Uncollected Medication – a case for thought

Doreen was in her 40s. She had been born with Cerebral Palsy and developed Epilepsy, Type 1 Diabetes Mellitus and Hypothyroidism as a young child.
It was thought that she had a degree of learning disability but this was not formally documented in her notes. In **2014** it was recorded that she had a "Persistent Delusional Disorder" in which she lives "*two days behind and frequently attends appointments two days late*" and GP receptionists were reminded to take this into account when advising her of booked appointments.

Doreen had moved into accommodation where she could live independently in **2015** with the support of a housing association. However, she mostly refused to engage with the support workers and would frequently "*tell them where to go*" or refuse to answer the door or be at home for meetings.

She had a hospital admission for Diabetic Ketoacidosis (DKA) in **August 2015**.

Returning home after her admission the next alert the GP received was from the housing association (HA) in August 2016. The HA said that she appeared to have been living without electricity for up to 2 weeks as she had not arranged to re-charge her electricity card. The GP reported this to the Adult Multi Agency Safeguarding Hub (MASH) who investigated and resolved the issue. Her clinical records were flagged “as vulnerable adult”.

At this time the GP also noticed that Doreen had failed to engage with the practice and had not been attending her diabetic reviews since her admission in **August 2015**. With encouragement, she was persuaded to attend for diabetic bloods and reviews with both the nurses and the clinical pharmacist at the practice.

However, Doreen still had a further admission for DKA and hypothyroidism in **October 2016** which was thought to have been related to poor compliance issues. As a result the GP practice arranged a home visit, which found her safe at home and she subsequently attended a diabetic review appointment with the clinical pharmacist in **November 2016**. The GP also alerted her named Social Worker and her Nominated Community Pharmacy to her compliance issues.

On **10th January 2017** the GP practice switched her to weekly scripts in an attempt to make it easier for the pharmacy and the GP to be alerted to any reduced compliance with collecting scripts. On **13th January** the pharmacy advised the GP practice that she had not picked up her medication. This triggered an unannounced GP home visit on **16th January**. Doreen was found to be well, but belligerent and she did not allow any health checks or discussion about her mental health. Due to a misunderstanding between the GP and the SW, no functional mental capacity assessment of her ability and her understanding of the need for her to comply with her medication was undertaken.

Uncollected Medication – a case for thought

On **8th February 2017** the GP based clinical pharmacist phoned the pharmacy and was advised that she had not collected her last 2 scripts.

On **6th March 2017** the GP practice received a "Did Not Attend (DNA)" her Diabetic Outpatients Appointment letter, signalling that she had DNAed six times since 2013.

On **6th April 2017** her pharmacy advised the GP practice that she had attended the pharmacy and collected a week's medication. The last prescription issued was dated 06/04/2017.

There was no further communication documented in the notes until the Coroner called on **1st June 2017** to advise that a very decomposed body had been found at her home address.

What Went Well?

- The Housing Association correctly investigated and alerted GP to her electricity supply issues.
- The GP surgery was aware of the adult safeguarding processes and correctly referred her to Adult MASH
- Adult MASH investigated and resolved her issues with obtaining a consistent electricity supply.
- There was evidence of good liaison between her GP and her social worker. Her case was discussed at regular GP practice meetings and her medical notes were appropriately flagged.
- There was evidence of liaison of the GP practice based pharmacist and her nominated pharmacy re-medicines management and her compliance issues.

What we were worried about?

- The breakdown in communication between the GP and the social worker which meant that there was no official assessment of her functional mental capacity to understand , administer and comply with her regular insulin and thyroxine replacement therapy.
- Although evidence of her collection and failure to collect medication was recorded in the notes, no further actions were triggered after 6/04/2018

Uncollected Medication – a case for thought

What is the learning from this case?

- In this case there was well documented communication between the GP practice, the SW and the patient's pharmacy in an attempt to keep her safe. When reviewed, the GP practice did think that she did understand her need to take her insulin although no formal mental capacity assessment was undertaken. Capacitous patients can choose to make unwise decisions. We will never know exactly why and when she either chose to stop her insulin or she became too unwell to collect it. However, neither the GP practice, nor the social work team nor her pharmacy questioned her whereabouts after 6th April 2017.

- The health service is currently set up as a primarily reactive service and out of sight is more often out of mind due to the enormity of our daily workloads. This lady slipped quietly from our collective sight. We do not know if the pharmacist had alerted the GP that Doreen had not been seen, the outcome would have been different. **We all have patients like her, so please consider using your professional curiosity when you are checking patient's uncollected medication and consider letting the GP know that there could be a problem.**

Dr Pippa Harrold

December 2018