Case Study
Mr Wilson

Mr Wilson's medication had been changed from Madopar to Co- Bendaloper. The last dose of Madopar should have been on the night of 14 August.

The Co- Bendaloper should have commenced on the morning of 15 August. However, the Madopar had not been stopped on the Medicines Administration Record (MAR) or removed from the medicines trolley. The Team Leader administering medication that morning gave both Madopar and Co-Bendaloper and did so again at lunchtime.

On carrying out the medication audit after lunch this error was noted.

The GP was contacted, and the GP stated that Mr Wilson should be fine as both medicines are short acting and any complications would have arisen already. The advice was to monitor and continue with the Co-Bendaloper dose for the rest of the day and to contact the GP again if there were any concerns.

The Local Authority receiving the referral of this concern telephoned the Care Home Deputy Manager who advised that this error had been an oversight and due to the error, she is in the process of carrying out a random audit to check that no further errors have been noted. At this stage none has been found. The error that occurred was in regard to a change in Mr Wilson's medication for Parkinson's Disease. The error led to him being given his old medication as well as his new medication.

The Home had immediately contacted the GP who advised on the consequences (as above) and that it was alright to continue the medication as prescribed going forward. Mr Wilson was asked how he felt; he said he felt no different and that his capabilities with his mobility/ balance had not been impacted. Mr Wilson agreed that a Safeguarding Concern could be raised but didn't want any fuss.

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