



Alice's Story

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University of Buffalo School of Medicine, Dept. of Family Medicine



Alice's Story





Who Was Alice?

- *Vital, energetic and independent woman,*
- *Mother*
- *Grandmother*
- *Friend*





She would rather die than ask a doctor or nurse if they had washed their hands.



Alice's Story – "there is little more painful than losing someone to preventable medical error".



"What's happening to me?"

Jul 12- Alice has pain & swelling in right leg. Alice drives her car for the last time.

Jul 13- Alice Admitted to Hospital. Tests indicate Gout.

Jul 17- Alice Discharged to Rehab due to difficulty ambulating.

Jul 28- Mary met with staff to plan discharge to home .

Jul 29- Mary notices Alice is hallucinating. Complaints of nausea & signs of malaise.

Jul 29- Mary finds that Alice has been on Flexiril, prescribed by hospital Doc and continued by Rehab Doc (*known to cause severe adverse drug effects in geriatric patients, including psychosis*). Neither hospital or rehab pharmacy intercepted this dangerous med. Per Mary's demand, Flexiril was stopped on this date.

Jul 30- Hallucinations continue with psychosis, noted as adverse drug effects of Flexiril. She feels that her life is in danger and acts out. No appetite or thirst.

Aug 3- Becomes incontinent, fearful with severely altered mental state. Admitted to Hospital for severe dehydration. MRSA detected.

Aug 6- Discharged from Hospital back to rehab . Severely disoriented & falls injuring back, hand and foot. Returned to Hospital ER for x-rays and returned to rehab.

Aug 9- Unable to eat, incontinent, severe abdominal & back pain. Mary asks if she has been tested for a UTI. Psychosis escalates during evening.

Aug 10- Mary told that UTI test "lit up like a Christmas tree" indicating serious UTI. Alice taken by ambulance to hospital. Alice weighs 132 lbs..

Aug 11- Alice again severely dehydrated & now has MRSA & UTI. Paranoia and psychosis continues.



Aug 13- Mary told Alice's medical issue was psychiatric & she should be discharged to Psych facility. Anti-psychotic med prescribed, Haldol (*serious side effects including confusion, loss of appetite, difficulty walking and speaking, tremors, all of which Alice experienced while on the drug*). Mary refuses transfer & requests emergency consult with UB Chief of Geriatrics.

Aug 18- UB Geriatrician determines that she is not delusional. He recommends removal of all adverse meds. In his opinion, damage done by medication cascade is likely irreparable due to her emaciated state.

Aug 19- Mary told by hospital that Alice's white blood count is alarmingly high. Advised to sign a DNR. Alice is now suffering from C-Diff & Apnea begins.

Aug 20 Alice is 108 lbs. (down 24 lbs.. in 10 days). Unable to eat or drink for days. Mary requests Hospice evaluation. Denied by Hospital MD.

Aug 21 Mary again requests Hospice assessment. Denied again. Mary takes request to admin & is granted. Hospice staff determine she is near death.

