Uncollected medication revisited - a case for thought

The Norfolk Safeguarding Adult Board were recently asked to consider how agencies worked together following the death of a man (C) aged in his 30's with care and support needs.

C had a history of mental health problems and was known to multiple services including the drug and alcohol services, homeless outreach team, primary care and adult social services.

C developed acute psychosis in November 2019 and was detained under Section 3 of the Mental Health Act 1983. He was discharged after one month under a Section 117 aftercare. A **Section 117** is a legal duty placed on health and social care to provide after care services for individuals who have been detained under Section 3,37,47,48 or 45A. It is a legal duty that comes into effect once the person is discharged from hospital with the aim of preventing further admissions. It is a multi-disciplinary and multi-agency responsibility shared by health and social care.

C's contact with his GP surgery was minimal however his surgery prescribed his weekly medication on the advice of his mental health specialist. This consisted of oral antidepressant medication, oral anxiolytic, asthma inhalers and in March 2020, oral antipsychotic medication after the patient reportedly was not concordant with his depot antipsychotic and requested oral medication instead.

The weekly repeat prescription was initially authorised by the responsible GP for 24 weeks on the practice computer system which meant that a medication review task would be triggered after this time. However it transpired that **the IT system would only trigger a medication review task once all 24 authorised weekly issues had been made rather than after a set period of 24 weeks**. C last collected his medication from the appointed pharmacy on 22.06 2020. As there were still 9 authorised weekly issues remaining, no task was generated for the GP to review the patient. The pharmacy did not notify the GP surgery of the uncollected medication but continued to request medication for a further two weeks which the GP surgery duly provided electronic scripts for. When his medication still remained uncollected the pharmacist placed a marker on the pharmacy IT system recording "*medication not dispensed*". **This marker was not visible to the GP surgery**. No further medication was requested and the GP surgery was not notified.

Currently GP surgeries have no means of identifying when patients do not collect medication and generally rely on pharmacy colleagues to notify them. In this case however the pharmacist did not notify the GP as there was an assumption that the patient had either been admitted to hospital again or was on holiday. As a large independent pharmacy there was also a high number of agency staff who were not familiar with C and his circumstances.

The practice was contacted in August 2020 and October 2020 by the police as part of a missing person's enquiry to find out if C had made contact. The receptionists taking the calls informed the police that C had not made contact. In March 2021 C's

allocated care coordinator contacted the surgery and informed the receptionist that C had been missing for 6 months. As there were no actions identified for the receptionist for any of these encounters, the duty GP was not informed. In June 2021 C's mummified body was found by police in a tent in woodland.

This case draws parallels with the case of "Doreen" highlighted by the Safeguarding Adult team in 2016. Doreen too had mental health issues, was homeless and often went missing. She failed to collect her weekly medication and although evidence of her failure to collect medication was recorded in the notes, no further actions were triggered. The case summary can be read here:

norfolksafeguardingadultsboard.info/document/144/DOREEN-A-Case-For-Thought18.12.2018V3-3.pdf?t=d45668238ff1a6f17b35d93041584ff35cfd1fe2

What went well?

- There was evidence of good communication between the community mental health services and the GP surgery.
- C was seen regularly by the mental health team. At his final contact in February 2020 there was evidence that C had capacity to make decisions about his treatment and he was making his own choices when not detained.

What we were worried about?

- There was limited evidence of communication between the GP surgery and pharmacy at the point that C stopped collecting medication.
- There was lack of professional curiosity on the part of the pharmacy when C ceased collecting his weekly repeat medication and instead medication continued to be requested from the GP surgery for a further two weeks.
- There was lack of professional curiosity by the reception team at the surgery when contacted by the police twice during the missing person's enquiry and again by C's care coordinator so the concern was not raised with their senior.
- As part of the enquiry it was understood that C did not have a mobile phone and his homeless status and propensity to travel further hampered communication with C.

What is the learning from this case?

- The health service is a primary reactive rather than proactive service. This has no doubt been aggravated by the covid-19 pandemic which placed greater strain on the delivery of primary care services. This gentleman slipped quietly from our collective sight.
- The importance of good communication between GP surgery staff and between the GP surgery and pharmacy colleagues for vulnerable patients on weekly scripts has been highlighted by this case.
- Please consider coding vulnerable adult in the records and discuss what this means and any actions that should be taken by clinical and non-clinical staff within the practice when supporting such patients.

The importance of applying professional curiosity in safeguarding adults has been highlighted again, 5 years after the case of “Doreen”. The Norfolk Safeguarding Adult Board have produced a useful guide on professional curiosity which can be accessed here: https://www.norfolksafeguardingadultsboard.info/document/351/NSAB-Professional-Curiosity-Partnership-VersionAPR2020FINAL04.pdf?t=9eeba0007cd44a71ff38ccafb5af5539ff4c503e

What are we doing about it?

The importance of the pharmacy notifying the GP surgery when a patient receiving weekly prescriptions has not collected their medication has been shared with Norfolk Local Pharmaceutical committee.

In collaboration with the Norfolk Local Pharmaceutical Committee, Norfolk and Waveney CCG are piloting a scheme whereby the GP surgery places a recurring message on the electronic repeat script with patient consent, for patients deemed to be vulnerable or at risk by the responsible GP. The message will read:

“If this patient fails to collect their repeat medication, please notify the GP surgery”

It is hoped that this simple measure will promote better communication and trigger professional curiosity by all those involved in the care of vulnerable or at risk patients.