Covert medication case study

Case study 1

A very well presented, 77 year old lady of German origin in residential care had a diagnosis of epilepsy and was awaiting an appointment with the memory service. Her mental state had deteriorated to the extent that she apparently no longer had an understanding of her condition. She liked to have as much independence as possible and liked to go out for walks with a carer or her daughter. She began to frequently refuse all of her medication claiming that she did not want to take drugs and her health was fine if she had a good diet. She enjoyed her food and particularly going out for lunch with her daughter. Her fits became more and more frequent and her falls more dangerous and it became impossible for her to leave the home safely. The home was frequently calling ambulances although she was not often admitted to hospital. Her daughter was becoming distressed and asked if anything could be done.

Her medication was:

- Amlodipine 10mg daily
- Simvastatin 40mg at night
- Paracetamol 500mg tablets 2 four times a day prn
- Epilim e/c tablets 200mg 3 twice daily

Further information:

- Her current BP was 140/85, weight 77kg, BMI 22.
- She has had no history of stroke or TIA.
- She has no official diagnosis of dementia.
- The paracetamol was prescribed for intermittent joint pains.

Detail the actions required to support this patient.

Actual actions taken

Step 1

Mental capacity assessment to assess her understanding of her co-morbidities necessary.

Step 1 of the MCA requires confirmation that a person is unable to make a decision because of an impairment of or disturbance in the functions of the mind or brain.

For this lady there was nothing to suggest that her epilepsy had any effects on her ability to make decisions but a dementia diagnosis was needed to confirm her sudden refusal of medication.

The second step of the MCA assessment could then proceed.

Multi-disciplinary assessment (MDT): GP, MCA lead, care homes pharmacist and daughter were present at the assessment with the lady.

She fully understood English and the discussion determined that she had no comprehension of her epilepsy and denied that she had fits, which caused her to fall. She believed that eating well kept her well and that medicines were poisons. She denied having raised blood pressure.

It was determined that she did not have capacity to understand the consequences of not taking her medicines and a best interest decision was the next step to take.

Step 2

The best interest decision needed to explore every option before covert administration could be considered.

The GP tried alternative formulations of Epilim including liquid, crushable and capsules overtly – they were refused at all times of day when given by different carers using gentle persuasion.

The use of simvastatin for primary prevention was discussed with the daughter and after risk benefit assessment it was stopped.

Her BP history was checked. She had been refusing her amlodipine for several weeks and her current BP of 140/85 was considered to make the stopping of amlodipine justifiable.

Pain management presented more problems but it was felt that the care home staff could assess her level of pain using the Abbey Pain scale.

Covert administration was agreed at a further MDT meeting.

Reasons documented

Epilim – high risk that frequent fits would potentially result in a fall and a fracture which would severely compromise her quality of life with her daughter and the care home.

Paracetamol- not appropriate for her to suffer pain because she did not comprehend that taking the paracetamol would stop her pain. Disguising

the liquid 250mg/5ml was agreed but if this was refused it would be reconsidered. It was also agreed that the pain would be monitored to review if the paracetamol was sufficient – step up to codeine or Butrans patch.

Step 3

The pharmacist advised that the crushable Epilim tablets 100mg could be crushed and sprinkled in her morning cereal and her desert at teatime. This was in preference to the liquid for which taste is more difficult to disguise. This was also checked with the manufacturer but the crushable tablet formulation is designed to be crushed.

The paracetamol liquid was to be added to her favourite fresh orange juice.

Step 4

All processes to be followed were recorded in her care plan and a note supplied to kitchen staff so that they were aware and could provide **appropriately flavoured food to help mask any taste.**

Step 5

Practical issues:

- One difficulty is in the quantity of tablets of Epilim needed (6 each dose). This could taint the flavour of her food and must be monitored.
- Care staff are very reluctant to give medication covertly and they needed to be involved and supported to explain why this was being done.

Step 6

It was agreed that the lady would be carefully monitored recording when she didn't eat or drink well especially important in view of her love of food.

Her frequency of fits must also be recorded so that a correlation could be seen between her refusal of a meal with the covert Epilim and her fits. This would be evidence of the continued need.

Review was necessary weekly at first reducing to monthly and 3 monthly.

Outcome

This lady was successfully maintained with covert Epilim and a Butrans 5mcg patch and retained a good quality of life for almost 5 years until she suffered a fall (not due to a fit) and fractured her neck of femur. She deteriorated rapidly in hospital as she did not cope with the change of environment and died 6 months later.