CASE STUDY: A DAY IN ADMINISTERING MEDICATION

Lisa was in her seventh month of caring for Mr Davis after joining her first Agency, and was comfortable in her daily routine of bathing, preparing meals and doing light chores around the house. She had formed a good relationship with Mr Davis, an 87-year-old man living on his own after the recent passing of his wife. Lisa was disheartened to see him slowly deteriorate and found she was helping with his mobility more and more. Up until 2 months ago, Mr Davis had never had any trouble administering his own medication, which consisted of 4 separate prescriptions, mainly for his heart and arthritis. These were taken at separate times during the day and at night. But as he had become more frail and less able to focus, Lisa had been given the task of assisting with the administering of his medications. This had happened over time and without the knowledge of her Agency. Lisa had never administered medications before and took Mr Davis's instruction on dosages and timings, not taking into consideration the instruction leaflets provided by the pharmacist who had prescribed them.

Mr Davis was a spritely old man, who loved reading. He mostly sat in the lounge or out in the garden when the weather permitted, but as his arthritis had begun increasing, he soon started spending more and more time in bed. One afternoon while Lisa was out buying groceries, Mr Davis had wandered from his room into the lounge, and had accidently lost his balance navigating his way from the corridor, down the three connecting stairs into the lounge. With a sudden twist and hard thump he found himself on the floor unable to move. Lisa on her return was suddenly faced with the shock of Mr Davis still lying in the same position, and unable to lift him herself, called for an ambulance. The unfortunate fall had shattered part of his hip and he was promptly scheduled for a hip replacement that same evening.

Lisa returned to Mr Davis's home and over the course of the few days he was in hospital recovering, went about preparing for his return. The following week, she went to the hospital to fetch Mr Davis. While there she had a brief consultation with the case manager, who gave Lisa instructions on the various medications that needed to be administered over the next few months. Lisa, having little to no training on the matter of medication administration, simply listened, took the prescriptions, and collected them from the hospital pharmacy.

That evening it dawned on her the severity of poor Mr Davis's condition and noted how much more energy and considerable responsibility the task of caring for Mr Davis had become. She was tired and feeling drained, as she lined up the medications for that evening, noting the 4 regular doses had now become 9, continued confidently administering what she believed to be the correct course.

A week had passed and Lisa had noticed a tremendous deflation in Mr Davis's energy levels, not only that, Mr Davis's sister Rita, his last remaining close relative had also noticed how severe his lethargy had become. As the weeks went by Rita became more and more concerned and started getting the distinct assumption he was not receiving the correct medications or that in the worst case scenario, Lisa was over administering. Having approached Lisa about the matter Rita could not understand why her brother was not recovering normally. Rita soon realized she had to do

something about the matter and phoned the hospital to ask for urgent assistance, when she was notified by Nurse Shelley that Mr Davis sounded like he was having an adverse reaction to his medications Rita phoned the Agency to have Lisa removed from her position.

As an Agency manager, how could this situation have been avoided and how would you go about ensuring resolution in the given circumstances and what appropriate measures would you take to address this situation with the client and/or family and also what measures would you take regarding the caregiver?