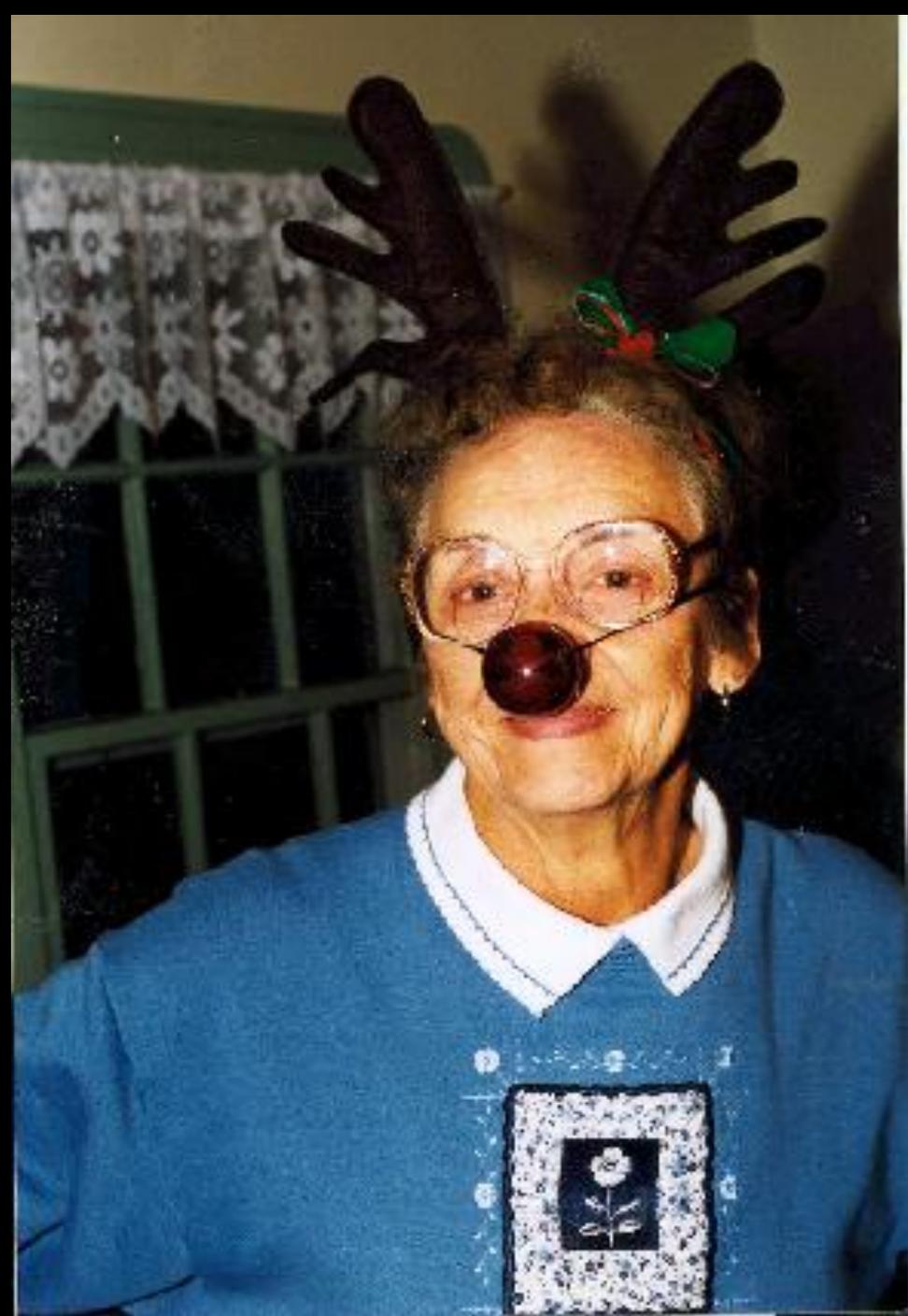
Aug 22- Discharged from hospital to Hospice House..

Aug 24- Upon arrival at Hospice, Alice had MRSA, UTI, C-Diff, & VRE (an often fatal infection).

Aug 29- Alice dies of Sepsis at Hospice -6 weeks after it all began.



**“ A hard task,
dying, when one
loves life so
much.”** Simone De Beauvoir





“Every life deserves a certain amount of dignity, no matter how poor or damaged the shell that carries it.”
Rick Bragg, All Over But the Shoutin’

Aug 22-

- When Alice was discharged from the hospital and taken to Hospice House.
- 5 weeks after the cascade of events began.
- 1 week before her death.





“no plan of care was implemented by nursing to address isolation, the reason for the isolation or interventions implementing isolation.”



**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

Western Regional Office 564 Delaware Avenue Buffalo, New York 14202

Richard F. Deane, M.D.
Commissioner

James W. Clynch, Jr.
Executive Deputy Commissioner

October 26, 2009

Mary Brennan-Taylor
480 Pine Street
Lockport, NY 14094

Re: Complaint #76714
Eastern Niagara Hospital-Lockport Division

Dear Ms. Brennan-Taylor:

The New York State Department of Health (the Department) has investigated your concerns regarding the care provided to your mother at Eastern Niagara Hospital-Lockport Division during her July - August 2009 admission. The investigation consisted of review of your mother's medical record, an unannounced onsite visit, staff interviews, and document reviews.

As a result of this review, the facility was found to be in violation of the State Hospital Code in the area of Nursing Services and Medical Staff. Specifically, no plan of care was implemented by nursing to address the type of isolation, the reason for isolation or interventions implementing isolation, in accordance with the facility policy. Additionally, the physician did not write an order for the category of the type of isolation.

A Statement of Deficiencies has been issued to the facility. In response, the facility will be required to provide a written Plan of Correction and implement corrective measures, acceptable to the Department to address this violation. The Department will continue to monitor the facility's compliance.

Thank you for sharing your concerns with the Department and providing the opportunity for facility review. If you have any questions, you may contact me at (716) 847-4337.

Sincerely,

Vee M. Harris
Health Care Surveyor
Western Region Hospital and Primary Care Services

cc: Kathleen Owens, Western Regional Office



**There is little
more painful
in life than
losing a loved
one to
avoidable
medical error.**

