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| **Title** | |
| **Buetow S, Henshaw J, Bryant L, O'Sullivan D.** Medication Timing Errors for Parkinson's Disease: Perspectives Held by Caregivers and People with Parkinson’s in New Zealand. Parkinson’s Disease. 2010;2010:432983 | |
| **Agreement** | **69/699** |
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| ***Abrupt Withdrawal of PD Medication:***Medication for PD is not given on time when it is stopped deliberately and abruptly. P12 described how the benign hallucinations of her husband with PD worsened in hospital. She attributed this sudden change to the morphine administered for his two broken hips. However, the hospital was said to have ascribed the exacerbation to his amantadine and *“made him go cold turkey*.” (*QCarer)* Amantadine was reinstated, states P12, only when she reminded staff that the abrupt withdrawal of amantadine could aggravate PD and its mental manifestations. Other participants, such as P11, spoke of medication *“omissions for several days”* in hospital, even though it is *“imperative that none of the Parkinson’s medications be halted.”QPwP*  ***Instructions Wrong, Vague or Misread.***  P16 stated that for two years her community pharmacy, despite *“a lot of the staff changing all the time,” (QPwP)* had dispensed two PD medications (sinemet and entacapone) to her with the labelled instruction: “Take six tablets once daily as directed.” Recognising this instruction as a dangerous mistake, she reported instead taking one tablet of each medicine every three hours.  Other wrong instructions were said to have been given in non-neurological, hospital wards through the mischarting of dosing frequencies. According to P20 *(Carer),* herself a practice nurse, this error led to her father with PD receiving doses at wrong times over two days. P12 also described how “*the charting would change (for her husband with PD) . . . they would have 8.00, 8.30 . . . and I would say, “He is supposed to get his pergolide on a full stomach.” “Oh, no, no, it’s charted for . . .”. Qcarer*  Other times, information was not wrong but misread: *“She (the House Surgeon) went back and said, “The nurse has not read it (the chart). It is 1300 hours, not 3.00 at all”” (P12) Qcarer.*  P4 similarly indicated that hospital staff “just glanced down” at her partner’s chart, getting “in the routine of giving him one without checking it thoroughly.” She reported that the neurologist had assured her that the chart was correct, and that “human error” accounted for her daily observation that the sinemet dosage was short and given *“late, anything up to three-quarters of an hour.”Qcarer*  In community settings, however, the problem was sometimes the vagueness of dispensing instructions. P19 *(Qcarer)* reported how her family had misunderstood instructions to take a medication “four times a day.” They had thought this indicated a need “to time the (Pd) medicine to four tablets over 24 hours” even though this led to “big lows and big highs” and interrupted their sleep for several months. On the basis of the advice of the prescriber, the Parkinson’s Society field officer explained to the family that “you need to give them during the daytime.”  ***Lack of Both Professional Knowledge and Caring Behaviour****.* Participants suggested that staff *“do not always understand the way the (PD) medications work” (P6) QPwP* and“*were not aware, I think, of the need for Parkinson people to have their medication at a given time” (P9) QPwP;* they *“regard the times as a suggestion . . . an indication of when you might get them” (P12) Qcarer.* P6 acknowledged that she was like them untilshe developed PD: “*I nursed a lot of them in the rest homes and hospitals that I have worked in and I was not aware really of the importance.”QPwP*  **Lay Forgetfulness**.  Timing errors were commonly also ascribed to lay error, through people with PD, and their caregivers: forgetting to administer the PD medication on time, for example because *“I am busy doing something” (P8) QPwP* ; forgetting to use what reminds them (e.g., the timer) when to take their medication; and forgetting *“whether I have taken it or not” (P3) QPwP.* These memory errors were reported to take place only occasionally.  Consequences included taking late or extra doses of sinemet to manage motor fluctuations (and then adjusting the timing of the remaining doses) but tending to miss the forgotten doses of other, less potent antiparkinson medications: “*I often do forget the ropinirole and that is not such an issue . . . I just skip that dose” (P5) QPwP* and *“I would suddenly think, “Oh, I forgot the amantadine and the pergolide and it is now 3.30 p.m.; there is no point in having it””* (P12) *QCarer.* | |