Shared learning

Theme of the week

Patient on modified diet administered whole tablets

Date

04/11/2024

Background and context

The patient has a level 6 (soft and bite size) diet consistency in place for her safety. The patient is for PO medications, and is prescribed three medications in tablet form. Prescribed medications should be prepared and administered in accordance the medications license and the patient's meal mat.

What happened?

It transpired that the patient was given their medications as whole tablets for a period of approximately ten days. Whilst the patient was able to manage this safely and no harm came to the patient, registered nurses did not modify the administration in accordance to the patient's oral intake consistency.

The patient's MAR chart did not provide a point of reference of how the medications should be prepared in line with the patient's oral intake consistency.

What should have happened?

When the patient successfully transitioned to PO medications proactively, the medication chart (MAR) should have reflected the correct preparation for each prescribed medication. This will demonstrate robust interdisciplinary working between nursing, medical and pharmacy.

What we will do differently next time

Registered nurses and ward medical team will liaise with RHN pharmacy, to ensure that medications are prepared in accordance to their license whilst ensuring safe administration to the patient to ensure that a clear point of reference is in place for the registered nurses. RHN pharmacy will recommend suitable alternative prescriptions when current medications are not appropriate for required modification.

What have we learned?

The importance of interdisciplinary working among a patient's treating teams to ensure that all aspects of their medical and nursing care is provided safely and in accordance to their personalised gudelines.

☑ I have read this

Name	Job role	Signature