SAFETY OF PEOPLE WITH INTELLECTUAL DISABILITIES IN GENERAL HOSPITALS.
HOW THE PHARMACIST CAN HELP REDUCE INEQUALITIES

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People with intellectual disabilities are vulnerable in healthcare environments. They experience health and healthcare inequalities. They have a different health profile from the general population and their needs are often unrecognised and unmet. People with intellectual who are admitted to general hospitals are at a greater risk of patient safety incidents. Pharmacists working in general hospitals are ideally placed to increase awareness of the many patient safety issues in this vulnerable group.

Wider socio-economic determinants of poor health outcomes for people with intellectual disabilities

Health inequalities are differences, variations and disparities in health status and/or in the distribution of health determinants between different population groups. To make progress in tackling health and healthcare inequalities pharmacists and others will require an understanding of the specific needs in order to address them. Fatal Accident inquiries in Scotland have highlighted the significant barriers and risks many people with intellectual disabilities face when using general hospital services.

WHAT THE PHARMACIST IN A GENERAL HOSPITAL CAN DO?

1. All pharmacy staff should be aware of specific vulnerabilities of people with intellectual disabilities
   - difficulties communicating and expressing needs and choices
   - difficulty understanding their diagnosis, treatment options
   - difficulty understanding the consequences their decisions can have on their health status
   - difficulties in adapting to a hospital environment and the expectations of hospital staff

2. Flanking of ‘intellectual disability’ / vulnerability on pharmacy computer system and on pharmacy paper recording systems.

3. Consider ‘expert’ pharmacist with interest / expertise in care of people with intellectual disabilities. Clear lines of responsibility for care of people with intellectual disabilities and/or other vulnerabilities eg travellers, prisoners.

4. Full and accurate prescription of medication in inpatient Medication Prescribing Administration Recording system - MPARs
   - Eg Epilim chrono / Epilim chronosherose, Tagretol / Tagretol retard. This should include all ‘as required / pm’ medications

5. Clarify any confusion with prescribed epilepsy rescue medication eg presentations of buccal Midazolam with various strengths

6. Question ‘nil by mouth’ on patient’s bed / notes etc. Does this mean that medication is not being administered? Why?
   - Is the patient receiving hydration?
   - Is the patient being fed?

7. Alert nursing staff to importance of anti-epileptic and mood stabilising medications

8. Medication incident reports to include detail that patient had intellectual disability. ‘Just’ learning culture for incident notification.

9. Feeding, eating, drinking and swallowing -FEDS- difficulties flagged on pharmacy computer system, MPARs, medical notes etc

10. FEDS equipment, as advised by Speech & Language Therapists –SALT - available to ensure adequate hydration, nutrition, medication administration

11. Form change to medication should be safe and appropriate ie crushing tablets, opening capsules etc. - pharmacist consultation

12. Effective written communication / transmission of information with healthcare team ie SALT, dietician, prescribers etc

13. SALT recommendations for thickening of fluid, liquid medications followed. Be aware of thickener recommended.

14. Make ‘reasonable adjustments’ when communicating with a person with intellectual disabilities ie more time for consultation, do not use medical jargon, use ‘easy read’ information resources

15. Recognise carer – family / paid - as a valuable and essential source of information concerning medication / care and support for the person

16. Ensure person with intellectual disability, where possible, involved in any discussions about medication and that there is an awareness of their ability to give consent to medical treatment

17. Ensure changes in medication are communicated clearly to patient, carer and on written prescription leaving hospital. This should include medications discontinued, dosage changes, medications added etc. Use ‘Health Passport’ if available.

18. Complaints made by people with intellectual disabilities and/or their carers should have high priority

19. Advocate for employment of Intellectual Disability Liaison Nurse in hospital

20. Pain recognition may be difficult and pain management may be inadequate

21. Emergency admissions are at more risk than planned admissions

22. Ensure Do Not Attempt Cardiopulmonary Resuscitation orders correctly interpreted - administration medication, hydration, nutrition

Many of the causes of intellectual disabilities may also lead to physical or mental ill health. This means that people with intellectual disabilities may be more likely to be prescribed multiple medications due to complex and multiple health needs which, in turn, can sometimes adversely affect health through side effects and drug interactions.

MEDICATION:

There is no quick way to improve the quality of care for people with intellectual disabilities. Innovations in care by many healthcare professions including pharmacy will be required. Research is needed to determine the role of pharmacists in improving health outcomes and reducing health inequalities in this vulnerable population group when they are admitted to general hospitals.

References: