery and Care of Critically Ill Child Group
Dr Andrew Gallagher	Paediatric Clinical Governance Group

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	NO	
	• Race	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Nationality	NO	
	• Gender	NO	
	• Transgender	NO	
	• Religion or belief	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
	• Disability - learning disabilities, physical disability, sensory impairment & mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	NO	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	N/A	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	NO
2.	Does the implementation of this document require additional revenue	NO
3.	Does the implementation of this document require additional manpower	NO
4.	Does the implementation of this document release any manpower costs through a change in practice	NO
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	NO
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval