IMPLEMENTATION OF COMMUNICATION STRATEGIES TO ENSURE SAFE MEDICATION SWALLOWING IN PATIENTS WITH DYSPHAGIA

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INTRODUCTION

Inappropriate oral medication administration to patients with dysphagia occurred on one unit in a complex continuing care facility, resulting in undesirable outcomes such as:

- Choking, crushing of sustained release medications
- Administration of medication in ways that were incompatible with the patient’s swallowing ability

Problems were attributed to miscommunication among the speech-language pathologist (SLP), nurse, pharmacist and MD. Communication strategies were implemented to reduce the frequency of disparities in oral medication administration to patients with dysphagia and improve patient safety.

OBJECTIVES

1. Identify the type and frequency of discrepancies involving oral medication administration in patients with dysphagia.
2. Determine if the diet texture order predicted that medications would be modified by the nurse before administration.
3. Implement communication processes improvements to promote safe oral medication administration in dysphagia.

METHODS

- Chart audits & nurse interviews were conducted to determine the success of the education program.
- The education program was measured using chart audits & nurse interviews.
- Communication strategies were implemented to reduce the use of inappropriate methods of oral medication administration to patients with dysphagia and improve patient safety.

RESULTS

Communication Process Changes:

- SLP consult note to include recommendations for swallowing solid and liquid medications and about the size of medication the patient can swallow.
- SLP recommendations to be written on the Patient Care Orders sheet, using standard phrases and include “Copy to Pharmacy”.
- Nurse to update the in-use MAR with SLP recommendations.
- Nurse to seek medication swallowing preferences in all new dysphagic patients and notify Pharmacy.
- Pharmacist to identify appropriate dosage form or consult with the physician to change the dosage form based on SLP recommendations.
- Pharmacist to add SLP recommendations to the MAR “Comments” & create a Pharmacy computer system ‘alert’.

Knowledge Translation Outcomes on Trial Unit:

- Pre-test score average 60%
- Post-test average 80%
- Participant satisfaction average 4.5 on a scale of 5

HOSPITAL-WIDE SPREAD

- Commitment to follow process changes was obtained from all SLP staff and inpatient Pharmacy staff.
- SLP phrases were posted on Sunnynet.

CONCLUSIONS

- Dysphagia occurs commonly in elderly long-term care patients.
- The diet texture order in patients with dysphagia does not reliably predict the method of oral medication administration used by nurses.
- A structured communication process is necessary to ensure that patients with dysphagia receive medications in a form that is safe for them to swallow.
- The use of standard phrases written in the Patient Care Orders by the SLP is an effective way of notifying Pharmacy and Nursing on how to modify medications.
- Availability of SLP recommendations on the MAR helps to ensure that safe medication administration practices for patients with dysphagia are followed.
- Effective interprofessional communication ensures that the most appropriate dosage form is dispensed by Pharmacy and is modified according to swallowing ability.

Table 1 – Medication Administration Orders for Solid and Liquid Dosage Forms in Dysphagia

<table>
<thead>
<tr>
<th>Standard Phrases for Solids</th>
<th>Typical Diet Order</th>
<th>Interpretation of Standard Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crush tablets/iod.ap capsules and mix into a small amount of pureed food</td>
<td>&quot;Pureed&quot;</td>
<td>Requires a uniform smooth texture (no lumps, no hard bits)</td>
</tr>
<tr>
<td>Crush tablets/iod.ap capsules and mix into a small amount of pureed food</td>
<td>&quot;Mashed&quot;</td>
<td>Can tolerate some variation in pureed texture</td>
</tr>
<tr>
<td>All tablets/capsules either whole in pureed food</td>
<td>&quot;No robbed consistencies&quot;</td>
<td>Can swallow tablets/capsules with water</td>
</tr>
<tr>
<td>All tablets/capsules at a time</td>
<td>&quot;Chopped&quot;</td>
<td>Can swallow tablets/capsules with water</td>
</tr>
<tr>
<td>Half large tablets</td>
<td>&quot;Chopped&quot;</td>
<td>Can swallow tablets/capsules with water</td>
</tr>
<tr>
<td>All tablets/capsules one at a time</td>
<td>&quot;Regular&quot;</td>
<td>Can swallow tablets/capsules with water</td>
</tr>
</tbody>
</table>

Table 2 – Acute Dysphagia

<table>
<thead>
<tr>
<th>Standard Phrases for Liquids</th>
<th>Typical Diet Order</th>
<th>Interpretation of Standard Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No liquid medication</td>
<td>&quot;Clear fluids&quot;</td>
<td>Requires very thick liquids</td>
</tr>
<tr>
<td>No solid food</td>
<td>&quot;Pureed&quot;</td>
<td>Requires very thick liquids</td>
</tr>
<tr>
<td>No solid food</td>
<td>&quot;Mashed&quot;</td>
<td>Requires very thick liquids</td>
</tr>
<tr>
<td>Medication allowed</td>
<td>&quot;Clear fluids&quot;</td>
<td>All liquids except those with alcohol</td>
</tr>
<tr>
<td>Medication allowed</td>
<td>&quot;Pureed&quot;</td>
<td>All liquids except those with alcohol</td>
</tr>
<tr>
<td>Medication must be in liquid form</td>
<td>&quot;NPO&quot;</td>
<td>No medication or food except water</td>
</tr>
</tbody>
</table>

Table 3 – Feeding Tube

<table>
<thead>
<tr>
<th>Standard Phrases for Feeding Tube</th>
<th>Typical Diet Order</th>
<th>Interpretation of Standard Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPO</td>
<td>&quot;Clear fluids&quot;</td>
<td>Requires very thick liquids</td>
</tr>
<tr>
<td>&quot;NPO&quot;</td>
<td>&quot;Clear fluids&quot;</td>
<td>Requires very thick liquids</td>
</tr>
</tbody>
</table>

Figure 1.1 – Chart Audit & Nursing Interviews

Figure 1.2 – Algorithm for Administration of Oral Medication

ACKNOWLEDGEMENTS

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