Riverside Surgery

www.riversidesurgeryhorsham.co.uk

48 Worthing Road
Horsham
West Sussex
RH12 IUD

T:01403 274700
F:01403 221999

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Dear Sir,

Background to the Regulation 28 Report

I write following the Coroner's inquest into the death of a former patient, Lee Hollman, who died on 23rd February 2013. The inquest was undertaken by the Assistant Coroner, Dr Karen Henderson, on 13th March 2014 at Horsham Magistrates Court.

Riverside Surgery was named as an Interested Person by the Coroner and I attended to provide an account of the care provided to Mr Hollman.

During the course of the inquest, the Coroner noted a number of matters which, although not causative of Mr Hollman's death, were of concern. I refer you to a copy of my letter to the Coroner dated for full details of the background to this case.

The Coroner concluded that Mr Hollman took his own life and issued a report under Regulation 28 to prevent future deaths in relation to Riverside Surgery's

prescribing policy. I enclose a copy of the Regulation 28 Report, as directed to the CCG and Royal College of General Practitioners (RCGP).

NHS England Invovlement

Soon after the event of Mr Hollman's death, the surgery met and submitted a Significant Incident Report. Copies of this report have been forwarded on to The Surrey and Sussex Area Team of NHS England as well as to the CCG.

Prior to the Coroner's inquest I disclosed my involvement to my appointed Responsible Officer [redacted], and self-referred to the Performance Screening Group of The Surrey and Sussex Area Team of NHS England. I have also discussed my professional performance with my Clinical Appraiser

Addressing the Coroner's concerns

As a surgery we are keen to learn from this tragic event and have reflected at great length on the medication errors which occurred. The policy for the issuing of repeat medications has been reviewed and re-written, particularly in respect to psychotropic medications. I enclose the new policy for your review.

We recognise that patients on psychotropic medications are vulnerable, may have altered awareness, suffer compliance difficulties and may exhibit suicidal ideation. Therefore, increased vigilance and review of these medications is required. The new process for providing a patient with psychotropic medication provides an additional review by the prescribing doctor to ensure that the medication prescribed is at the correct dose and that risk of harm is reduced.

I have outlined below how the Riverside Surgery has addressed each of the areas of concern highlighted by the Coroner:

1. ***Failure to maintain sufficiently accurate and updated medical records.***

The medication prescribing process for patients under the care of the CMHT has been revised in the following key respects:

1. Upon seeing a patient recently reviewed by the CMHT, we consider whether we are in possession of the most up to date correspondence and record any issues arising. This informs further collaboration with the CMHT and promotes timely communication between the two organisations.

2. Correspondence received from the CMHT is sent to the GP responsible for ongoing prescribing of medications. The Repeat Prescribing Policy stipulates that any change in medication for a patient under the care of the CMHT may be made only upon receipt of correspondence from the CMHT confirming the new prescription. Any medication change is then recorded in the patient records.

3. When a repeat prescription is stopped, the clinical IT system (TPP SystmOne) requires the user to input the reason why that repeat has been stopped. This reason will subsequently reappear when any attempt is made to reinstate the repeat prescription. This will prompt the reviewing GP to check the recent medication list on the surgery's clinical IT system against the CMHT medication list.

These processes ensures that information about a patient's mental health medication is contemporaneous. Thus ensuring the medical records are accurate and can be relied upon to guide the prescribing of medication safely.

2. Failure to remove Trazodone from the repeat prescription record.

The new measures outlined above ensure that any changes to prescribed medications are properly recorded, with reasons given. The new system also promotes increased vigilance of medication changes by the CMHT. Increased communication with the CMHT ensures that the correct medications are prescribed and issued to the patient.

3. Failure to delete the old dosage of Quetiapine from the relevant medical records.

The key aspects of the new procedure are as follows:

1. There is now a restriction of psychotropic medication to 1 month of issue. Previously such medication could be issued for up to 6 months at a time. After each month a GP is required to re-issue the medication. During this process, the GP will review the prescription in light of the most recent clinical correspondence from the CMHT. Administrative staff can no longer print out an authorised repeat of medication.

2. We have updated the IT system to reinforce the policy. To illustrate this, I enclose screen shots showing the stages of the issuing process. The intention of this change is to reduce the risk of human error.

3. A GP now reviews the medication being prescribed whenever relevant correspondence is received by the CMHT or when the patient requests medication. This increases the number of reviews by a GP to ensure the correct medication and dose are prescribed at the correct time.

4. The lack of an effective system to issue repeat prescriptions.

The revised repeat prescribing protocol addresses concerns about the issuing of the repeat prescriptions. This has been disseminated to all clinical and administrative staff, with a change in the Clinical IT system functioning to support the correct implementation of this policy.

The coroner raised particular concerns regarding the Duty Doctor having to sign all the repeat prescriptions for a particular day. We have subsequently reviewed this practice and now have allocated the signing of prescriptions to the issuing GP, who is likely to be more familiar with the patient and their medication. The significantly reduces the number of prescriptions that each GP will sign on any given day by 66-80% (based on 3-4 GPs on duty).

Prescriptions that run onto multiple sheets will be stapled together, so to avoid being separated. This is important for ensuring that multiple doses of the same medication are visible for review when signing.

5. Failure to review patients within their own guidelines with regard to repeat prescriptions.

Throughout the year the GP's have and continue to hold specific Mental Health Reviews. In the most recent Quality Outcome Framework (QOF - 2013/2014) review of our clinical records confirmed that reviews were being carried out in accordance with the relevant guidelines.

Increasing our communication and collaborative working with the CMHT is ongoing. Increasing the number of steps in the issuing of mental health medications produces a higher number of reviews of the patient record and their medications by the GP.

In addition to the annual mental health review performed by the surgery, there are regular reviews in different forms that mental health patients receive. These are review of specialist consultations through correspondence submitted by the CMHT, case review meetings with the Mental Health Liaison Practitioner and face to face reviews with the patient. This translates to ongoing and regular review of those patients with mental health problems seen by the CMHT along established practice guidelines.

Improved liaison with the Community Mental Health Team

The practice met with representatives from the Horsham Community Mental Health Team (CMHT) on 10th March 2014 to discuss care of patients and to improve communication between our two organisations. We are also due to meet shortly with the recently appointed Consultant Psychiatrist [redacted] [redacted] I enclose the minutes of our recent meeting with our Mental Health Liaison Practitioner.

[redacted] a GP at the practice, has been in contact with Ms. [redacted] Prescribing Advisor, Medicines Management Team at the Horsham & Mid Sussex CCG to discuss further the prescribing of mental health medications, the communication between Horsham CMHT and Riverside Surgery. We are expecting further communication from [redacted] ATS Clinical Lead NWS for Sussex Partnership NHS Trust in this regard.

Conclusion

We hope that the changes introduced at the Riverside Surgery and referred to above will prevent any repetition of the errors that occurred in this case. The processes we have adopted and are in the process of adopting will reduce risk and significantly reduce the chance of similar problems from recurring.

We have significantly modified our policies and processes to safeguard our patients safety and to promote high quality patient care at Riverside Surgery.

On behalf of Riverside Surgery,

Yours faithfully

MB ChB, MRCGP, DCH
GMC: 6118767
GP Principal