# Acute Training Solutions

## Care of Medicine - Case studies

**Read each case study and discuss, in small groups, the processes that should have been in place to prevent the situation happening. Secondly, discuss and decide what actions should be taken against the person or people who contributed to the tragic events happening.**

**Case study 1**

Colin Whalley died three days after being admitted to Whiston Hospital with an exacerbation of his chronic obstructive pulmonary disease (COPD), a condition which commonly causes breathing difficulties.

Nurse Mary Sanchez admitted she failed to administer aminophylline, a drug used to open constricted airways, "in line with the prescription" when she treated the 68-year-old at the hospital in Merseyside.

The patient was due to be given two doses of the drug, one undiluted over a period of 20 minutes and another diluted over a period of 24 hours.

The second dose was incorrectly administered undiluted in just over an hour.

**Case study 2**

Douglas Lamond, 86, who was registered blind, received his weekly medicines in pill boxes assembled at his local 'Boots' branch, with tablets placed in separate plastic compartments to take on different days.

He received many different medications for complaints including heart problems and type 2 diabetes.

In March last year, Suffolk Coroner's Court heard how a dispensing error was made on a day when the pharmacy was "very busy", and the responsible pharmacist did not notice this when completing checks.

Dispenser Susan Hazelwood said Mr Lamond's prescription changed and he required extra pills - and in slitting open a box she thought was for him, she added the pills and re-sealed the box - something that was against standard procedures.

But she had accidentally picked up a completed box for another patient with a similar surname, Antony Lampard, which was two shelves above the boxes for Mr Lamond.

Mr Lamond died two days after the pills were delivered to him.

He was wrongly dispensed the anti-diabetic drug gliclazide, which is used to lower blood sugar levels, and he did not receive his usual prescription of bisoprolol, a beta-blocker used to treat high blood pressure.

**Case study 3**

A care home decided to change the pharmacy that supplied its medicines. The new community pharmacist ordered medicines on behalf of the care home. He sent a letter to the GP Practice explaining the change in pharmacy arrangements along with a request for the monthly prescriptions for residents.

The medicines requested for Mr Brown were correctly issued by the practice using his computerised record. However, at this point, a mistake was made and three additional items from Mr Green's records were accidentally added to Mr Brown's medication record.

The prescriptions were sent to the community pharmacist who did not realise that extra items had been added. Both the pharmacy Patient Medication Record (PMR) and the Medicines Administration Record (MAR) were updated and the medication was dispensed into the monitored dose system (MDS).

The care home staff did not check or query the additional items for Mr Brown. The additional medicines were administered to Mr Brown. When the medicines for Mr Brown were reordered, the extra items were prescribed again because they were now listed in the computerised records at the surgery.

After two months Mr Brown became ill in the care home. The GP was called and he noticed that the medicines list contained medicines for a disease that Mr Brown did not have. Mr Brown was transferred to hospital, where he contracted an infection. After three months in hospital he died.